Portfolio 1: Major Research Project

Staff Experiences of Their Journey with Trauma-Informed Care in Homeless Services

Clare Weston

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Abstract

BACKGROUND: A paradigm shift in the homelessness sector has been called for given the high prevalence of trauma for people experiencing homelessness (PEH) and the challenging conditions for staff working in the sector. Trauma-informed care (TIC) has been increasingly introduced in homelessness services since the conceptualisation of the framework in 2001 (Harris & Fallot, 2001). Nevertheless, there remains an evidence gap in our understanding of the transition to TIC, particularly in a UK context. Consequently, the aim of this project is to explore the experiences of staff transitioning towards TIC as a contribution towards closing this gap.

METHODOLOGY: A critical realist epistemology served as the foundation to qualitatively explore staff experiences of their journey with TIC in the homelessness sector. The study utilised a trauma-informed research approach to conduct semi-structured interviews with 16 staff from various homelessness organisations across the UK.

FINDINGS: Three main themes were generated using reflexive thematic analysis. First, 'connecting with TIC through trauma itself' revealed the need to address a traumatised sector; staff experiences of emotional resonance with TIC and how TIC supports staff in their work. Second, 'relationships at the heart of the TIC journey' highlighted the importance of client-guided TIC journeys; mechanisms of coming together in TIC and the limits of collectivism in TIC. Third, 'where there is challenge, there is also hope' reflected the systemic challenges faced by staff but also the hope and potential for TIC to transform service delivery, emphasising TIC as a lifelong journey.

CONCLUSIONS AND IMPLICATIONS: The study offers rich insights into staff experiences of their journey in TIC. Strengths and limitations of the study are noted. Recommendations for services include collective care, utilisation of psychological practitioners to support TIC and increasing evaluation practices of TIC in services. Further recommendations for policies and government include co-production, national TIC policies and increased funding for the homelessness sector. Future research may benefit from longitudinal designs to explore TIC journeys at different time points.

Chapter 1: Introduction

1.1 Chapter Overview

The present research explores staff experiences of transitioning to trauma-informed care (TIC) in homeless services. In this chapter, I will elaborate on my personal and epistemological position and define key concepts related to the project. To provide a background for my research, I will discuss homelessness in the context of UK governmental policy and the current provision of UK homelessness services. Psychological trauma, it's impact and the prevalence of trauma for PEH will be denoted. A summary of TIC and it's application in the homelessness sector will be outlined. The chapter will conclude with consideration of the impact on staff working in homelessness and how TIC relates to their work.

1.2 Personal and Epistemological Position

1.2.1 Positioning Myself as a Researcher

Positionality, as defined by Savin-Baden and Major (2013), represents the researcher's chosen perspective in a study, influencing the research process and its outcomes (Rowe, 2014). Positionality further refers to an individual's worldview and their stance on a research task within its social and political context (Savin-Baden & Major, 2013; Rowe, 2014).

In Appendix A, I reflect on my professional context that contributes to my positionality. Here, I will discuss my personal positionality. As a White British, middle-class, able-bodied, cis-gendered female Clinical Psychologist-in-training, I recognise my many privileges and believe I have a responsibility to contribute to redistributing power within society to those in less privileged positions.

Experiencing multiple traumas has fuelled my passion for researching TIC. Understanding my own trauma, its effects on my body and my interactions with the world has been healing for me. I believe that enabling an understanding of trauma for survivors is crucial for recovery.

Experiences of frequent moving, re-locating across the UK several times, and a brief period of housing instability have often led me to ponder what makes a home. These experiences highlighted my own privileges, allowing me to consistently have a secure roof over my head during these transitions. Having friendships with people who were experiencing homelessness and witnessing them encountering challenges with services who struggled to recognise how trauma was impacting their ability to receive help left me feeling frustrated. The present project felt essential to enact my privileges and actively participate in developing services to provide a different path forward for my friends and others in a similar position.

1.2.2 Epistemological Position

This research was undertaken from a critical realist epistemological stance. Critical realism (CR) is a philosophical approach that asserts that there is a reality independent of our thoughts and perceptions, but our understanding of this reality is mediated by human experiences and social constructs (Bhaskar, 2008). Combining a realist ontology, which acknowledges the existence of objective structures and mechanisms, with a constructivist epistemology, which recognises that our knowledge of these structures is inherently fallible and socially influenced (Sayer, 2000). CR seeks to identify and explain the underlying causes and mechanisms that generate observed phenomena, emphasising the importance of context and the interplay between structure and agency (Archer et al., 2016).

This approach is particularly fitting for researching TIC in the homelessness sector as it recognises both homelessness and trauma as real phenomena while understanding that PEH's experiences are influenced by their socio-cultural contexts (Sayer, 2000). CR allows for a nuanced exploration of how trauma and homelessness intersect, considering the layered and subjective experiences of individuals. Additionally, it emphasises understanding the underlying mechanisms and contextual factors influencing observable phenomena, making it suitable for examining staff experiences in TIC. This philosophical approach acknowledges the complexity of social realities,

allowing researchers to explore how structural conditions, such as policies and organisational cultures, interact with individual experiences of TIC (Bhaskar, 2008). CR can facilitate a comprehensive analysis that uncovers the causal mechanisms behind staff perceptions and practices (Archer et al., 2016). Moreover, it supports the identification of power dynamics and systemic issues that may affect the implementation and effectiveness of TIC, providing a robust framework for developing strategies to improve support for both staff and clients in the homeless sector (Fletcher, 2017; Houston, 2010).

1.3 Key Concepts

1.3.1 Homelessness

Defining homelessness is a complex task, as it's a phenomenon with varying economic, socio-political, cultural and structural factors influencing its existence (Hopper, 2012). Presently, the Housing Act (1996) in the UK defines homelessness as 'rooflessness' and 'houselessness'. Section 175 expands to define a person who experiences homelessness as an individual who may be at risk of violence or domestic abuse; no accommodation available to them to occupy; it is not reasonable for an individual to continue to occupy the accommodation available to them; no secure entry to accommodation; no legal right to accommodation or lives in a mobile vessel that does not have a place to be kept (Housing Act, 1996).

The European Federation of National Organisations Working with the Homeless (2017) devised the European typology of homelessness and housing exclusion (ETHOS) with four conceptual categories, 'roofless' 'houseless', 'insecure' and 'inadequate', with further operational definitions and examples of living situations that may fall within the above concepts. Recognition of factors such as unfit housing and threat of eviction within the latter two concepts offers a broader recognition of the challenges faced by people experiencing homelessness. ETHOS' (2017) definitions also acknowledge more hidden forms of homelessness, such as temporary accommodation with friends or family; living in extreme overcrowded conditions and people living under threat of violence in their home. ETHOS

has been named as a global definition of homelessness and will be used as the main definition in this project (Busch-Geertsema et al., 2015).

1.3.2 People Experiencing Homelessness

There have been varying terms used to identify individuals who experience homelessness in the literature. It has been argued that using terms such as ‘homeless people’ can dehumanise someone who is experiencing homelessness whilst removing the opportunity of hope by insinuating a permanent status of being without a home (Williams, 2022). It has been suggested that the term ‘people experiencing homelessness’ (PEH) centres the person first, allowing for recognition of an experience without it defining them (Palmer, 2018). Tsai et al. (2023) conducted a survey to explore preferred terms within this population, and adults with histories of homelessness were found to be more likely to use the term “person experiencing homelessness” than “homeless person”. Thus, PEH will be used as the term to discuss the population centred in this research. Clients will also be used as a term to describe PEH who are using homelessness services, following the language utilised by participants in the study’s findings.

1.3.3. Multiple Disadvantage and Complex Needs

Increasing national awareness in the UK of intersecting inequalities has led to concepts like 'multiple disadvantage' and 'complex needs,' encompassing substance misuse, criminal justice contact, mental health issues, and homelessness (Department for Levelling Up, Housing and Communities and Ministry of Housing, Communities and Local Government, 2021). Evidence highlights systemic barriers for those facing multiple disadvantages, aiming to create holistic services (Lamb et al., 2019; McCarthy et al., 2020). While it is crucial to understand the interrelation of these experiences, the evidence does not always denote specifically that experiencing homelessness is included in the presentation. Homelessness presents unique challenges that require distinct research to better inform the understanding of multiple disadvantage. This report focuses on experiences of homelessness to enhance knowledge in this area.

1.3.4 Trauma-Informed Care

There have been varying definitions offered for TIC in existing literature (Harris & Fallot, 2001; Elliot et al., 2005; SAMHSA, 2017). The present project will utilise the Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines due to their international recognition and representation in UK government guidelines (Office for Health Improvement & Disparities, 2022).

SAMHSA offer the following definition of TIC, integrating the four 'R' key assumptions:

> *A program, organisation, or system that is trauma-informed realises the widespread impact of trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatisation. (SAMHSA, 2017, p.9)*

SAMHSA's (2017) framework further denotes six key TIC principles: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice and cultural/historical/gender issues. To provide guidance on implementation, SAMHSA (2017) suggest ten implementation domains of TIC to be considered within organisations based on previous evidence establishing TIC (Elliot et al., 2005; Fallot & Harris, 2006; Farragher & Yanosy, 2005; Huang et al., 2012). These domains include governance and leadership, policy, physical environment, engagement and involvement, cross-sector collaboration, screening, assessment and treatment services, training and workforce development, progress monitoring and quality assurance, financing and evaluation. The present project utilises these principles and implementation domains to guide the systematic literature review (SLR), the study's participation criteria and the recruitment process.

TIC has been considered as moving away from a traditional medical model of "What is wrong with you?" to a story-based approach of "What happened to you?" (Sweeney et al., 2018).

1.4 Understanding Homelessness

Homelessness is a pressing social issue that affects individuals and communities worldwide, with far-reaching consequences on health, wellbeing, and social stability (Fazel et al., 2014; Busch-Geertsema et al., 2010). Research indicates that a complex interaction of structural and psychosocial factors significantly heightens the likelihood of an individual becoming homeless (Anderson & Raynes, 2004; Fazel et al., 2014). Poor housing provision, restricted welfare support, poverty, and varying forms of oppression are some factors that can lead to homelessness and generate barriers to exiting this status (Anderson & Christian, 2003; Giano et al., 2020). PEH frequently have complex needs (Fitzpatrick et al., 2015). Compared to the general population, PEH have reduced health outcomes, with higher mortality rates and greater complexity in health status (Aldridge et al., 2019; Rogans-Watson et al., 2020). Life experiences of PEH are frequently associated with addiction, mental distress, violence, neglect or trauma (Buccieri et al., 2020; Whitbeck et al., 2015). Further challenges exist in the social and structural contexts that precipitate and perpetuate difficult experiences for PEH.

Accounting for the quantity of individuals who experience homelessness is a challenging task, as the varying definitions mean that often individuals are not counted within official figures. The statutory homelessness figures in 2022-23 estimated 298,430 households required assistance from councils in England to prevent or relieve homeless, and 104,510 households were in temporary accommodation, an increase of 10% from the previous year (Department for Levelling Up, Housing and Communities (DLUHC), 2023). Government snapshot data estimated 3,069 individuals sleeping rough on a single evening in autumn 2022, a 26% increase from the previous year (DLUHC, 2023). Additionally, Shelter estimated 271,000 people were experiencing homelessness in England in January 2023, with 1 in 208 people living without a home (Shelter, 2023). The significant and increasing numbers of PEH underscore the importance of developing best practices to support this population.

1.5 Homelessness Services and Related Policies

Understanding governmental policies is crucial for contextualising current service provision and the historical development of homelessness services. In 2002, the government reformed the Homelessness Act (2002), recognising that existing legislation was insufficient to cope with the rising numbers of homelessness in the late 1990s and early 2000s in the UK. The Homelessness Act (2002) transferred responsibility from central government to local authorities to manage service providers and develop local homelessness strategies. The 2003 Supporting People programme (Jarrett, 2012), run by local government and the voluntary sector, provided housing support regardless of housing status, consolidating various funding streams. Due to this transition, statutory funding streams such as the supportive housing maintenance grant and transitional housing benefits were lost. Local authorities now oversee strategy and funding for single homelessness services, with voluntary organisations as primary providers (Blood et al., 2020). Settings include hostels, supported accommodations, physical healthcare services, outreach teams and mental health teams. As a consequence of a lack of a unified strategy and provider system, it is usual that PEH will have to access several supportive organisations dependent on their needs, highlighting the importance of multi-agency collaboration (Blood et al., 2020). Buckingham (2009) noted this shift might increase demands on voluntary organisations and their staff, requiring new skills and expertise.

A further key governmental strategy informing homelessness services includes the Ending Rough Sleeping for Good strategy (DLUHC, 2022), which specifically targets people sleeping rough, e.g. sleeping outside or in places not designed for living (Public Health England, 2020). The strategy names the importance of integrated services, providing increased funding for drug and alcohol treatment teams to support cooperation with outreach teams, hostels, and third-sector organisations (DLUHC, 2022). The strategy further recognises the rising mental health needs of PEH, with 82% of PEH respondents self-reporting having a mental health vulnerability (Ministry of Housing, Communities & Local Government, 2020). However, criticisms of the strategy include

insufficient investment in mental health services and a shortage of affordable housing (Kerslake Commission, 2023). Further criticism can be seen in the 27% increase of rough sleeping from 2022 to 2023 (Shelter, 2024); therefore not meeting aims to end rough sleeping by 2024 as initially proposed by the Conservative and Unionist party manifesto (2019) and corroborated by the strategy (DLUHC, 2022). These policies and strategies illustrate how the homelessness sector has been characterised as a 'traumatised system' (Blood et al., 2020), given the ongoing challenges that services are navigating in their attempts to provide coordinated, comprehensive support for PEH.

1.6 Psychological Trauma

The definition of trauma has evolved in its conceptualisation, rooted initially in war and military contexts, and notably defined as post-traumatic stress disorder (PTSD) in the DSM-III after the Vietnam War (American Psychiatric Association, 1980; Jones & Wessely, 2006). The 1960s social revolution and women's rights movement increased recognition of marginalised groups and victims of interpersonal violence (Figley, 2002; Olff et al., 2007). Consequently, the DSM-IV broadened the definition of trauma stressors (Andreasen, 2010). The DSM-5 was further rectified to acknowledge traumatic events having an impact either witnessed, experienced indirectly or directly (American Psychiatric Association, 2013). This evolution has driven the development of trauma-focused therapies and the recognition of long-term effects, leading to a need for developing TIC frameworks (Greene et al., 2004; Harris & Fallot, 2001).

Trauma includes the effects of disasters, accidents, violence, neglect, abuse, and betrayal (SAMHSA, 2014). Recognising social traumas like inequality, racism, poverty, and historical trauma is crucial (Kirmayer et al., 2014). Homelessness has been recognised as a traumatic event, as seen in Tsai et al.'s (2020) research, whereby 14.1% reported homelessness as their worst traumatic event. Research links trauma to mental distress, such as depression, psychosis and anxiety (Sweeney et al., 2016). Public opinion also sees trauma as a contributor to mental health issues (Angermeyer & Dietrich, 2006). Neuroscience shows childhood trauma impacts adult brain function (Teicher et al.,

2016). Lower socioeconomic groups and the global majority are more likely to experience trauma (Hatch & Dohrenwend, 2007).

Trauma's impact highlights the need for trauma-informed approaches. Those diagnosed with PTSD may experience sleep difficulties, emotion dysregulation, memory disturbances, dissociative episodes, and aggression (Van der Kolk et al., 2005). Trauma can manifest physically through stress-related symptoms (Van der Kolk et al., 2005). Continuous trauma exposure affects emotional wellbeing, cognition, relationships, and identity (Centre for Substance Abuse Treatment, 2014). Traumatic experiences can overwhelm coping resources, alter perceptions, and lead to behavioural changes, impacting interactions with support services (Clervil & DeCandia, 2013). Effective support requires understanding the causes of behaviour and offering flexible, personalised care, considering trauma's extensive effects and diverse coping strategies (Harris & Fallot, 2001). Given this background on psychological trauma, it's important to explore its prevalence among those accessing homelessness services.

1.7 Prevalence of Trauma in Populations Accessing Homelessness Services

PEH are more likely to have experienced trauma in comparison to the general population (Bassuk et al., 2001). Ayano et al. (2020) conducted a meta-analysis of 19 studies across seven countries with 20,364 participants, finding that 27.38% PEH met criteria for a PTSD diagnosis. Similarly, Deck & Platt (2015) identified that 30% of their sample of PEH met the criteria for PTSD, but many of this population did not report any other traumatic events beyond losing their own home. Several studies have demonstrated that PEH experience both in childhood and adulthood a higher number of traumatic events and adversities (Liu et al., 2021; Sundin & Baguley, 2015; Woodhall-Melnik et al., 2018). Edalati et al. (2017) explored adverse childhood experiences (ACEs) among PEH, reporting 66.4% experienced emotional abuse, 32.7% experienced sexual abuse, and 43.9% experienced physical abuse, further noting homelessness itself as a traumatic event experienced. Additionally, evidence suggests a correlation between marginalisation, racism, oppression and a

history of trauma with lifetime homelessness (Fusaro, Levy & Schaefer, 2018; Olivet, Dones & Richard, 2019).

Whilst traumatic experiences can be a risk factor for someone likely to experience homelessness, the settings of services and their processes for accessing support have been reported as traumatic at times in themselves (Coates & McKenzie-Mohr, 2010; Yatchmenoff et al., 2017). Furthermore, the experience of homelessness has been documented as an increased risk for experiencing trauma and a greater likelihood of causing trauma reactions or re-traumatisation for those with a history of trauma (Pope et al., 2020). One explanation offered for this includes the use of shelters or precarious housing situations can limit one's coping strategies (Crawford, 2022). Riley et al. (2020) found that PEH were more likely to be criminally victimised in comparison to individuals with stable housing. The notion of homelessness as a traumatic event supports the need for trauma-informed interventions and approaches within services.

1.8 Towards Trauma-Informed Care

TIC was initially developed in the USA by Harris and Fallot (2001), calling for a paradigm shift in light of recognising services were not built at the time to recognise the impact of trauma in individuals, risking re-traumatisation. Harris and Fallot (2001) suggested the delivery of services should be informed by understanding the effects, impacts and prevalence of trauma for individuals, with four principles underpinning: understanding trauma, understanding trauma survivors, understanding services and understanding the service relationship. Building on this, Elliot and colleagues (2005) provided ten principles of TIC following investigations of trauma-informed services providing support to women who had experienced interpersonal violence. Example principles include minimising re-traumatisation and emphasising client strengths (Elliot et al., 2005). The development of TIC has been heavily influenced by the ACES study, which focuses on events like childhood abuse and household dysfunction (Felitti et al., 1998). However, this framework often overlooks the impacts of societal discrimination, such as racism, ableism, homophobia and more

(Bernard et al., 2021; Wade et al., 2014). Therefore, it's crucial to balance privileged trauma conceptualisations with those less recognised, like the above, in the delivery and research of TIC. SAMHSA's (2017) definition depicted in section 1.3.3 has been scaffolded through the previous collective evidence offered on TIC (Feltiti et al., 1998; Harris & Fallot, 2001; Elliot et al., 2005).

At present, there is debate on the scope and nature of TIC, as it is a concept that has been viewed as a culture, organisational structure as well as a treatment framework (Hopper et al., 2010; Bateman et al., 2013). Several external mechanisms have been recommended regarding the implementation of TIC such as trauma-informed supervision, reflective practice, trauma-informed training, trauma-informed leadership and utilising trauma-informed policies (SAMHSA, 2017; Bristol, North Somerset and South Gloucestershire (BNSSG) Trauma working group, 2021). TIC has been a growing paradigm across multiple sectors such as education, the criminal justice system, mental health and substance misuse (Purtle, 2020).

Within a UK context, TIC was recognised in the NHS Long-Term Plan (2019) and NHS Mental Health Implementation Plan (2019). Further acknowledgement has been seen in NHS Education for Scotland (2017), Public Health Wales (2016) and Safeguarding Board for Northern Ireland (Bunting & Montgomery, 2019), recommending TIC in public services. Becoming a trauma-informed organisation has been explained as a transformation process rather than a one-off goal within these documents. Despite widespread acknowledgement in national, regional and local policies in the UK; approaches remain driven from the bottom-up by key leaders within local authorities or smaller-scale organisations in England, who are calling for more co-ordinated working to be supported by the UK government and NHS leaders (Emsley, Smith, Martin & Lewis, 2022). An evidence-policy gap has been named whereby UK policies on the implementation of TIC have not been backed with UK-specific, methodologically robust evidence for the effectiveness of the approach (Emsley, Smith, Martin & Lewis, 2022). Evaluating large system transformation can prove methodologically

challenging, requiring support from funders and commissioners. Consequently, there remains a gap in UK-based evidence to support the notion of TIC being implemented within healthcare services.

1.8.2 Trauma-Informed Care in Homelessness Services

TIC has been increasing in it's presence across the homelessness sector in countries such as USA (Barry et al., 2023; Edwards et al., 2023; Sullivan et al., 2018; Ward-Lasher et al., 2017), Canada (Kahan et al., 2019; Schiff et al., 2019), Australia (Every et al., 2020; O'Connor et al., 2023) and the UK (Burge et al., 2021). Given the evidence of high prevalence of trauma for PEH, the framework offers potential to guide services to provide holistic, effective care (Milaney et al., 2020). Existing evidence of implementation of TIC is limited, predominantly situated with quantitative data offering promising initial findings for improvements for PEH (Crawford, 2022; Edwards et al., 2023; Sullivan et al., 2018). Further discussion of TIC implementation has been offered by experts in the field within opinion articles (Prestridge, 2014; Radis, 2020). However, there is a notable gap in the empirical literature in understanding the process of change to TIC within homelessness. Other domains of support, such as forensic services (Stamatopoulou, 2019) and mental health services (Palfrey et al., 2018), have explored the transition to TIC, providing insight into the realities of policy and research translated into practice. Further evidence is warranted to support understanding in the homelessness sector regarding transitioning to TIC, spotlighting potential enablers and barriers.

1.8.3 Trauma-Informed Care and Psychologically Informed Environments

When considering TIC in homelessness services, it is important to highlight its sister approach, Psychologically Informed Environments (PIE). Homeless Link (2024) have provided briefings on PIE and TIC as distinct yet interrelated mechanisms of improving service support for PEH. PIE can be considered as an overarching framework to implement psychological theory to inform practice and within environmental design (Keats et al., 2012). Keats et al.'s (2012) guidance recommends PIE as a method of working with people with histories of complex trauma who were either experiencing homelessness or at risk of losing their home. PIE can be viewed as holding five

key areas: developing psychological awareness, staff training and support, learning and enquiry reflection, spaces for opportunity, as well as the 3 Rs (rules, roles and responsiveness) (PIElink, 2017). Whilst TIC's origins began in the US, PIE was generated in the UK as part of the Royal College of Psychiatrists' Enabling Environments Initiative (Keats et al., 2012). TIC can be viewed as a branch of PIE, whereby it utilises psychological theory with an explicit trauma focus (Homeless Link, 2024). PIE emphasises creating supportive environments that address the psychological and emotional needs of individuals, whereas TIC specifically aims to recognise and address the impact of trauma within these environments (PIELink, 2024). With growing recognition of the high prevalence of trauma for PEH, for staff working within services and within the homeless sector itself, there has been a growing pull towards utilising TIC to address the aforementioned factors (Ayona et al., 2020; Blood et al., 2020; Homeless Link, 2024; Schiff & Lane, 2019). The evidence gap surrounding TIC has been exacerbated by the emphasis on PIE in the UK (Lemieux-Cumberlege, 2022).

1.8 Staff in Homelessness Services

Staff in homelessness services face increasing pressure due to the rise in UK homelessness and "traumatising" commissioning conditions (Blood et al., 2020). Overwhelming demand results in relentless workloads and unrealistic expectations of staff (Peters et al., 2022; Wirth et al., 2019). This pressure is exacerbated by inadequate social and emotional support, insufficient training, low pay, workplace discrimination, and complex team dynamics, all impacting staff wellbeing (Kerman et al., 2022; Wirth et al., 2019). Emotional strain is heightened by the need to support individuals with severe disadvantages, exposing staff to threats, violence, overdoses (Kerman et al., 2022; Wallace et al., 2018), and frequent death (Lakeman, 2011; Valoroso & Stedmon, 2020). Continuous exposure to trauma can lead to secondary traumatic stress or vicarious trauma (Schiff & Lane, 2019).

Research highlights the psychological impacts on staff in this sector. Maguire et al. (2017) noted a lack of studies on burnout among frontline staff. To address this evidence gap, Schiff & Lane (2019) found high PTSD rates (33%) among Canadian homelessness service staff. Wirth et al. (2019)

reported significant mental health difficulties among staff, citing stressors like helplessness in effecting change and difficulties with maintaining professional boundaries. Similarly, a systematic review found staff often feel helpless due to inadequate organisational systems (Peters et al., 2022). Lemieux-Cumberlege & Taylor (2019) reported high depression and stress levels among UK staff, with organisational support playing a crucial role in mitigating these effects. Therefore, exploring support mechanisms for staff is vital for enhancing their wellbeing whilst ensuring the sustainability and quality of homelessness services.

1.9 Trauma-Informed Care and Staff in Homelessness Services

Despite the growing recognition of TIC, how staff experience using this approach and its impact remains largely unexplored. The literature on trauma and TIC has expanded significantly in recent years, primarily focusing on the prevalence and mitigating factors of trauma for service recipients rather than staff (Edwards et al., 2023; Hetling et al., 2018; Kahan et al., 2020; O'Connor et al., 2023; Sullivan et al., 2018). Research has also examined the implementation of TIC training (Burge et al. 2021), but significant gaps persist in understanding how TIC interacts with staff wellbeing. Given the high rates of traumatic stress among staff, it is crucial to investigate if TIC mitigates these experiences (Schiff & Lane, 2019). SAMHSA's (2017) TIC guidelines dictate a high sense of responsibility for staff to consider multiple aspects of TIC implementation, but given the existing sociopolitical pressures, one wonders how this is experienced in practice by staff pivotal to shifts in service delivery.

Chapter 2: Systematic Literature Review

2.1 Overview

A systematic literature review (SLR) is a methodology for collating, identifying, and analysing studies within a systematic procedure to provide conclusions on a particular topic and identify any gaps in knowledge for further investigation in research (Siddaway et al., 2019). This section details a SLR to explore the current understanding of the implementation of TIC in the homeless sector, given the discussion in Chapter 1 highlighting an evidence gap within this field.

2.2. Rationale for the Current SLR

An existing literature review was found by Hopper et al. (2010), which summarised existing research on TIC in the homelessness sector from both empirical and non-empirical sources, providing an oversight of existing approaches since TIC's conceptualisation (Harris & Fallot, 2001). The authors noted that the available research was insufficient for evaluating TIC in the homelessness sector, prompting them to include evidence from substance use and mental health fields in the review (Hopper et al., 2010). The review suggested initial promising findings for TIC's effectiveness; however, the authors emphasised the need for more empirically-based practices specific to homelessness (Hopper et al., 2010). Fourteen years later, it is crucial to explore whether recent literature offers new insights into the developments of TIC in the homeless sector.

An initial scoping literature search[1] found that many papers discuss the use of TIC integrated with other approaches, causing difficulty in isolating out the specific effects of TIC (Edalati et al., 2020; Every & Richardson, 2018; Wood et al., 2020). This is supported by Hanson & Lang (2014) who describe TIC as "an amorphous concept that has been defined in a number of ways, making it difficult to evaluate [trauma-informed] initiatives" (p.96). The scoping review also demonstrated that

[1] A scoping review can be defined as a method of literature searching that provides an overview of a broad topic, allowing for exploration of the general related literature within a topic as opposed to providing answers to a limited question associated with a systematic literature review (Peterson et al., 2017). This was carried out in September 2023 on Google Scholar and the University of Hertfordshire library database.

the literature now available on TIC in the homeless sector is situated in a wide variety of sources, including grey literature such as opinion pieces, unpublished evaluations, non-peer-reviewed reports and reflective accounts.

Whilst value is found in these forms of knowledge and grey literature can be a crucial source of information in systematic reviews (Paes, 2017) as well as reducing publication bias (Adams et al., 2016), this SLR focuses on empirical research. This is to address the concerns of the aforementioned existing review (Hopper et al., 2010), to maintain a quality standard of included articles, and with the hope that using systematic, replicable methods of research will provide much needed clarity on the TIC approach. Consequently, the present SLR aims to provide an updated synthesis of existing literature, to answer the question:

What does the empirical literature tell us about trauma-informed services in the homelessness sector?

2.3 SLR Methodology

2.3.1 Search Strategy

A systematic literature search was initially carried out in September 2023 and updated in January 2024. The following databases were searched using terms in Table 2: Scopus, PsycINFO, PsycArticles, PubMed, CINAHL and MEDLINE due to containing journals relating to trauma and/or the homeless sector. A further search was also conducted on Google Scholar to determine if there were any other sources of empirical literature beyond the initial databases chosen that may support the aims of the SLR. On Google Scholar, the titles were screened up until the 33rd page of studies found and concluded after 4 consecutive pages displaying non-relevant literature. A further search of Cochrane and Prospero databases were carried out to check there were no similar literature reviews in progress.

The SPIDER tool (Cooke et al., 2012) was utilised to support planning the search strategy (Table 1).

Table 1

SPIDER Tool

	SPIDER	
S	Sample	Homelessness sector, people experiencing homelessness, staff working in homelessness
PI	Phenomenon of Interest	Trauma-informed care
D	Design	Empirical literature of any research design
E	Evaluation	Outcomes, experiences, views
R	Research type	Qualitative, quantitative and mixed methods empirical studies.

The final search terms are listed in Table 2 below, following a discussion with a specialist librarian and an initial scoping review. The search terms were determined utilising the University of Hertfordshire library's search planning form (Appendix B).

Table 2

Search Terms

Concept 1		**Concept 2**
Homeless* OR housing	**AND**	Trauma-informed* OR Trauma informed*

Concept 1. The term homeless* was chosen as this allowed for breadth of identifying papers which utilised different characterisations of homelessness which has shifted over the aimed publication date period, e.g. either "homeless people" or "people experiencing homelessness". Housing was chosen as an additional term to capture research that discussed utilising TIC for transitional housing, which meets the definition for PEH (Housing Act, 1996).

Concept 2. Search terms were initially drafted as "trauma-informed care", "trauma-informed practice" and "trauma-informed approach". Recognising that these search terms eliminated some initial key papers, the search terms were broadened to "trauma-informed*" to ensure all potentially eligible papers were captured.

Terms such as “implementation,” “implementing,” “delivery,” and “transition*” were further considered as additional search terms to identify literature detailing the TIC process. However, these terms did not provide a breadth of papers; therefore, a broader approach to searching was maintained.

2.3.2 Inclusion/Exclusion criteria

Table 3 depicts the SLR’s inclusion and exclusion criteria determined to answer the review question. Papers utilising a range of data (e.g. mixed methods, qualitative and quantitative) were included. This was due to the little research identified on this topic from the scoping review, and to capture all available empirical information in this area.

It was chosen to examine TIC practices relating to adult populations only since children, young people or families who may be experiencing homelessness have different needs, governmental policies and service guidelines, thus warranting a separate review (Murran & Brady, 2023). Given the nature of TIC being interpreted in varying ways depending on context, SAMHSA’s (2017) ten implementation guidelines and six key principles of TIC (pg. 14) were utilised as an established standard to identify relevant papers using the intervention. Additionally, papers were only included if they were discussing TIC as a standalone intervention[2] in order to assess the associated impact and outcomes.

[2] An example of an integrated intervention can see been in Wood et al. (2020) whereby TIC was combined with a survivor-centred advocacy approach, resulting in difficulty ascertaining the specific effects of TIC.

Table 3

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion criteria
Articles/studies published in the English language only	Articles published in any language other than English
Published during and after 2001. Date limited from 2001 onwards due to the first conceptualisation of the TIC framework (Harris & Fallot, 2001)	Published prior to 2001
Empirical in nature: Qualitative studies, RCTs reporting baseline data, Mixed methods studies, Quantitative descriptive studies, and Quantitative non-randomised controlled trials (including cohort studies, case control studies, and cross-sectional studies) will be included	Descriptive in nature: Narrative review material only, literature reviews, editorials, book chapters and commentaries, opinion pieces, review articles, discussion papers, letters or editorials
Services providing support for PEH aged 18 and over (e.g. shelters, housing, third sector organisations, NHS providers).	Study designs that include dissertations, conference abstracts, systematic reviews, meta-analyses
The implementation of TIC according to one of SAMHSA's (2017) 10 implementation guidelines discussed in more than one section of the paper	Trauma approaches which are not fitting with SAMHSA's (2017) principles; assumptions or implementation guidelines for TIC
Adherence to SAHMSA's (2017) six key principles of TIC	Not enough information within the literature to ascertain TIC definition and implementation (e.g. evidenced by referencing the approach in at least 2 of 4 sections: introduction, methods, results and discussion)
TIC as a singular intervention approach	Papers that discuss the implementation of TIC combined with other theoretical approaches or interventions
	Studies discussing the prevalence of trauma and TIC discussed as a recommendation, not as an active intervention implemented within the research
	Solely focused on trauma-focused therapies e.g. trauma-informed cognitive behavioural therapy; eye movement desensitisation and reprocessing (EMDR) therapy, etc.

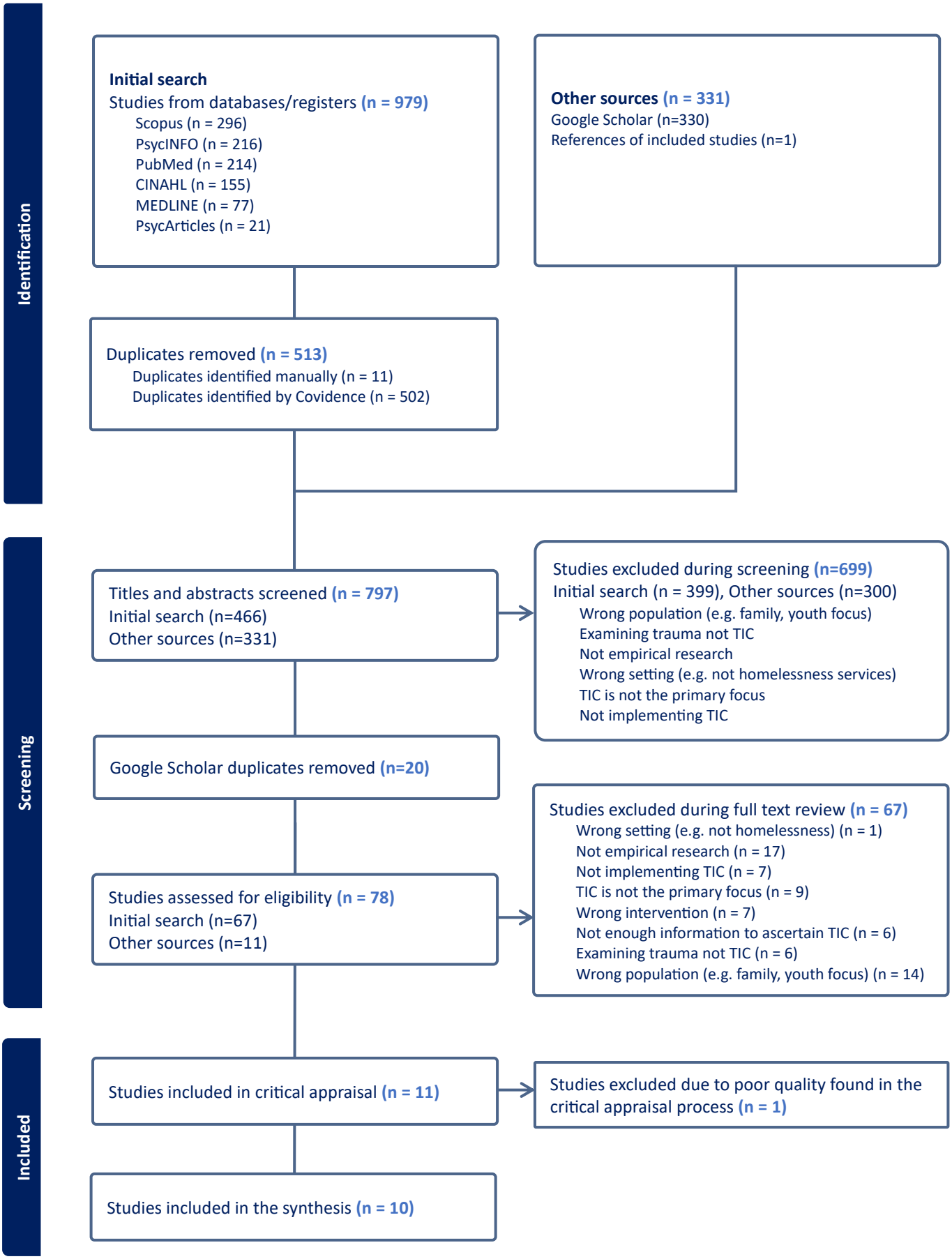
2.4 Results of the SLR Search

The initial search identified 979 papers, of which 513 duplicates were removed. Titles and abstracts of the remaining 466 papers were screened using the inclusion and exclusion criteria, removing a further 399 papers. Title and abstracts of Google Scholar articles up until 330 items were screened and resulted in the exclusion of 300 articles. Following this, 20 Google Scholar articles were

manually removed due to duplication with the initial search results. A total of 77 papers were screened in the full-text review, leading to 10 papers meeting criteria for inclusion in the review. The references of the 10 papers were hand-searched to identify any additional papers that met inclusion criteria, leading to a further paper identified for inclusion for quality appraisal. A total of 11 papers were critically appraised. The process is outlined in Figure 1.

Figure 1

PRISMA Diagram



2.4.1. Summary of Included Papers

A total of 11 papers were included for the quality check and critical appraisal. The sample of papers included six quantitative papers (Burge et al., 2021; Crawford, 2022; Edwards et al, 2023; O'Connor et al., 2023; Schiff et al., 2019; Sullivan et al., 2018), four qualitative papers (Barry et al., 2023; Every et al., 2020; Hetling et al., 2018; Kahan et al., 2023) and one study using mixed methods (Ward-Lasher et al., 2017). Table 4 depicts a summary of each paper.

Table 4

Summary of Included Papers

Author(s), Year of Publication, Title	Context & Participant characteristics	Aim of the study	Methodology & Outcome measures (if applicable)	Analysis	Results, Key Findings & Conclusions	Strengths	Limitations
Barry, A., Hoffman, E., Martinez-Charleston, E. DeMario, M., Stewart, J., Mohiuddin, M., Mihelicova, M. & Brown, M. (2023) **Title:** Trauma-informed interactions within a trauma-informed homeless service provider: Staff and client perspectives.	**Context:** Homeless service organisations in a large Midwestern city in USA. **Participant characteristics:** 29 participants in total. 17 service providers who had worked in the HSO minimum for the last 12 months: 66.7% were cisgender women, mean age 40.1, 50% White, 5.9% Hispanic and 16.7% Black American. 17 service participants who had received services from the HSO in the last 6 months: 58.8% were cisgender	This study aims to provide practical insights for developing trauma-informed interaction strategies between service providers and participants in homeless service organizations (HSOs).	Qualitative - semi-structured interviews and a demographic survey. No outcome measures used.	Thematic analysis – Braun & Clarke's approach (2006).	Six themes regarding provider approaches to TIC interactions with participants: provide a sounding board, promote safety, foster understanding and respect, build relationships and trust, facilitate connection to services, and ensure flexibility in service provision. Participants noted three themes regarding their views of TIC interactions with providers: possess education and experience, build relationships and	Exploration of themes according to both sets of participants in order to provide nuanced understanding. Utilisation of four coders to support rigour of analysis.	Vulnerable to sampling bias due to reliance on purposive sampling. Single setting focus in a specific geographical region may limit generalisability to other settings. Unclear on researcher positionality.

	women, mean age 52.6, 76.5% Black American, 5.9% American Indian, 3.3% Hispanic, 11.8% White.	trust, and demonstrate supportive interpersonal styles.

Burge, R.,Tickle, A. & Moghaddam, N. (2021) **Title:** Evaluating trauma-informed care training for services supporting individuals experiencing homelessness and multiple disadvantage.	**Context:** Seven services supporting people experiencing homelessness within the same organisation in the United Kingdom. **Participant characteristics:** Staff from seven services for people experiencing homelessness who attended a four day training event. 88 participants completed one time-point measure of TICOMETER. 80 completed responses at baseline, 18 responses post-training, 26 responses for follow up (one year). 9 of those completed all three time points.	To explore the effects of a four-day TIC and psychologically informed environments training package across seven services.	Quantitative - outcome measure delivered at pre-training, post-training and follow-up. **Outcome measures:** TICOMETER.	Effect of pre-training scores on response rate over three time-points - ANOVA with post hoc Tukey's Honestly Significant Difference pairwise comparisons. Differences in mean scores between the three time-points tested via paired-sample t-tests. Changes on individual level calculated using the reliable change index. Pearson's r correlations used to explore potential relationship between pre-training and changes in scores following training for each domain.	Three of five TICOMETER domains higher than pre-training scores. Individual-level analysis showed some participants' scores decreased following training. Training modestly improved the degree of TIC as measured by TICOMETER and effects sustained at one-year follow-up.	Multiple methods of analysis to provide different perspectives on the data. Offers outcome measurement at three time points to provide insight into longer-term effects (e.g. pre, post, 1 year follow-up).	No control group. Low response rates at post-training and follow-up intervals.

Crawford, K. (2022) **Title:** Evaluating Trauma-Informed Care Practices in an Interdisciplinary Homeless Service Collaboration.	**Context:** Group of social service providers in a southeastern USA city who provide support for people experiencing homelessness or at risk of homelessness. **Participant characteristics:** 91 respondents out of a total 435 staff of four organisations: behavioural health organisation (BHO), housing services organisation (HSO), HIV/AIDS support service organisation and the medical clinic. 15.4% male, 82.4% male. 46.2% direct care staff, 28.6% administrative, 24.42% supervisors.	To evaluate the degree of TIC practices within a group of social service providers.	Quantitative – Formative evaluation design. **Outcome measures:** Bespoke online survey-summated scale assessment based on the five domains of TIC adapted from the Trauma-Informed Organisational Self-Assessment (Guarino et al., 2009) with 101 questions and Likert scale responses.	Mean scores calculated for the whole sample and individual organisations according to overall TIC score and 5 TIC domains. One-way ANCOVA to compare differences across four organisations. LSD post-hoc analysis to determine where differences were.	Domains rated highest across organisations included assessing and planning services, whereas consumer involvement had the lowest ratings. Significant difference in mean scores for the four organisations in the overall TIC score, as well in the domains of staff support, planning and assessing policies, and adapting policies. Post-hoc analysis showed in many domains that Medical Clinic scores were statistically lower from those of BHO and HSO.	Offers interpretation on the differences in scores between organisations relating to organisational contexts. Robust reliability analysis of the survey due to high Cronbach's alpha coefficient of .987 for all 101 items. High reliability for each domain with alphas from .913 to .969.	Low response rate (20.92%) to the survey data. Variation in sample sizes from each organisation limits application of comparisons.

Edwards, K., Mullet, N. & Siller, L. (2023) **Title:** Trauma-informed practices of a sober living home for women with addiction and victimization histories.	**Context:** Sober temporary living home (SLH) a part of a Support, Education, Empowerment and Directions (SEEDs) programme in Arizona, USA, which supports women who have histories of addiction, victimisation and experiences of homelessness. **Participant characteristics:** 52 women experiencing homelessness with histories of domestic and/or sexual violence residing in the temporary sober living home. Mean age was 41.6, range 22-67. Majority of participants were white non-Hispanic (79.7%)	To examine the correlates of perceptions of trauma-informed practices at a SLH.	Quantitative - several outcome measures. **Outcome measures:** Trauma Informed Practices Scale (TIP), Personal Progress Scale-Revised (PPS-R), Housing Instability Index (HII), Centre for Epidemiological Studies Depression Scale (CES-D), PTSD Checklist - Civilian Version (PCL-C), bespoke financial worries measure, Conflict Tactics Scale Revised Short Form (CTS2S), Revised Sexual Experiences Survey (SES).	Frequencies and mean scores, Pearson r and biserial correlation analyses, Ordinary Least Squares (OLS) regression.	High perceptions of trauma-informed practices within the SLH on average. Longer stays at the SLH increased participants endorsement of several TIPs domains including environment of agency and respect, access to information on trauma, emphasis on strengths, and cultural responsiveness and inclusivity. High level of worry about finances and housing instability correlated to lower levels of perception of trauma-informed practice.	Multiple measures of different variables to explore potential correlates. Analytical strategy involved a thorough examination of the variables of interest, including frequencies, means, correlations, and regression analyses.	Women without children were excluded utilising listwise deletion on TIPS analysis - limited ethical consideration of asking them to complete data without using their scores in final analyses for this section. Sole use of quantitative self-report limits understanding of why certain perceptions may be in place for participants.

Every, D., Pedler, A. & Collyer-Braham, S. (2020) **Title:** Out of the Storm: extreme weather resilience for community homelessness.	**Context:** Trauma-informed resource programme designed to improve preparedness of people experiencing homelessness during extreme weather in Adelaide, Australia. **Participant characteristics:** 38 project staff (Red Cross and Hutt St Centre staff – 12), speakers, presenters at meetings (5), agencies that displayed programme posters (2) and participants, peer workers and end users (17). Unknown amount of peer workers in group discussions.	To evaluate whether the Out of the Storm trauma-informed programme met the project aims of increasing people's preparedness, social capital and empowerment.	Qualitative – Participatory observation, interviews, two group discussions with peer outreach workers and engagement-tracking checklists.	No method of analysis stated. No outcome measures stated.	Out of the storm activities supported people's access to relevant information and weather-protection items and built confidence, opportunities and social connections within the community and with emergency services organisations and health providers.	Data collection and analysis process carried out with lived experience collaborators. Multiple methods of data collection to support the claims of the findings e.g. participatory observation, interviews, group discussions.	No discussion on ethical considerations. Lack of detailed information on participant characteristics and recruitment method. No discussion on researcher positionality for qualitative research.

Hetling, A., Dunford, A., Lin, S. & Michaelis, E. (2018) **Title**: Long-Term Housing and Intimate Partner Violence.	**Context:** Long-term housing site in New Jersey, USA, for female survivors of intimate partner violence who are experiencing homelessness. **Participant characteristics:** 8 female participants who were living on site of Dina's Dwellings. Age range stated as early 20s to early 50s. Ethnicities included Caucasian, African American, Latina, South Asian.	To understand how a long-term housing facility utilising TIC supports the journey to healing and recovery from intimate partner violence.	Qualitative – four focus groups and two rounds of individual in-depth interviews with residents. No outcome measures used.	Constructivist feminist grounded theory.	Themes included journeys to healing, housing as the foundation of healing and housing as a platform for service provision and community building.	Offers a combination of different settings and time points to gather qualitative data e.g. focus groups and interviews across 7 months. Utilises an epistemological stance (feminist) that is well fitting for the context. Researcher positionality discussed in relation to qualitative research.	Small sample size – findings are site and case-specific. Half of the research team had prior working relationships with the service and no reflections on how this was considered in the research process.

Kahan, D., Lamanna, D., Rajakulendran, T., Noble, A. & Stergiopoulous, V. (2019) **Title:** Implementing a trauma-informed intervention for homeless female survivors of gender-based violence: Lessons learned in a large Canadian urban centre.	**Context:** Trauma-informed, peer-facilitated group psychosocial intervention (PEACE) delivered within a transitional housing shelter in Toronto, Canada, for females experiencing homelessness and gender-based violence. **Participant characteristics:** 12 clients (11 female-identified, one bi-gender), aged between 19-24. Sole direct service provider, programme manager, one youth worker, one transitional housing team lead and three peer mentors offered staff perspectives.	To understand client and provider experiences of a community-based trauma-informed intervention for females experiencing homelessness. To identify enablers of successful implementation and engagement.	Qualitative - semi-structured interviews. Review of notes and minutes from PEACE group meetings. No outcome measures used.	Thematic analysis – Braun & Clarke's approach (2006).	Identifies enablers of a trauma-informed peer-led intervention e.g. program quality, flexibility, accessibility. Further identifies challenges e.g. difficulties with boundary retention, insufficient training of peer mentors. Offers implications e.g. future groups to consider how to support spontaneous trauma disclosures in similar settings.	Investigator triangulation utilised to support the claims of the findings. Inclusion of both client and service provider perspectives to provide wide variety of views.	Unclear on how the interview schedule shifted across the data collection period. No reflection on research teams' relationship or positionality to the participants or context.

O'Connor, C. M., Poulos, R. G., Sharma, A., Preti, C., Reynolds, N. L., Rowlands, A. C., ... & Poulos, C. J. (2023) **Title:** An Australian aged care home for people subject to homelessness: health, wellbeing and cost-benefit.	**Context:** New purpose-built residental aged care home implementing TIC for people who are experiencing homelessness in Sydney, Australia. **Participant characteristics:** 35 residents admitted during the study period (March 2020 - April 2021). Ages 67-81. 12 females, 23 males. 37.1% who have experienced homelessness, 62.9% at risk of homelessness.	To evaluate the new purpose-built residential aged care home using TIC.	Quantitative - Outcome measures. **Outcome measures:** Australian Functional Measure (AFM), Roland Universal Dementia Assessment (RUDAS), Clinical Frailty Scale (CFS), Timed Up and Go Test (TUG), Geriatric Depression Scale (GDS), Personal Wellbeing Index-Adult (PWI-A), EuroQol-5 Dimension (EQ-5D VAS), EQ-5D-5L at baseline (admission), six months and twelve months.	Mann-Whitney U pairwise comparisons and linear mixed-effect models.	Over time, significant improvement shown in personal wellbeing scores, with clinically significant improvements in overall health related quality of life. Levels of physical functional independence, frailty, and global cognition were stable, but cognitive functional ability declined over time. Evidence supporting a trauma-informed approach.	The use of appropriate statistical analyses, including non-parametric measures for skewed data and linear mixed-effect models to account for missing data and individual variability, enhances the rigour of the study's findings. Utilises outcome measures that have both clinician and self-rated perspectives.	Small sample may contribute to a type II error with improvement trends for PTSD and health related quality of life. Survivor bias - 42.9% of residents identified as frail died within first 12 months of admission, meaning greater representation in the 'not frail' group.

Schiff, J., Liu, J., Wenger, C. & Knapp, J. (2019) **Title:** Staff Exposure to Trauma and the Impact of Trauma-Informed Care.	**Context:** 19 agencies offering support for people experiencing homelessness in Calgary, Canada. **Participant characteristics:** Staff working within 19 homeless-serving agencies. 74% female, 18-60 years of age. 32% worked in shelters, 34% in permanent housing, 14% in transitional housing, 29% provided supports and a small cohort provided residential treatment. Variety of staff roles from case manager to shelter staff to intake worker.	To explore levels of staff self-reported stress and if this is mitigated by the presence of a culture of TIC.	Quantitative – Survey with multiple outcome measures looking into different domains. **Outcome measures:** PCL-6 for PTSD symptoms, PROQoL which measures compassion satisfaction, compassion fatigue and burnout, Life Events Checklist (LEC-5).	Correlations and mediation analysis.	High rates of traumatic experiences and stress by frontline workers in homelessness services. Mediation analysis shows a direct link between trauma-informed organisational practices and reduction in staff-reported traumatic stress symptoms when controlling for extent of TIC training and years working in homelessness services.	High completion rate of surveys (97%). Cronbach alphas completed for each instrument to compare to established norms in previous research to confirm internal reliability.	Not all aspects of TIC measured in the survey e.g. no discussion on culture or gender issues. Mediation analysis assumes a specific directionality of effects – may have missed a reciprocal relationship or further context using this analysis with trauma-informed training and post-traumatic stress.

Sullivan, C., Goodman, L., Virden, T., Strom, J. & Ramirez, R. (2018) **Title:** Evaluation of the effects of receiving trauma-informed practices on domestic violence shelter residents.	**Context:** Domestic violence shelter residents in Ohio, United States of America (USA) for people without a home. **Participant characteristics:** 57 domestic violence survivors who had been in shelter for at least 14 days. All women. 70.4% White, 18.6% Black, 3.7% Hispanic, 3.7% Native American, 3.7% multi-racial.	To explore the extent to which trauma-informed practices related to changes in residents' levels of self-efficacy, safety-related empowerment and depressive symptoms over the course of 30 days.	Quantitative - Online surveys. **Outcome measures:** Trauma Informed Practice (TIP) scale, General Self-Efficacy Scale (GSE), Measure of Victim Empowerment Related to Safety Scale (MOVERS), Centre for Epidemiological Studies Depression Scale (CES-D).	Hierarchical multiple regressions.	Resident perception of the degree to which they received trauma-informed services was associated with significant improvement in their self-efficacy and safety-related empowerment but had no impact on depressive symptoms. Depressive symptoms decreased over time, regardless of receipt of trauma-informed practice.	The study utilised well-established scales to measure each domain. Measurement at two time points (pre and post) allowed for more specific measurement of the impact of TIC - timely post-measurements completed.	60 out of 106 participants provided both Time 1 and Time 2 surveys, which could introduce selection bias if those who dropped out differed systematically from those who remained in the study. Reliant on shelter staff to collect the data rather than researchers may have made it difficult to be aware of all ethical considerations. Further, due to confidentiality, this may have impacted what participants report.

Ward-Lasher, A., Messing, J. & Stein-Seroussi. (2017) **Title:** Implementation of trauma-informed care in a housing first program for survivors of intimate partner violence: A case study.	**Context:** One agency in a Southwestern state, USA, that provides trauma-informed housing stabilisation services for survivors of intimate partner violence who are experiencing homelessness using a Housing First model. **Participant characteristics**: 7 female employees of the agency (3 administrators, 4 practitioners) who work directly in the Housing First programme. Average experience of working with domestic violence survivors for more than 4 years.	To explore how TIC is implemented within a Housing First model in a single domestic violence agency.	Mixed methods - Semi-structured interviews with agency staff, observation of staff meeting and analysis of secondary client outcome data. Case study research design. **Outcome measures:** Bespoke pre-existing survey designed by the agency according to wellbeing domains (e.g. safety, self-esteem, knowledge) with client responses either “agree” or “disagree”.	Case study analysis	Themes included: connecting trauma and housing, trauma-informed interventions, engagement and being a trauma-informed agency. 98.9% agree safety improved and knowledge of domestic violence increased since using services. Perceived child knowledge increase agreed by 92.9%.	Multiple forms of data in the study to support rigour of findings. Inclusion of quantitative findings alongside relevant qualitative findings to support reader understanding.	No disclosure of the researcher's position in relation to the project for qualitative analysis reflexivity. Client perspectives only offered in the form of agreement / disagreement to particular statements whereas staff participated in semi-structured interviews. Lack of consideration of power differentials in providing different platforms for sharing opinions. No detailed description of data analysis procedure.

2.4.2 Quality Check and Critical Appraisal of the Literature

The quality of papers included in the review were assessed using three quality appraisal tools according to each paper's methodology. The three qualitative papers were evaluated utilising the Critical Appraisal Skills Programme (CASP) checklist which provides a framework widely adopted in academia to systematically appraise the quality of qualitative research (Table 5) (CASP, 2018). The CASP tool was selected as it is designed for health-related research and is suitable for novice researchers (Long et al., 2020). During the critical appraisal process, it was identified that one qualitative study did not have insufficient information to assess the quality of the paper, as demonstrated in Table 5 (Every et al., 2020). Consequently, the paper was re-assessed in the full text review process and excluded from the final synthesis due to a lack of information to meet the empirical research inclusion requirements stated in Table 3. The six quantitative papers were appraised using the Joanna Briggs Institute (JBI) checklist for quasi-experimental research which has nine items, with nine being the maximum score (Table 6) (Barker et al., 2024). The JBI tool was chosen as it can be adapted to different types of quasi-experimental designs, making it versatile and suitable for a broad range of research contexts (Barker et al., 2024). Each study had to meet a minimum of five points to be included in the review, which was met by all papers (Barker et al., 2024). The mixed method study was appraised utilising the Mixed Methods Appraisal Tool (MMAT), which does not specify a numerical threshold for inclusion. Instead, the tool is proposed to support a more nuanced approach to quality assessment (Table 7) (Hong et al., 2018). The MMAT was selected as it is considered as one of the most comprehensive tools for appraising multi-method research (Makabe et al., 2022).

A consistent strength across all studies is the clear statement of research aims, which supported in assessing the appropriateness of methodology chosen. When considering data collection methods, several papers did not provide justification for their method of gathering data. For example, Kahan et al. (2020) and Every et al. (2019) did not sufficiently discuss their rationale for

selecting specific interview methods over others like focus groups, which may raise concerns about the appropriateness of the research design in addressing the aims. Whilst mixed methods research can offer a comprehensive perspective, the MMAT appraisal tool highlighted limitations of Ward-Lasher et al.'s (2017) quantitative data in contrast to qualitative data standards (Regnault et al., 2018). This may be explained by the use of secondary data gathered by the participating agency, which leaves questions surrounding the ethics of the data collection process.

The majority of papers demonstrated a clear recruitment strategy, ranging from inviting all clients who have contact with the site (Edwards et al., 2023; Hetling et al., 2018; O'Connor et al., 2023; Sullivan et al., 2018); all staff who participated in training (Burge et al., 2021); all staff within consenting participatory organisations (Crawford, 2022; Schiff et al., 2019) or purposive sampling to ensure distributed views across the participating organisation (Barry et al., 2023). Some papers were unclear on their recruitment strategy, making it difficult to assess the representativeness of their samples (Every et al., 2020; Kahan et al., 2020; Ward-Lasher et al., 2017). Whilst recruitment was a relative strength, there was a wide distribution of completion rates for papers with quantitative data, ranging from 11.25% (Burge et al., 2021); 20.92% completion rate (Crawford, 2022); 56.6% for both time points (Sullivan et al., 2018) to 97% (Schiff et al., 2019). The latter paper credited their high completion rate due to incorporating time for survey completion within a pre-existing staff meeting. While this method boosted response rates, it raised ethical concerns about whether participants had the full ability to opt-out.

Most studies sufficiently discussed ethical considerations such as confidentiality of participants' data and upholding anonymity. The relationship between researchers and participants was only considered in one study (Hetling et al. 2018); this is therefore a considerable weakness across most papers. Whilst this is predominantly associated with more qualitative approaches, it is still a feature that can demonstrate rigour across all research methodologies (Ryan & Golden, 2006).

Examination of the relationship between researcher and participants allows for consideration of power dynamics.

Appropriate statistical analyses were highlighted as a strength across all quantitative data, excluding the mixed methods research (Burge et al. 2021; Crawford, 2022; Edwards et al., 2023; Schiff et al., 2019; Sullivan et al., 2018; O'Connor et al., 2023). Although control groups can support demonstration of the effects of an independent variable, no control groups were utilised in this collection of papers. This may be explained by the nature of the quasi-experimental research being applied in services where ethical considerations of excluding some from trauma-informed practices may have outweighed the benefits of control groups (Street & Luoma, 2002). Three (Barry et al., 2023; Hetling et al., 2018; Kahan et al., 2020) out of four (Every et al., 2020) qualitative papers well-documented their data analysis procedure to enable transparency for the reader. A particular strength was the use of multiple researchers within the analytic process of these three papers, thus incorporating diverse perspectives and supporting rigour claims.

All papers discussed strengths and limitations of their research, apart from the excluded paper (Every et al., 2020). Several papers utilised both staff and client perspectives, recognising this as a strength of providing a comprehensive view of the implementation of TIC (Barry et al., 2023; Every et al., 2020; Kahan et al., 2020; Ward-Lasher et al., 2017). Single-site papers offered cautions regarding generalisation.

Table 5

Critical Appraisal Skills Programme (CASP) Qualitative Checklist

	Barry et al. (2023)	**Every et al. (2019)**	**Hetling et al. (2018)**	**Kahan et al. (2020)**
Was there a clear statement of the aims of the research?	Yes	Yes	Yes	Yes
Is a qualitative methodology appropriate?	Yes	Yes	Yes	Yes
Was the research design appropriate to address the aims of the research?	Yes	Can't Tell – not discussed	Yes	Can't Tell – no discussion on their rationale for one-to-one interviews over other methods e.g. focus group.
Was the recruitment strategy appropriate to the aims of the research?	Yes	Can't Tell – not enough information	Yes	Can't Tell – unclear on how service providers were recruited
Was the data collected in a way that addressed the research issue?	Yes	Can't Tell – no discussion on rationale for choices	Yes	Yes
Has the relationship between the researcher and participants been adequately considered?	Can't Tell	No	Yes	No
Have ethical issues been taken into consideration?	Yes	No - not discussed	Yes	Yes
Was the data analysis sufficiently rigorous?	Yes	No – not discussed on the process of analysis	Yes	Yes
Is there a clear statement of findings?	Yes	No – only discusses one perspective on the intervention (e.g. positives), no discussion on credibility of findings	Yes	Yes

How valuable was the research?	This study considers their findings in relation to existing TIC frameworks. They offer insight into similarities and distinctions between service provider and service receiver perspectives. Future directions are highlighted with suggestions of including administrative roles in service providers and applying the study in wider geographical contexts.	Highlights value of a collaborative co-design for the programme with detail on how it benefited the local community and service providers. No discussion on future research implications or transferability.	Offers insight into how existing TIC approaches can be developed e.g. how to factor in the absence of stability contributing to trauma experiences. Emphasise wider policy implications e.g. a national need for increased longer term housing options for survivors of intimate partner violence.	Identifies barriers and enablers for trauma-informed psychosocial interventions for PEH. Discuss areas for future research to identify specific benefits relating to interventions e.g. quality of life, mental health symptoms.
Overall impression (0/10 scoring)	Include due to meeting majority of criteria (9/10)	Does not meet the majority of criteria due to lack of information included in study (3/10) - exclude	Include due to meeting majority of criteria (9/10)	Include due to meeting majority of criteria (7/10)

Table 6

Joanna Briggs Institute (JBI) Checklist for Quasi-Experimental Research

Authors	**Burge et al. (2021)**	**Crawford (2022)**	**Edwards et al. (2023)**	**O'Connor et al. (2023)**	**Schiff et al. (2019)**	**Sullivan et al. (2018)**
1. Is it clear in the study what is the 'cause' and what is the 'effect' (i.e. there is no confusion about which variable comes first)?	Yes	Yes	Yes	Yes	Yes	Yes
2. Were the participants included in any comparisons similar?	Yes	No – high variability in representation from each organisation e.g. 73.6% of respondents from BHO, 6.6% HSO, 11% HIV/AIDS organisation and 8.8% medical clinic	Yes	Yes	Yes	Yes
3. Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?	No	No	No	No	Can't Tell – it is possible other factors may have been occurring at the same time as TIC that explain the mitigation of post-traumatic stress	No
4. Was there a control group?	No	No	No	No	No	No

5. Were there multiple measurements of the outcome both pre and post the intervention/exposure?	Yes – 3 time points	No – taken at only one timepoint	No – (baseline and follow up data were collected but only analysed follow up data in this study)	Yes – three time points	No – taken only at one timepoint	Yes – two time points
6. Was follow-up complete, and if not, were differences between groups in terms of their follow-up adequately described and analysed?	Yes – follow-up not fully complete but analytical procedure accounted for this	Yes – follow-up not fully complete but analytical procedure accounted for this	Yes – follow up not fully complete but adjusted analytical procedure to account for this	Yes – follow-up not fully complete but analytical procedure accounted for this	Yes – low level of incompletion but accounted for and adequately described	Yes – follow up complete
7. Were the outcomes of participants included in any comparisons measured in the same way?	Yes	Yes	Yes	No – some completed by researchers, some supported by care staff	Yes	Yes
8. Were outcomes measured in a reliable way?	Yes	Yes	Can't Tell – some standardised measures used, bespoke measure used for certain domains (e.g. Financial Worry) but no internal reliability score calculated	Yes	Yes	Yes
9. Was appropriate statistical analysis used?	Yes	Yes	Yes	Yes	Yes	Yes
Overall appraisal (score out of 9)	Include (7/9 points)	Include (6/9 points)	Include (6/9 points)	Include (7/9 points)	Include (6/9 points)	Include (8/9 points)

Table 7

The Mixed Methods Appraisal (MMAT) Tool

Category of study designs	Methodological quality criteria	Ward-Lasher et al. (2017)
Screening questions (for all types)	S1. Are there clear research questions?	Yes
	S2. Do the collected data allow to address the research questions?	Yes
Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions		
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	Yes
	1.2. Are the qualitative data collection methods adequate to address the research question?	Yes
	1.3. Are the findings adequately derived from the data?	Yes
	1.4. Is the interpretation of results sufficiently substantiated by data?	Yes
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	Yes
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	Can't Tell – no strategy discussed
	4.2. Is the sample representative of the target population?	Can't Tell – not enough information provided
	4.3. Are the measurements appropriate?	Can't Tell – full detail of bespoke measure not provided
	4.4. Is the risk of nonresponse bias low?	Can't Tell – they do not know total response rates as they utilised secondary data
	4.5. Is the statistical analysis appropriate to answer the research question?	Can't Tell – not described
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?	Yes
	5.2. Are the different components of the study effectively integrated to answer the research question?	Yes
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	Yes

	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	No
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	No
	Overall impression	Strengths shown in qualitative aspect of paper. Minimal information on the quantitative methodology. Quantitative findings reported as percentages embedded within qualitative claims to contextualise the information. Due to this nature of the presentation of the data, to be included in the present study.

2.5 Thematic Synthesis

This synthesis aimed to explore existing empirical literature on TIC in the homelessness sector and below provides insights into common themes on the topic.

2.5.1 Synthesis Method

Thematic synthesis (TS) was chosen as a method of analysing the collective data across all studies included in the review as it allows the inclusion of rich, contextualised data from a variety of study designs (Thomas & Harden, 2008). TS is based on inductive reasoning, whereby themes are developed using a constant comparative approach (Thomas & Harden, 2008). The method offers a structured approach for integrating and analysing multiple types of data, such as quantitative and qualitative, allowing for the extraction of themes and patterns that might not be evident when examining a single type of data alone e.g. solely quantitative studies. TS complements a critical realist perspective by synthesising data to uncover patterns and themes that reflect the interplay between observable events and the deeper, often unobservable, social and contextual forces that influence them (Mukumbang et al., 2022).

The review followed a convergent integrated approach according to the JBI methodology for mixed methods systematic reviews which has been shown as a suitable method for understanding the process of implementation, barriers and facilitators of an intervention (Hong et al., 2017; Stern et al., 2021). The convergent integrated approach requires a process of data transformation, whereby data is shifted in a mutually compatible format. Data transformation in the current review involved considering the quantitative data as 'qualified'; recognising it's information as textual descriptions to be compared with qualitative data (Lizarondo et al., 2020).

Prior to beginning analysis, the author read each included study several times. Data extracted from the studies included all results, findings and discussions. Data was inputted into NVivo for the first stage of analysis involving line-by-line coding. As per Thomas & Harden's (2008) TS guidance, the author independently coded each fragment according to it's meaning and content

(Appendix C). Following initial code generation, the second stage involved codes being grouped into descriptive themes. During this stage, codes were considered for similarities and differences in order to group into shared meaning descriptive themes. The third stage of TS involved the generation of analytic themes using the descriptive themes developed in stage two (Appendix D). Consideration of types of data, such as first-order, second order and third-order were weighed up in confirming how they informed the final analytical themes (Appendix E). Weighing these different types of data helps in maintaining the contextual relevance of the findings, ensuring that the synthesised themes are grounded in the experiences and contexts of the participants, while also being informed by scholarly interpretations and cross-study syntheses (Barnett-Page & Thomas, 2009). Analytic themes offer a novel interpretation of the topic area going beyond original data sets (Thomas & Harden, 2008).

2.5.2 Synthesis Findings

Four analytic themes and corresponding subthemes were developed as a result of following the synthesis method described (Table 8).

Table 8

Synthesis Themes

Analytic Themes	**Subthemes**
Knowledge of trauma	Client awareness and psychoeducation Staff training, knowledge and competency
The role of relationships	Collaboration Peer and social relationships Staff-client relationships
Wellbeing in relation to TIC	Client wellbeing Staff wellbeing
Systemic dynamics in TIC	Systemic safety Systemic limits Systemic needs

2.5.2.1 Theme 1: Knowledge of Trauma.

Nine out of the ten papers included in the synthesis discussed the role that knowledge of trauma plays within the implementation of TIC across a breadth of settings and populations (Barry et

al., 2023; Burge et al., 2021; Crawford, 2022; Edwards et al., 2023; Hetling et al., 2018; Kahan et al., 2020; Schiff et al., 2019; Sullivan et al., 2018; Ward-Lasher et al., 2017). The function of knowledge differed according to the identity of the participant group discussed, leading to the differentiation of the two subthemes 'client awareness and psychoeducation' and 'staff training, knowledge and competency'.

2.5.2.1.1 Subtheme 1A: Client Awareness and Psychoeducation.

Knowledge of trauma was discussed in terms of clients building awareness of the effects of trauma through contact with a service delivering TIC, with three papers referencing structured psychoeducation sessions on trauma for clients as a key process in the intervention (Kahan et al., 2020; Sullivan et al., 2018 & Ward-Lasher et al., 2017). Building awareness of what constitutes as trauma; the effects of trauma and considering how it resonates with a client's own experience was referenced by a staff member with regard to clients' experiences:

> *"…there's a lot of self-awareness that's building in terms of, like identifying what are different forms of violence, and stuff, for them to really be able to resonate whether or not they've experienced this. Or maybe, when X, Y, Z happened to me, that actually was a form of violence. And maybe they didn't see it in that light before."* (Kahan et al., 2020).

Some papers discussed how clients building awareness was supportive of their ability to change perspectives, shift their future actions and develop improved coping skills (Kahan et al., 2020; Hetling et al., 2018, Ward-Lasher et al., 2017):

> *"…participants talked about the need to educate survivors about how trauma impacts their emotions and behaviour. Both administrators and practitioners said that domestic violence education was crucial to understanding the triggers associated with trauma and housing, and is an important part of helping survivors develop coping skills."* (Ward-Lasher et al., 2017).

Interestingly, only two papers offered direct clients' perspectives on the perceived benefits of developing awareness of trauma (Ward-Lasher et al., 2017; Hetling et al., 2018): *"In her words, "I just didn't realize how much the trauma aspect has been affecting my life ... [Before] my way of dealing with things was to escape and that is not helpful."* (Hetling et al., 2018). Thus, there is further scope for enquiring about clients' perceptions of their own process of developing awareness of trauma.

2.5.2.1.2 Subtheme 1B: Staff Training, Knowledge and Competency.

Seven papers discussed staff training and education concerning TIC (Barry et al., 2013; Burge et al., 2021; Crawford, 2022; Kahan et al., 2019; Hetling et al., 2018; Schiff et al., 2019 & Sullivan et al., 2018). Training and education were discussed as avenues to enhance awareness of trauma and associated symptoms in order to understand clients' needs and adapt their approach accordingly. Five papers referenced the importance of staff competency with TIC in their learning outcomes from their findings (Crawford, 2022; Kahan et al., 2020; Hetling et al., 2018; Schiff et al., 2019; Ward-Lasher et al., 2017). Barry et al.'s (2023) paper demonstrates staff perspectives on how holding knowledge of trauma allowed staff members to *"putting yourself in that [client's] position"* in order to *"better connect with them."* Staff holding knowledge was shown to be an avenue of educating clients, as discussed by a client: *"The one thing I can say is by informing us on what they know, that's how it helps, it helps educate us"* (Barry et al., 2023).

Training was perceived as a method of increasing the knowledge and skills of staff members: *"The post-training knowledge and skills scores were significantly higher than pre-training scores with a medium effect size."* (Burge et al., 2021). However, critiques arose concerning the depth and breadth of these training programs. Despite the observed improvements in staff knowledge post-training, there are varying reports on the sustainability of this knowledge and its application to practical settings (Burge et al., 2021). This discrepancy suggests that while training enhances theoretical understanding, its translation into consistent, practical competence over time remains a possible challenge.

There was also reference to job roles in relation to holding knowledge of trauma, as Hetling et al. (2018) & Ward-Lasher et al. (2017) discussed the importance of training all staff from direct service providers, administration and maintenance staff that may need to interact with clients: *"maintenance staff who need to enter apartments should understand the impact of trauma and residents' need for space, and they should be trained on respectful interactions and how to respond ethically to unique circumstances."* (Hetling et al., 2018). Recognition in these two studies of staff competency across varying skill sets highlights the role all staff play in facilitating a trauma-informed service.

2.5.2.2 Theme 2: The Role of Relationships.

The role of relationships was found as an overarching theme within the present review as a method of implementing TIC. Three sub-themes were identified: Staff-client relationships, client peer and social interactions as well as collaboration.

2.5.2.2.1 Subtheme 2A: Staff-Client Relationships.

Eight papers discussed the features and engagement principles underlying the staff-client relationships within TIC in homelessness settings (Barry et al., 2023; Burge et al., 2023; Crawford, 2022; Edwards et al., 2023; Hetling et al., 2018; Kahan et al., 2020; Sullivan et al., 2018 & Ward-Lasher et al., 2017). An administrator participant highlighted how a staff-client relationship serves as the vessel and foundation for delivering TIC: "…it's the relationship that gets you to the outcomes. So [practitioners] focus [on] the relationship that they build with the [client]." (Ward-Lasher et al., 2017).

Many papers emphasised the expectations and responsibilities of staff to uphold particular values in order to work with clients, such as offering care (Barry et al., 2023; Ward-Lasher et al., 2017), being dependable for clients (Barry et al., 2023), empowering clients (Crawford, 2022, Edward et al., 2023, Sullivan et al., 2018), offering no judgment (Barry et al., 2023; Kahan et al., 2020), being open (Barry et al., 2023; Ward-Lasher et al., 2017), showing respect (Barry et al., 2023; Burge et al.,

2021; Edwards et al., 2023; Kahan et al., 2020) maintaining boundaries (Barry et al., 2023; Kahan et al., 2020), thinking about how to build trust (Barry et al., 2023) and holding an empathetic position to clients' circumstances (Barry et al., 2023; Sullivan et al., 2018).

Barry et al. (2023) was a particularly prominent paper within this sub-theme due to exploring the nature of staff-client interactions in trauma-informed settings. The authors offered reflections on the high level of responsibility for staff to uphold engagement with clients, stating staff's role as *"being a sounding board and source of emotional support—while remaining calm"* (Barry et al., 2023). A participant from the same study discussed the difficulty of managing such responsibility during moments of high expressed emotions with clients, leading to a physiological response for staff:

> *"I think you can talk all you want to about what to do when a participant comes and is yelling in your face or takes a swing at you or something, but when you're in that situation and your heart's racing and there's just things running through your mind it's sometimes hard to have a calm voice"* (Barry et al., 2023).

Observing the vast number of considerations for staff to uphold within this review leads to curiosity about support for staff for these processes. Burge et al. (2021) demonstrate that trauma-informed training can support staff's self-rated TICOMETER (Bassuk et al. 2017) relationship scores, maintained at both 6 months and a year after training: *"The post-training relationships scores were significantly higher than pretraining scores with a medium effect size."* Further mechanisms of suggested avenues of staff support will be discussed in the theme "Wellbeing in relation to TIC".

2.5.2.2.2 Subtheme 2B: Peer and Social Relationships.

Whilst a less prominent subtheme across review papers, peer and social relationships were discussed within four articles (Barry et al., 2023; Hetling et al., 2018; Kahan et al., 2020; Ward-Lasher et al., 2017). Clients' social networks were discussed in terms of incorporating family members for education about the impacts of trauma, including children (Ward-Lasher et al., 2017), as well as

participants using their social networks as a method of recruitment for a trauma-informed intervention (Kahan et al., 2020). Trauma-informed temporary housing was viewed as a method of "community building" through provision of activities and programmes that supported client healing (Hetling et al., 2018).

Peer relations between clients were discussed in terms of disclosure of traumatic experiences amongst peers (Kahan et al., 2020); the value of listening and sharing experiences (Barry et al., 2023; Kahan et al., 2020); some of the challenges in building relationships with peers (Hetling et al., 2018; Kahan et al., 2020) as well as having peer mentors as part of the TIC programme (Kahan et al., 2020). Disclosures of traumatic experiences were reflected upon within a trauma-informed group programme, whereby the authors interpreted reports from those who self-disclose as a *"positive"* experience with *"feelings of validation" (*Kahan et al., 2020), as well as finding it particularly *"powerful"* in the context of participants *"just never had anybody to listen to them"* (Barry et al., 2023). On the other side, witnessing others' disclosures had mixed effects, whereby hearing others' experiences provided an opportunity to *"encourage each other"* and bring peers closer together; whilst there were reports of *"acute distress"* in hearing another's experience that was *"triggering"* (Kahan et al., 2020).

In terms of challenges, Hetling et al. (2018) interpret "*women expressed challenges to forming friendships with other women who are also trying to navigate their own journeys to healing",* linking this to a participants' contribution:

> *"Each of us, I think, has our own story, our own problems. It's kind of hard for me, you know, with other people." It's recognised that the interaction between different needs, different traumatic experiences and different identities mean that coming together was perceived as difficult at times, although residents in the study described "an overall sense of support throughout the building"* (Hetling et al., 2018).

Peer mentors were utilised within the trauma-informed intervention for homeless female survivors of domestic violence and considered a *"key ingredient"* by the authors (Kahan et al., 2020). Peer mentors were considered more *"accessible"* due to their shared lived experience with attendees, with one attendee describing, *"They're just like regular people who are in the group with you",* allowing for greater openness and honesty from attendees. Whilst peer mentors were viewed as useful once in place, there were difficulties with retention of mentors, as well as lack of clarity on the role (Kahan et al., 2020).

2.5.2.2.3 Subtheme 2C: Collaboration.

Relationships in TIC were also discussed within six papers in terms of collaboration between agencies as well as co-production with clients regarding service provision (Barry et al., 2023; Burge et al., 2021; Crawford, 2022; Hetling et al., 2018; Kahan et al., 2020; Ward-Lasher et al., 2017).

Access to information about other services and supporting clients with connecting to those services were both considered useful in several studies (Barry et al., 2023; Hetling et al., 2018; Kahan et al., 2020; Ward-Lasher et al., 2017). In particular, connections with outside organisations were named as useful in the context of *"mental health"*, as well as helping other services understand *"the unique individualized needs of residents"* (Hetling et al., 2018). When there was a lack of access to other services, this was considered as *"hindering"* ability to provide support for specific needs such as "*transportation and mental health"* (Barry et al., 2023). One paper discussed the benefits of across agency connections allowing for *"feedback and support within a shared community of practice"* (Kahan et al., 2020).

Co-production was explicitly discussed and used in one intervention as a method of promoting "*empowerment and choice"* for clients (Kahan et al., 2020). Co-production was commented on as a recommendation for future studies in two papers on TIC training (Barry et al., 2023; Burge et al., 2021); with another paper acknowledging that all participating organisations in a homelessness service collaboration *"had lower TIC scores in client involvement"*, thus also

recommending future programme delivery addresses methods to increase co-production (Crawford, 2022). Consequently, it can be inferred that there is a wish for developing co-production within homelessness settings but limited discussion on its utility is available in the existing evidence.

2.5.2.3 Theme 3: Wellbeing in Relation to TIC.

All papers included in the review considered wellbeing in relation to the implementation of TIC, with five of those discussing client wellbeing (Edwards et al., 2023; Hetling et al., 2018; Kahan et al., 2020; O'Connor et al., 2023; Sullivan et al., 2018) and five considering staff wellbeing (Barry et al., 2023; Burge et al., 2021; Crawford, 2022; Schiff et al., 2019; Ward-Lasher et al., 2017).

2.5.2.3.1 Subtheme 3A: Client Wellbeing.

A range of domains of client wellbeing were explored in studies, with a predominant theme of exploring the association between mental health and TIC (Edwards et al., 2023; Hetling et al., 2018; Kahan et al., 2020; O'Connor et al., 2023; Sullivan et al., 2018). Physical health and cognition were considered in one paper, stating *"Linear mixed-effect models showed that over time, there was no change in motor functional independence, level of frailty, mobility, or global cognition"* (O'Connor et al., 2023). The authors made sense of these findings through comparison to other studies observing physical decline in older adult populations, suggesting that a trauma-informed approach may have encouraged self-efficacy for clients in carrying out daily activities for themselves with tailored support (O'Connor et al., 2023).

Four papers reported improvements in clients' mental health in association with implementing TIC, specific to clients' self-efficacy, self-worth, minimising self-blame and reducing post-traumatic symptoms (Hetling et al., 2018; Kahan et al., 2020; O'Connor et al., 2023; Sullivan et al., 2018). Hetling et al. (2018) emphasised the healing journey for clients' wellbeing throughout the paper, discussing receiving support from case managers, building confidence and all residents reporting re-discovering *"me time".* A participant residing in trauma-informed temporary housing described their improvements in terms of reduction of worry: *"It's really a healing process because it*

helps you, like you [interviewer] said, think less. You don't have to worry about that. That's something less that you have to think about." (Hetling et al., 2018). Sullivan et al. (2018) infer from their quantitative analysis that "*survivors overall reported increased self-efficacy, higher safety-related empowerment, and decreased depressive symptoms from the beginning to the end of their shelter stays".* Interestingly, the decreased depressive symptoms were not predicted by the presence of trauma-informed practice and instead, inferred as *"the result of moving from a chaotic environment into a setting that afforded immediate safety and calm"* (Sullivan et al., 2018). Edwards et al. (2023) had a similar finding whereby, *"mental health symptoms and recent victimization were unrelated to perceptions of the extent to which the SLH was trauma-informed".* There were no changes in depressive symptoms in O'Connor et al.'s (2023) sample, instead, *"there was a trend for improvement in PTSD (F1,33.58 = 4.06, p = 0.052); importantly, this change is clinically significant".* Whilst the initial evidence is encouraging for TIC's ability to reduce specific trauma symptoms, the available research seems to gesture towards a less direct effect on reducing experiences of depression.

2.5.2.3.2 Subtheme 3B: Staff Wellbeing.

Exploring staff wellbeing presented a slightly different focus to client wellbeing within five papers, whereby there was more specific reference to the prevalence of traumatic experiences for staff within data (Barry et al., 2023; Schiff et al., 2019), or acknowledgement of this in the discussions of the findings (Burge et al., 2021; Crawford, 2022; Ward-Lasher et al., 2017). Schiff et al., (2019) explored traumatic exposure for homelessness staff, finding that *"41 % of respondents (response rate 98% of 312 participants) reported PTSD symptoms that would potentially lead to a diagnosis",* also caveating this may not be fully representative due to historical evidence of *"under-reporting traumatic symptoms"*. There was further exploration of traumatic events witnessed or experienced, with 98% reporting at least one traumatic incident in their lives, and 58% reporting at least some of these events were *"part of their job"* (Schiff et al., 2019). Correspondingly, Barry et al. (2023) infer in

their findings how *"vicarious or direct trauma experiences enabled service providers to understand the nuances of working with a homeless population with higher exposure to trauma",* framing these experiences as a method of enabling staff to be better equipped to carry out their work.

Acknowledgement of staff experiences of trauma leads to the question of what support may be available for addressing this aspect of wellbeing. Schiff et al. (2019) reported *"trauma-informed care in the organisation was found to be negatively associated with traumatic stress"*, suggesting the intervention may act as a supportive mechanism, but, it remains unclear how this functions. Ward-Lasher et al. (2017) reported a culture of *"employee self-care"* promoted as an integral part of being a trauma-informed housing first programme, including the ability to ask for help and a participant stating *"our supervisors are supportive about whatever it is we need."* Although there is some element of understanding mechanisms of staff wellbeing and support in these two papers, this area remains unclear in terms of considering what else supports staff in a trauma-informed organisation beyond supervision and self-care. Corroborating this curiosity, Crawford (2022) reports that across several agencies in a homeless service organisation, staff support had *"lower scores"* in comparison to other measurements of trauma-informed practice, suggesting this may be an area for further understanding.

2.5.2.4 Theme 4: Systemic Dynamics.

Systemic dynamics was defined through three subthemes—systemic safety, systemic needs, and systemic limits—to highlight the multifaceted approach required in TIC. Together, these subthemes illustrate the complexity of integrating TIC within systems, emphasising the need for comprehensive strategies that address both the direct and indirect factors influencing client and staff experiences in these settings.

2.5.2.4.1 Subtheme 4A: Systemic Safety.

The subtheme of 'systemic safety' references eight papers' discussion on the importance of creating safe environments that cater to both the physical and emotional needs of individuals within

the implementation of TIC (Barry et al., 2023; Crawford, 2022; Edwards et al., 2023; Hetling et al., 2018; Kahan et al., 2020; Schiff et al., 2019; Sullivan et al., 2018; Ward-Lasher et al., 2017). Safety was discussed in how it is enacted in the system through interactions and the wider environment of services. Safety was described by a client: *"as an integral feature that was tied directly to the ability to recover from trauma"* (Hetling et al., 2018). Across four studies, the emphasis on ensuring physical safety is noted (Barry et al., 2023; Kahan et al., 2020; Schiff et al., 2019; Ward-Lasher et al., 2017). For instance, all but one service provider discussed the need to maintain physical safety to facilitate therapeutic interactions, with Barry et al. (2023) interpreting from their findings, *"promoting physical safety [is] integral to being able to provide trauma-informed services"*. Emotional safety is equally prioritised, as indicated in reports where *"emotional and physical safety in interactions between service providers and participants [is] described as an integral foundation for interactions and trauma-informed service provision"* (Barry et al., 2023). In fact, Schiff et al. (2019) explored the associations between psychological safety and physical safety on traumatic stress for staff, reporting *"psychological safety is of greater importance (relatively) than physical safety".* It remains unclear, following these findings, as to whether there are differing priorities of type of safety according to population, e.g. client vs staff and this may be an interesting focus of future research.

In terms of the environment, specific examples of safety were offered in the form of designing "*very warm and inviting"* spaces for trauma-informed work to take place, whereby *"home-like touches have been described as important for the establishment of emotional safety"* (Kahan et al., 2020). Flexibility in service provision where staff can meet with clients *"where they are"* (Barry et al., 2023) or *"in their community"* (Ward-Lasher et al., 2017) was described by three papers as enabling a safe, trauma-informed approach (Kahan et al., 2020). Additionally, ensuring choice for clients' engagement was discussed in two papers as a method of providing safety by addressing power dynamics often disrupted by trauma (Barry et al., 2023; Kahan et al., 2020). Examples of choice include *"how and when to participate"* (Kahan et al., 2020), meeting locations, meeting regularity, meeting set-up and content focus (Barry et al., 2023).

2.5.2.4.2 Subtheme 4B: Systemic Needs.

Eight papers spoke about various systemic needs within TIC implementation where service delivery must adapt and transform to effectively support those affected by trauma (Barry et al., 2023; Burge et al., 2021; Crawford, 2022; Edwards et al., 2023; Hetling et al., 2018; Kahan et al., 2020; O'Connor et al., 2023; Ward-Lasher et al., 2017). Examples of systemic needs include individualisation of care, cultural competence, long-term housing, and an overall culture shift required.

Individualised care was more widely discussed across six papers as a systemic need in the implementation of TIC (Barry et al., 2023; Edwards et al., 2023; Hetling et al., 2018; Kahan et al., 2020; O'Connor et al., 2023; Ward-Lasher et al., 2017). Specifically, individualised care was discussed in terms of the service needing to adapt to the unique circumstances and needs of clients. Examples of individualisation of care included accommodating gender preferences (Hetling et al., 2018; Kahan et al., 2020); past traumatic experiences (Barry et al., 2023; Hetling et al., 2018; Ward-Lasher et al., 2017); clients' goals (Barry et al., 2023) and practical needs (Barry et al., 2023). O'Connor et al. (2023) highlight the importance of individualisation according to age and physical health: *"Older individuals subject to homelessness require dedicated services that specialise in both homelessness and aged care domains".*

Regarding individualised care, only one paper discussed cultural competence in TIC as a systemic need. Edwards et al. (2023) explored the relationship between the ethnicity of clients and perceptions of the trauma-informed approach as culturally inclusive: *"results suggested that white women, compared to non-white women, reported higher perceptions that SEEDs were culturally responsive and inclusive"*. The authors discuss the importance of staff training to develop cultural inclusivity of trauma-informed services; stressing the need for tailored, individualised care (Edwards et al., 2023).

Moreover, the subtheme extends to discussing the practical needs of trauma-informed service delivery, such as the provision of long-term housing and minimising financial concerns as critical for offering stability to clients (Edwards et al., 2023; Hetling et al., 2018). Edwards et al. (2023) interpret from their findings: *"higher levels of worry about finances as well as housing instability were consistently related to lower levels of perceptions that [sober living homes] were trauma-informed".* Similarly, a participant in Hetling et al. (2018) stated: *"I mean because 30 days [in a temporary shelter], in my mind I'm like all I've got is 30 days! And you're stressing out. I mean that is paralyzing."* Both papers indicate that clients experiencing instability within housing and finances may reduce a clients' ability to benefit from TIC, therefore highlighting the importance of services addressing these needs to support clients.

Furthermore, systemic needs also include the organisational structures necessary to implement effective TIC (Burge et al., 2021; Crawford, 2022; Ward-Lasher et al., 2017). Crawford (2022) inferred that one of the three organisations who scored the highest for TIC may be due to *"the mandates in place that certain policies and procedures are formalised",* whilst recognising that overall state regulatory systems support their practice. Training and culture shifts within organisations are highlighted as essential for adopting trauma-informed approaches. As noted by Burge et al. (2021) in their interpretation of their findings: *"Training needs to be complemented by a culture shift supported not only by changes in policy for organisations and systems but also service commissioning – services can only do so much within the constraints in which they operate"*.

This observation underscores that while individual practices are crucial; systemic and organisational changes are equally important to create a sustainable trauma-informed environment that meets the systemic needs of those it serves.

2.5.2.4.3 Subtheme 4C: Systemic Limits.

The subtheme 'systemic limits' in TIC refers to several critical barriers to the effective implementation and sustained practice of TIC discussed across all ten papers (Barry et al., 2023;

Burge et al., 2021; Crawford, 2022; Edwards et al., 2023; Hetling et al., 2018; Kahan et al., 2020; O'Connor et al., 2023; Schiff et al., 2019; Sullivan et al., 2018; Ward-Lasher et al., 2017). Two papers referenced elements of TIC training being insufficient on its own to meet client needs (Burge et al., 2021; Hetling et al., 2018). Burge et al. (2021) report findings where trauma-informed training *is "not sufficient to change respect for clients or service delivery, as measured by the TICOMETER".* Further comment is offered on the importance of a holistic approach in delivering TIC, including wider cultural changes in services (Burge et al., 2021).

Another significant challenge is the limited resources available for TIC implementation. Various studies (Barry et al., 2023; Burge et al., 2021; Crawford, 2022; Kahan et al., 2020) point to disparities in the availability of resources, which affect how TIC principles are applied and the extent to which they can be sustained. For instance, different health service organisations (HSOs) report varying challenges based on their available resources, impacting the consistency and quality of TIC application (Barry et al., 2023). This limitation often results from financial constraints, staffing issues, and the infrastructural capabilities of organisations, emphasising the need for more robust funding and resource allocation strategies to enhance TIC effectiveness across the board.

Finally, the limits of research on TIC effectiveness and implementation further complicate the understanding and expansion of TIC practices (Barry et al., 2023; Burge et al., 2021; Crawford, 2022; Edwards et al., 2023; Hetling et al., 2018; O'Connor et al., 2023; Schiff et al., 2019; Sullivan et al., 2018; Ward-Lasher et al., 2017). Many studies included focused on narrow populations or specific settings, which limits the generalisability of their findings (Barry et al., 2023; Edwards et al., 2023; Hetling et al., 2018; O'Connor et al., 2023; Schiff et al., 2019; Sullivan et al., 2018; Ward-Lasher et al., 2017). Additionally, there were reports of varying completion rates from 20.92% of invited staff (Crawford, 2022), 11.25% (Burge et al., 2021), to 97% (Schiff et al., 2019). These varying response rates cause curiosity about the views of those who chose not to participate about the implementation of TIC.

These systemic limitations demonstrate the critical need for an expanded focus on addressing the insufficiencies in knowledge, resources, and research within the field of TIC in the homeless sector.

2.6 Conclusion of the SLR

The present SLR on the implementation of TIC identified ten eligible studies for synthesis, revealing four key themes to answer the review question: "What does the empirical literature tell us about the implementation of TIC in the homelessness sector?"

First, 'knowledge of trauma' emphasised the importance of educating both clients and staff about trauma as part of TIC delivery. Client-oriented psychoeducation aids client healing and resilience, while staff training fosters supportive environments for client recovery. Second, the 'role of relationships' highlighted that empathetic, respectful, and empowering interactions between staff and clients are crucial. Client peer and social relationships, along with collaborative staff networks, enhance TIC effectiveness, suggesting the benefits of integrated services and shared practices.

Third, 'wellbeing in relation to TIC' considered the different aspects of client and staff wellbeing. TIC improves client self-efficacy and trauma-related symptoms, though its link to depression remains unclear. For staff, TIC reduces traumatic stress but necessitates further exploration of support mechanisms, including self-care and collective approaches. Finally, 'systemic dynamics' addresses the need for systemic safety, individualised care, cultural competence, and resource sustainability. Comprehensive strategies should focus on both immediate needs and long-term solutions to effectively implement and sustain TIC.

Limitations of the SLR must be noted. Firstly, the review included six papers situated within the USA, two in Canada, one in Australia and one in the United Kingdom. The limited evidence base identified in the UK context may reflect the predominant culture of PIE as an approach utilised in the homelessness context (Phipps et al., 2017). Literature has attempted to make the distinction, as discussed in the Introduction, therefore the present review wanted to uphold separate definitions to

understand the current utilisation of TIC. Consequently, a gap has been identified that warrants further exploration of the use of TIC within UK services.

Another consideration of the present review was synthesising diverse data types through a mixed methods review including both quantitative and qualitative data. Interpreting themes across these differing forms of data required inclusion of both 'findings' and 'discussion' sections of all studies to support inclusion of authors' sense-making (e.g. second-order data) of quantitative findings. Whilst careful consideration was taken to ensure consistent interpretations across the data, a higher quantity of codes were found from qualitative sources in the initial synthesis stages due to the rich, in-depth data of these papers. An ongoing reflective process by the present researcher was key to support the analytical rigour and transparency of the synthesis (Appendix F). Although these processes were followed, reflection on the overall synthesis demonstrates a greater representation of second-order data within quantitative papers in comparison to a greater representation of first-order data from qualitative papers. It is possible that a future SLR taking a convergent segregated mixed methods approach (Lizarondo et al., 2020) to the same review question may generate alternative findings with a more balanced approach to synthesising data types.

Additionally, several papers discussed providing site-specific evidence, limiting generalisability of their findings. Whilst providing rich in-depth information, it is possible that single-site research may be influenced by factors within the local context, such as available resources, local policies and community norms that influence the outcomes. As evidenced by Crawford (2022), comparing organisations led to differing findings in implementing TIC. Conducting research across several organisations may provide insight into possible universal factors within the implementation of TIC.

2.7 Rationale for the Current Research and Aims

The findings of the SLR leave curiosity about further understanding of staff experiences given the nature of expectations to uphold responsibility for providing a supportive space for clients and

the several TIC engagement principles to adhere to. Given the nature of prevalent work-placed traumatic experiences for staff noted in the literature, research into understanding how these factors assimilate and therefore sit with staff is imperative, especially due to the lack of discussion on how TIC may be supportive for staff. With consideration of the systemic needs and limits expressed in implementing TIC, there is space for further understanding on how these themes may intersect to impact on staff, particularly given the thin representation of staff's first-hand experiences in research. Additionally, the SLR found evidence of TIC being an established practice within participating services, but little has been commented on in regards to the transition into becoming a trauma-informed service and what the facilitators and barriers of this process have been.

There is yet to be an in-depth exploration of the experiences of staff carrying out TIC in the homeless sector in the UK and how TIC implementation may lead to suggested findings in previous research, such as reduced stress for both staff and PEH (Schneider et al., 2022; Schiff et al., 2019). It is hoped that an exploration of staff experiences of utilising the TIC approach in homelessness services may provide contextual information to supplement the SLR's findings, for instance, understanding further what contributes to their self-rated increased confidence in utilising TIC (Burge et al., 2021). The marked focus on outcome measures and quantitative data underscores the need for qualitative exploration to understand how staff experience TIC in their work and engage in the transition to a different way of working.

Given the rationale outlined above, this research aims to address literature gaps by exploring staff experiences of transitioning to TIC in homelessness services through the following question:

What are the experiences of staff transitioning to trauma-informed homelessness services?

Chapter 3: Methodology

3.1 Chapter Overview

The present chapter will outline and explain the choices behind the research design, participant recruitment, data collection, study procedure, ethical considerations, the involvement of a research consultant, and the data analysis method.

3.2 Design

3.2.1 Choice of Qualitative Design

The current study uses a qualitative design, implementing semi-structured interviews and employing reflexive thematic analysis (RTA). A qualitative approach allowed for an in-depth, rich and nuanced exploration (Allan, 2020). As emphasised in the Introduction and SLR, much of the existing empirical literature employs quantitative methods, and it was felt that a qualitative design would supplement the existing evidence surrounding staff perspectives in TIC. Qualitative research, being flexible and adaptive, also enabled the researcher to respond to emerging insights and evolving questions as the study progressed (Maxwell, 2013). Furthermore, with an emphasis on reflexivity and co-construction of knowledge between researchers and participants, the choice of a qualitative design enriched the authenticity of the findings (Rabbidge, 2017).

Choice of qualitative design also relates to the project's epistemological position. CR seeks to uncover the causal mechanisms that explain why things happen, making qualitative methods particularly supportive in discovering these mechanisms (Vincent & O'Mahoney, 2018). By applying this approach, the present project can explore the deeper, often unobservable factors that affect how staff experience and transition to TIC in the homelessness sector.

3.2.2 Choice of Reflexive Thematic Analysis

This study employed a qualitative method, RTA, which identifies themes with patterned meanings or responses (Braun & Clarke, 2022a). Braun and Clarke (2022a) outline three types of thematic analysis (TA): codebook, coding reliability, and reflexive. Codebook TA, while structured, can

be restrictive by using predefined codes and themes, hindering new insights (Boyatzis, 1998). Coding reliability TA, involving multiple coders and consensus, aligns with a positivist epistemology and an objective truth, which does not fit this project's goals (O'Connor & Joffe, 2020). RTA was selected for its iterative and recursive processes, allowing movement between data and analysis for emerging insights (Braun & Clarke, 2022a). It is flexible according to the research needs, supporting various depths of coding, theme quantities, and inductive or deductive approaches (Braun & Clarke, 2022a). Transparency is maintained through extensive data excerpts and explicit reflexivity about researchers' assumptions, values, and biases, enhancing the clarity of the subjective elements involved (Kiger & Varpio, 2020). However, RTA's lack of structure can challenge the development of coherent and meaningful themes, risking superficial analysis without rigorous reflexivity and iterative review (Braun & Clarke, 2023; Terry et al., 2017). This project addressed these challenges by maintaining frequent reflexive diary entries and engaging reflexively with the supervisory team.

RTA can be carried out from different epistemological standpoints (Braun & Clarke, 2022b). RTA marries CR well, whereby both approaches emphasise the importance of context: RTA highlights how context shapes participants' experiences, and CR recognises that understanding context is crucial for identifying causal mechanisms (Danermark, 2019). Reflexivity is another key synergy; RTA encourages researchers to acknowledge their influence on the research process, enhancing transparency and rigour, a principle also valued in CR (Maxwell, 2018).

3.2.3 Consideration of Alternative Methodologies

During the process of weighing up qualitative methodological avenues, grounded theory was considered. Grounded theory (Glaser and Strauss, 1967) aims to establish a model of a social process or multiple processes through 'grounding the theory' in the data (Charmaz, 2017). It was considered that a grounded theory approach could provide a deeper understanding of the processes surrounding the implementation of TIC, as this has not yet been fully understood. However, it was

felt that the flexibility of thematic analysis would allow a greater scope of understanding staff experiences (Braun & Clarke, 2022b), a pertinent place to start within an under-researched area.

Interpretative Phenomenological Analysis (IPA) was also considered for the current study's methodology (Smith, Larkin & Flowers, 2009). IPA allows researchers to gain a deep, detailed understanding of participants' lived experiences by focusing on how individuals make sense of their personal and social worlds, providing rich, nuanced insights (Smith, Larkin & Flowers, 2009). Whilst IPA offers a rich participant-centred approach, the method tends to lean on smaller sample sizes to achieve its findings (Pietkiewicz & Smith, 2014). In contrast, TA offers an opportunity to identify patterns within larger groups which felt more appropriate according to the study's aims to interview staff with a variety of roles and from a variety of services across the UK.

3.2.4 Data Collection via One-to-One Interviews

Semi-structured interviews are commonly used for data collection within qualitative research due to fitting a variety of forms of data analysis (Willig, 2013). Conducting semi-structured one-to-one interviews allows researchers to gain in-depth insights into participants' experiences, perceptions, and feelings, balancing structured guidance and flexibility (Kallio et al., 2016). This adaptability enables interviewers to probe deeper into specific topics as they arise during the conversation (DiCicco-Bloom & Crabtree, 2006). The private and focused environment of one-to-one interviews helps build rapport and trust between the interviewer and the participant, encouraging open and honest sharing about sensitive or personal topics (Adams, 2015). As the present study wishes to explore how staff navigates TIC whilst holding their own experiences and stories, an individual interview would allow for greater safety and sensitivity in discussions. Additionally, semi-structured one-to-one interviews capture rich, contextual data, leading to a comprehensive understanding of the research topic and allowing for real-time clarification and exploration of complex issues, which helps to avoid misinterpretations (Rabionet, 2011).

Alternative methods of data collection were considered during the design of the project. Focus groups, while valuable for generating rich, qualitative data through group interaction and discussion, did not feel the most appropriate methodology for the current aims. To elaborate, it was considered that focus groups might collect an organisational narrative, with the possibility of individuals contributing what they believe is suitable for their peers to hear rather than their full perspective (Forsyth, 2018). Additionally, co-ordinating schedules with professionals across different organisations for a focus group may have proven difficult, and thus could have limited participation for interested candidates (Stewart & Shamdasani, 2014). Alternative methods such as diary-keeping and participant observations can require time-intensive commitment from participants, and in light of the knowledge surrounding staff experiences of distress whilst working in the sector, it felt appropriate to choose a method that could be most adaptable to their needs.

3.2.5 Trauma-Informed Research

Qualitative studies are directed by ethical guidelines to ensure participant safety, review design, and maintain the overall quality of studies (King, 2019). A trauma-informed research approach does not replace ethical guidelines; instead, it can be complementary in offering another perspective to the decisions made within research (Campbell et al., 2023). Trauma-informed research can be considered as adhering to trauma-informed principles in order to ensure participants feel respected and involved, enabling collaboration, ensuring safety for all involved and reducing the risk of harm (Alessi & Kahn, 2023). There are several guidance documents available on conducting trauma-informed research (Alessi & Kahn, 2023; Campbell et al., 2023; Dowding, 2021; Edelman, 2023; Isobel, 2021). I chose two particular frameworks to support methodological decision-making and review to hold myself accountable for delivering trauma-informed research.

Firstly, Dowding's (2021) guidance was chosen as it was created within the Fulfilling Lives South East organisation, a service that supports people with multiple and complex needs, including experiences of homelessness, therefore devised within a similar context to the present project.

Dowding's (2021) guidance provides a checklist on how to meet five trauma-informed principles, including choice, voice, trust & transparency, collaboration and safety when conducting research. The checklists for before, during and after interviews were reflected upon while carrying out the current study (Appendix G).

Secondly, I used Isobel's (2021) framework to reflect on my approach to trauma-informed research within my reflexive diary to support recognising my own biases, emotional responses and how I attend to such responses with consideration of self-care. The framework supported generating reflections on my interactions with participants and the data. This gave me space to consider my relationship to power within the work and how safety is maintained not only in the direct interactions with participants but also in the data analysis process, where I continued my engagement with their experiences, stories and voices. Appendix H is an excerpt from using the reflective prompts of Isobel's (2021) framework relating to data analysis.

3.3 Consultation with Experts by Experience

The intrinsic worth of incorporating first-hand experiential knowledge in healthcare is widely recognised, underscoring the importance of lived experiences and expertise from Experts by Experience (EbE) (Ahuja & Williams, 2005). This value is evident in the declarations and strategies of professional organisations (Division of Clinical Psychology, 2015, 2018; Health and Care Professions Council, 2017) and healthcare providers (NHS England, 2022). National government strategies (Department of Health & Social Care, 2017) also highlight the significance of EbE involvement, emphasising the importance of collaborative efforts to enhance services and outcomes.

The present project recruited an EbE, also regarded as a research consultant in our process, who works in a homelessness organisation transitioning to TIC. The research consultant joined the research team as an integral contributor throughout (See Appendix I for contractual agreement). They were involved with developing the interview schedule, reviewing key documents (e.g. research poster, study advert, information sheet), considering recruitment strategies, troubleshooting

recruitment hurdles, considering ethical dilemmas, reviewing analytic themes and offering considerations for clinical implications. The research consultant was thanked for their time through online shop vouchers provided by the University of Hertfordshire. Working alongside the research consultant provided gifts of authentic insight, enhancing the relevance of findings, and undoubtedly added richness to the project that would not have been possible without their involvement.

3.4 Participants

3.4.1 Recruitment of Participants

The present study utilised a purposive and snowballing sampling method to target recruitment of staff working within a homelessness service that are transitioning to TIC. The recruitment involved three tangents: contacting organisations known to be presently carrying out TIC, utilising key mailing lists in the UK within the homeless sector, and snowballing through existing participants to connect to potential new participants. The recruitment process was carried out between July - November 2023.

Three homelessness organisations[3] were initially identified as avenues for recruitment through existing relationships with the second supervisor of the project. Organisational approval was sought out through key contacts. One of the aforementioned organisations were unable to provide access to potential participants due to ongoing internal organisational processes. Initial months of recruitment saw difficulty with gaining participants. Therefore, I applied for an ethics amendment to allow for a widening of the recruitment strategy in order to reach out to organisations without existing relationships with the research team. I screened UK-based homelessness services' websites and identified suitable organisations through their discussion of implementing TIC. I emailed the available contact details with an initial enquiry and if responded to, shared the recruitment poster (Appendix J) and the introductory document to the research project (Appendix K). Through this method, I built a key relationship with another homelessness organisation and sent the

[3] Organisations have not been named to preserve anonymity of participants.

aforementioned documents to their 'TIC' mailing list, which included representatives from homelessness services across the UK.

The recruitment strategy further included distributing the research poster (Appendix J) and eligibility criteria (Appendix L) within a recruitment e-mail (Appendix M) to two key mailing lists: 'Housing Services Professionals' and 'Psychology in Homelessness Network'. From the latter mailing list, a relationship was built with a national organisation who facilitated organisational involvement and advertised the participation opportunity by distributing the eligibility criteria (Appendix L) and recruitment poster (Appendix J) to teams who supported PEH across England. A further 'snowballing' recruitment strategy was utilised whereby all confirmed participants were asked if they were aware of anyone else who may be interested in participation at the end of their interview.

A project briefing meeting was offered to management from the engaging organisations which took place online with me to provide an overview of the project and detail participation involvement. Building connections with leadership in organisations via this opportunity solidified organisational support for participation and aimed to mitigate any potential recruitment challenges. Following management approval, recruitment e-mails (Appendix M) were sent within the organisation as well as announcements within team meetings to raise awareness of the project. Within two organisations, I was invited to attend team meetings to provide quick briefings on the participation opportunity.

3.4.2 Participation Criteria

Table 9 indicates the inclusion and exclusion criteria for recruitment of participants. Decision making on the inclusion and exclusion criteria required consideration from the project team.

Table 9

Inclusion and Exclusion Criteria for Participation

Inclusion criteria	Exclusion criteria
Minimum experience of working within the homelessness sector for 6 months	Currently work within a homelessness organisation outside of the UK context
Working within a homelessness organisation both prior to TIC being implemented and during the implementation of TIC	Do not work in organisation transitioning towards TIC / have not begun "journey" to TIC
Contact with PEH on at least a monthly basis	Have worked in the sector for less than 6 months
At the minimum, they have attended at least two TIC sessions, whether this is in the form of reflective practice, post-incident debriefing sessions, training or a supervision session focused on the TIC approach	
Awareness of TIC and what it means	

Initial design of the project led to considerations of whether to invite participants to categorise the stage of their transition e.g. 'beginning TIC, developing, advanced, leadership' (Appendix N) and analyse themes utilising the information of stage to decipher if there were differing experiences according to stage. However, discussions with the project team and experts in the sector enabled realisations that, presently, there is potential for varying interpretations of what stages may look like due to a wide variety of methods of implementing TIC in the sector. A further viewpoint was offered in these discussions about how a professional with years of experience utilising TIC may still consider themselves as 'beginning' depending on the context of their service and external limitations of service provision impeding TIC. Thus, a foundational understanding of themes regardless of stage of transition was viewed as a necessary first step to inform the current landscape.

3.4.3. Participants Characteristics

Estimation of an adequate sample size has been discussed as a complex task, particularly for reflexive TA (Braun & Clarke, 2022b). The present study initially aimed to collect 12-20 interviews following recommendations to anticipate a lower and upper sample size to collate sufficiently rich, complex and multi-faceted data (Sim et al., 2018). The research team reflected on completion of

recruitment throughout the interview stage with consideration of whether sufficient data had been collected to meet the project's aims. The final sample comprised sixteen participants.

Participants demographics were gathered through the 'Demographic Information' form (Appendix P) hosted through Qualtrics alongside the consent form (Appendix Q). Demographic information such as gender, ethnicity, age, staff role and employing organisation were collected. The questionnaire contained open-ended boxes to write their chosen identity terminology for each question. In the circumstance where somebody used unique identity terminology that may risk identification, I discussed the concern of non-anonymity with the participant and informed them that adjustments to the terminology must be made to uphold anonymity. Each participant was given the opportunity to choose alternative wording or the option for the researcher to alter the term to ensure informed consent. Demographic information was anonymised and stored directly onto UH Herts OneDrive, separate from interview data.

Participants demographics are summarised in Table 10. Participants worked across a number of regions, including: Bristol, Yorkshire, Norfolk, South Wales, Somerset, Cambridgeshire and London. Regions have been described as broad areas and not matched with participant characteristics to preserve anonymity. Participants' job roles included lead in services[4], senior support worker, team manager, support worker, psychological therapist, assistant psychologist, recovery coach, social worker, senior practitioner, housing co-ordinator[5], and a non-medical prescriber.

[4] Amended title to preserve anonymity
[5] Amended title to preserve anonymity

Table 10

Participant Characteristics

Alias	Age Bracket	Gender	Ethnicity	Other identity information disclosed
Amelia	18-25	Female	White English	Not disclosed
Annie	46-55	Female	White British	Not disclosed
Arthur	35-44	Male	White English	Not disclosed
Bronwen	25-34	Female	White Welsh	Low socioeconomic status background
Elena	35-44	Female	White British	Not disclosed
Elliott	45-54	Male	White British	Not disclosed
Enzo	35-44	Male	White British	Not disclosed
Ewa	35-44	Female	White Other	Not disclosed
Gemma	45-54	Female	White British	Not disclosed
Jamie	Not disclosed	Male	Not disclosed	Not disclosed
Lillian	35-44	Female	White British	Not disclosed
Lyle	25-34	Male	White British	Lived experience of homelessness
Nadeem	Not disclosed	Male	Not disclosed	Not disclosed
Rhys	45-54	Male	White Welsh	Not disclosed
Rosa	25-34	Female	Latin	Not disclosed
Sahla	46-55	Female	Asian British	Indian Muslim

3.5 Data Collection

3.5.1 Data Collection and Measures

In order to collect participants' views in a qualitative manner, individual interviews were carried out. Due to the nature of recruiting across various organisations and mailing lists, all participants were offered to meet for up to 60-90 minutes via video call at a mutually convenient time to allow for a universal data collection method. The interviews were recorded on Teams and a back-up recording on Zoom (both University of Hertfordshire cloud encrypted).

A semi-structured interview schedule was devised with the investigators and the research consultant (Appendix R). A debriefing information sheet was provided to all participants following completion of the interview (Appendix S).

3.5.2 Devising the Interview Questions

An open-ended interview schedule was devised with the project team with the aim of providing a framework to allow participants to explore their experiences of transitioning to TIC in their workplace. To allow for researcher flexibility in the interview, the interviews followed a semi-structured format to allow for follow-up questions or explore any curiosities (Smith, 2005). Due to the nature of the topic revolving around trauma, specific wording was considered and reviewed to ensure a sensitive, comprehensive interview schedule.

Four key areas were identified as focus points for questions whilst developing the interview schedule: eliciting staff's experiences of transitioning to TIC, their perspectives on TIC in the homeless sector, their personal/professional connection to TIC, and hopes for future directions of TIC. The interview schedule had several revisions according to all the project team's recommendations to avoid any duplication of questions and incorporate themes of questions together. The final interview schedule can be seen in Appendix R.

To support confirmation of the interview schedule, a pilot interview was carried out with the research consultant. Utilising the guidance of the research consultant proved crucial at this stage of devising interview questions to ensure questions felt appropriate for someone working with a TIC approach in homelessness services. Additionally, this allowed for reflection on how the interview process itself fit the recommended trauma-informed criteria for conducting interviews (Appendix G) (Dowding, 2021). Consequently, adaptations were made in terms of specific prompts for setting up the interview process to ensure consistent, safety building discussions were in place prior to beginning the questions.

3.6 Procedure

The overall procedure is highlighted in Figure 2. All potential candidates were invited to e-mail me with their interest. Upon contact, I provided the eligibility criteria (Appendix L) and the information sheet (Appendix O) via a Qualtrics survey. Questions and further briefing took place over

e-mail contact. Once an individual confirmed further interest following reading the information sheet and self-identified as eligible, they were invited to complete the consent form (Appendix Q) and a demographics information sheet (Appendix P) via a Qualtrics survey. Once consent was confirmed, arrangements were made to set up an online interview with the participant according to their availability.

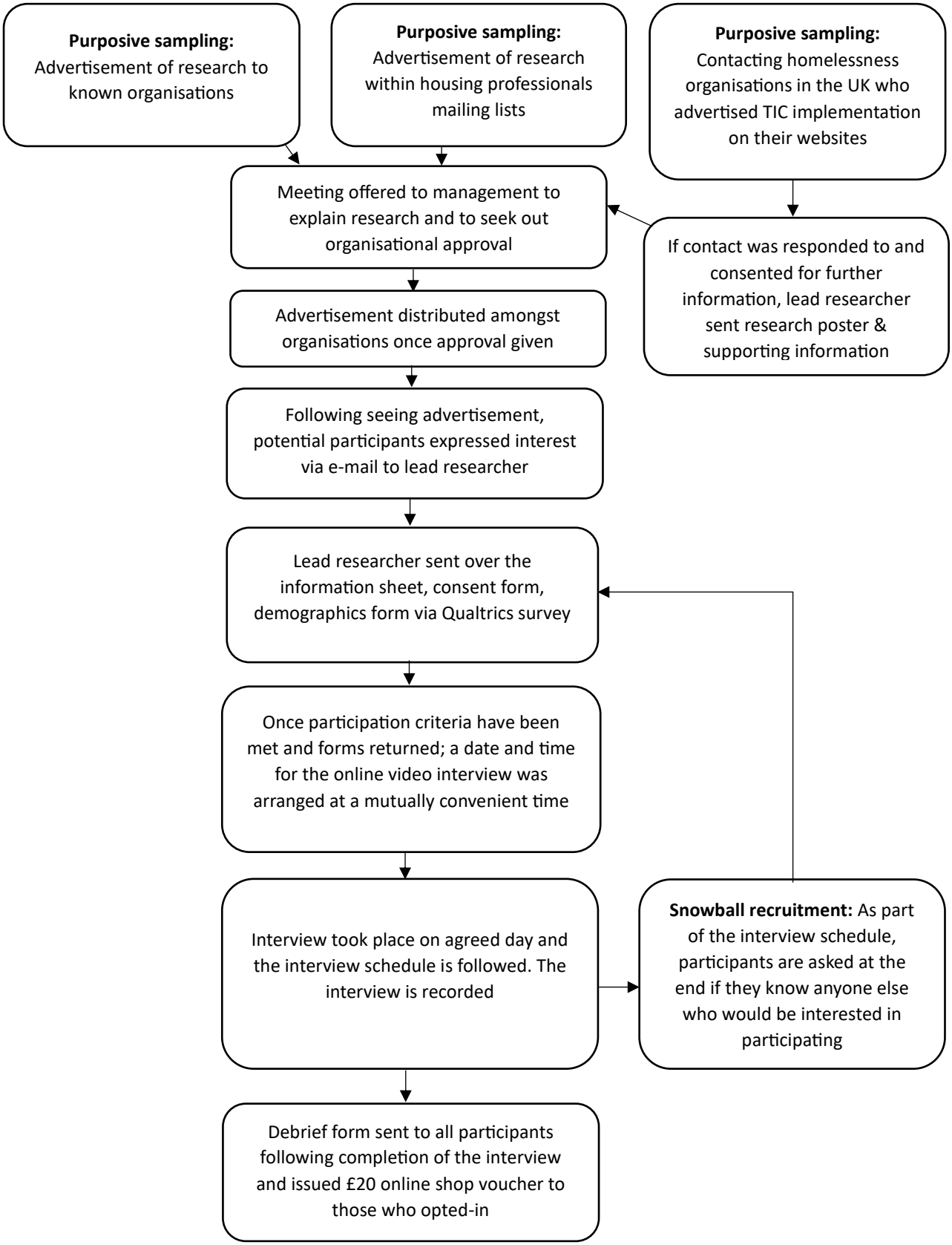
On the day of the interview, prior to the commencement of questions, participants were given an opportunity to ask for any further information and asked to re-confirm verbally their consent to participate. A reminder was given about their ability to terminate the interview at any time and to withdraw their data at any point up until prior to the commencement of data analysis. Participants were invited to share if they had any additional needs to be considered during the interview, as well as inviting them to take as many breaks as required. Participants were given the opportunity to ask questions at the end of the interview and they were then reminded of the next stages of the research project.

A debriefing information sheet (Appendix S) was given to all participants following the completion of the interview. Participants were given a choice to opt-in to receive an online shop voucher worth £20 from the DClinPsy research team's allocated vouchers provided by the University of Hertfordshire's Procurement team as remuneration. The University's agreement for volunteers and lay members involved in research (Appendix T) was completed with each participant before issuing the voucher. The vouchers were provided imminently after the interview to ensure the participant was aware there was no expectation to attend any further engagements with the research.

I transcribed all the recorded interview data and imported into NVivo 12 for data analysis. To uphold accuracy of transcription, I re-listened to each interview to review transcribed data which also supported the familiarisation stage of data analysis depicted in 3.8.

Figure 2

Study Procedure



3.7 Ethical Considerations

Key ethical issues have been considered in the design of this project including procedural ethics such as informed consent, confidentiality and sensitivity of the topic.

3.7.1. Ethical Approval

Due to the nature of the study utilising a broad recruitment strategy with mailing lists and targeting third sector organisations, NHS ethical approval was not required. Ethical approval was sought and received through the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee (Protocol number: LMS/PGT/UH/05370(2)) (Appendix U). Two amendments were made to widen the recruitment strategy and to request the ability to thank participants for their time with online shop vouchers worth £20 provided by the University of Hertfordshire's research team. Permission for advertisement for recruitment was sought from senior management in the contacted organisations (Appendix V). Adherence to the Code of Human Research Ethics by the British Psychological Society (Oates et al., 2021) was maintained throughout the project.

3.7.2. Informed Consent

All participants who expressed interest in the research were provided an information sheet (Appendix O) via a Qualtrics survey. Participants were given the opportunity to ask any questions relating to the information sheet before confirming consent. The consent form (Appendix Q) was included in the Qualtrics survey. Consent was re-visited at the beginning of the interview and re-confirmed verbally.

3.7.3. Confidentiality

With regard to confidentiality, participants were assured that their participation would not be divulged. A confidentiality agreement was affirmed at the beginning of interview, as well as aided by the information sheet and consent form (Appendix O & Q). Data was managed in line with the Data Protection Act (2018).

Interviews were conducted and recorded on a password-protected Teams account within the UH Herts OneDrive Cloud. Secondary recordings were made using the researcher's phone logging into the Zoom app, which is directly linked to the OneDrive Herts cloud, so the data was directly stored in an encrypted and password-protected setting. The data was only accessed by the project's lead researcher in line with UH Data Management Policy (University of Hertfordshire, 2023). At the point of transcription, participants had a choice to provide a pseudonym to be allocated to their information, otherwise one was allocated to their data by the lead researcher. Demographic information sheets were anonymised and stored in a password-protected document on a UH Herts Staff OneDrive. All identifying information and details will be destroyed at the end of the project to ensure confidential participation. Information has been kept anonymous in the report write-up and will remain so in future dissemination efforts.

3.7.4 Sensitivity of Topic

Ethical considerations also included keeping participants safe and supported given that the research invited participants to consider trauma. I considered TIC as a sensitive research topic, which can be further defined as any content that may cause emotional or physical harm and/or psychological distress, either to participants or researchers involved in a project (Sipes et al., 2020).

Discussing TIC may bring up difficult experiences within the professional and personal context for a participant. This consideration was highlighted in the information sheet and discussions at the beginning of the interview, alongside an invitation to participants to share if they have any needs to be taken into consideration with the interview taking place online. Recognition and management of distress in an interview necessitates careful judgment and skilful responsivity of an interviewer (Pascoe-Leahy, 2022). Utilising the research team to generate considerate wording for interview questions alongside discussions as a team pre-data collection was imperative to support the interviewer's skills for ensuring participant safety. My reflexive diary process supported me in maintaining continuous consideration of the sensitivity of the topic (Appendix W).

A debrief sheet signposted resources for further support, including recommendations for reaching out for internal support in their working organisation and detailing national organisations that may be of support (Appendix S). The contact details of the lead researcher and primary supervisor were provided to all participants to allow for the opportunity to debrief further, if required, beyond the standard initial debriefing information.

3.8 Data Analysis

A six-phase RTA was chosen as the data analysis framework (Braun & Clarke, 2022a). Themes were derived in an inductive fashion to ensure they remained closely linked to the data. I utilised electronic versions of the data over the duration of the analysis, with both audio recordings and written transcripts. The two formats of the data enabled me to weigh up varying insights and understandings. Table 11 depicts the data analysis process. Appendices X and Y offer some of my reflections on experiencing data analysis.

Table 11

Reflexive Thematic Analysis Stages

Stages of RTA	Analysis description
Phase 1: Familiarisation with the data	I began the familiarisation process as the initial stage of analysis following the completion of data collection by exploring all transcripts in their entirety (Braun & Clarke, 2022a). I carried out familiarisation by re-listening interviews and reading transcripts. During this process, I took reflective notes and kept a log of any potential coding directions to return to during subsequent data analysis phases.
Phase 2: Generating initial codes	Following familiarisation with the data, I generated initial codes (Braun and Clarke, 2022a). The transcripts from all interviews were coded inductively using NVivo 12. An example of a coded transcript can be seen in Appendix Z. All codes were re-visited with corresponding quotes to begin initial grouping of codes according to similarities in meaning, following a non-linear and iterative process.
Phase 3: Searching for themes	Once all initial coding was complete, I moved into sorting the overarching codes into possible themes (Braun & Clarke, 2022a). To support this process, I utilised electronic mind maps to see how

	each code may fit into certain themes. An example initial theme mind map can be seen in Appendix AA. I considered the different levels within a theme, possible sub-themes and relationships between themes (Braun & Clarke, 2022a).
Phase 4: Reviewing themes	Reviewing themes involved several stages of consideration. Firstly, I reviewed any collated extracts associated with each sub-theme and theme to ensure a meaningful pattern, while reflecting on themes to ensure they were distinct from one another (Braun & Clarke, 2022a). Several iterations of this process, going back to quotes, altering the wording of codes and travelling back to overall theme generation, supported achieving depth of analysis and interpretations of meaning. Consultation with the research team at several time points during the review of the theme process supported researcher reflexivity and refinement of theme language. Examples of different stages of theme mapping are seen in Appendix AB.
Phase 5: Defining and naming themes	Theme definitions were written up to clarify and illustrate the central organising concepts (Braun & Clarke, 2022a). At this stage, I reflected on Braun & Clarke's (2022a) idea of ensuring to "let things go" if ideas or concepts do not fit into final theme generation. To support this, I re-visited extracts in order to organise them into a "coherent and internally consistent account" within each theme (Braun & Clarke, 2022a). The finalised thematic map is shown in Figure 3.
Phase 6: Producing the report	The final phase required writing up the analysis into the results chapter. I took time to consider how to present the themes and sub-themes according to their meaning and distinct identities. This process enabled further refinement of theme language utilised, leading to alterations of final sub-themes. I considered how to demonstrate a coherent narrative of the overall themes to support the reader to follow the story of the data. I chose extracts to support this process and demonstrate each theme.

Chapter 4: Findings

4.1 Overview

The present chapter discusses the themes and subthemes generated through reflexive TA of the interviews with sixteen staff members.

Three main themes were identified and are depicted in Figure 3 and Table 12 below with corresponding sub-themes. These themes represent my interpretation of the meaning that participants ascribed to their experience of their TIC journey in homelessness services. Therefore, I have attempted to capture their 'reality' in the analytic process. To illustrate the themes and associated sub-themes, I have used verbatim extracts from the interview transcripts for each theme. There have been occasions whereby it was necessary to omit elements of extracts to be considerate of the word limit.

Figure 3

Thematic Map

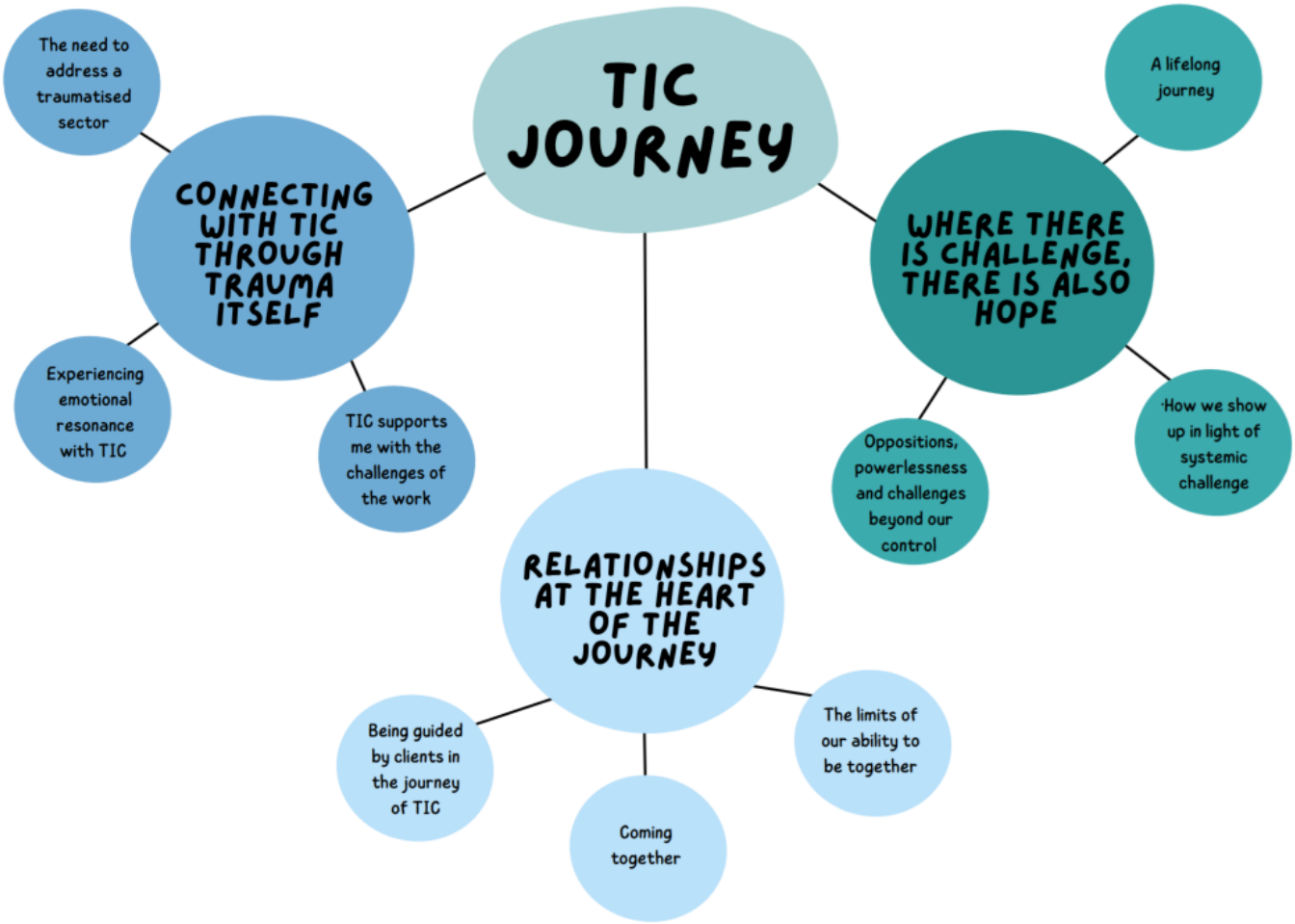


Table 12

Theme Summary Table

Theme	Subthemes
Connecting with TIC through trauma itself	The need to address a traumatised sector Experiencing emotional resonance with TIC TIC supports me with the challenges of the work
Relationships at the heart of the TIC journey	Being guided by clients in the journey of TIC Coming together The limits of our ability to be together
Where there is challenge, there is also hope	Oppositions, powerlessness and challenges beyond our control How we show up in light of systemic challenge A lifelong journey

4.2 Theme 1: Connecting with TIC Through Trauma Itself

This theme illustrates participants' discussions on how they connect with TIC through trauma itself. The connections are described in multiple ways, firstly, participants recognise trauma occurring across the sector, thus demonstrating the first subtheme, a need to address a traumatised sector. The second subtheme discusses how participants connect with TIC through emotional resonance. Resonance is depicted as participants' *"visceral"* responses to TIC or as TIC providing a *"life-changing"* perspective. The final subtheme discusses how TIC supports participants in the challenges of the work, providing frames of reflection or enhancing their empathetic lens.

4.2.1 Subtheme 1: The Need to Address a Traumatised Sector

This subtheme highlights the pervasive presence of trauma throughout the homelessness sector. It encompasses the traumatic experiences of both clients and staff, trauma occurring in client-staff relationships, workplace trauma for staff, and collective traumatic events affecting the entire sector. The recognition of trauma in these different domains led to an acknowledgement of the need for TIC to address the multiple layers of trauma.

Participants spoke about assuming an existence of traumatic experiences for all clients, recognising the specific context of being homeless meaning there is a greater likelihood of a client having prior experiences of trauma:

"I suppose from a starting point it's that recognition of trauma and with our client group, I would struggle to find someone who hasn't experienced trauma."- Lillian

One participant suggested that taking a TIC lens and treating everyone as if they have experienced trauma, even if they haven't, has no negative consequences. Instead, it promotes a universally beneficial approach:

"It [TIC][6] doesn't affect anyone negatively. Like if you, if someone hasn't had trauma but you still treat them like they have, it's, there's no downside. It's not like they're being treated unfairly. It's just treating everyone in a particular way that's only beneficial." – Lyle

Some participants spoke about TIC including being aware of traumas such as discrimination:

"I think it's also being aware of kind of other areas of sort of like discrimination for example, and sort of people's social economic backgrounds, that the kind of, almost unspoken about things, that people often don't get a chance to talk about or maybe decline to talk about for different reasons because maybe they don't feel safe, uh, talking about them. So yeah, I think that it, it's ultimately it's like helping someone you know, to, to heal, to understand themselves better and sort of grow from there after having that sort of safe space to to talk from." – Arthur

There was also recognition that both clients and staff will have experienced trauma:

"I think probably fundamentally it's recognising, you know that, a lot of people we work with but also ourselves as well as workers, […][7] will have been through things in life which may affect our view of the world, our view of other people, how we feel about things, how we respond to things. […] And trying to understand, you know, how somebody is in the context of that." - Elliott

[6] . In order to provide context to some participants' quotes, brief sentences in brackets will be used throughout this chapter e.g. [when discussing reflective practice].

[7] Any words or sentences that have been omitted will be shown by three dotted lines inside brackets e.g. […].

Participants also named how services can cause harm and trauma for clients, which has enhanced their own connection with trauma-informed principles such as minimising harm and prioritising safety for clients.

"I think a very poignant one for me was when a pregnant lady who came to us was housed with a local authority and was put in a room without bed or table and chairs. And that doesn't feel like a trauma-informed approach. […] For me, the damage was done when that pregnant lady opened that door after being on the streets and saw an empty room and that was the offer that the local authority made to her. And I think that, that damage it could have triggered loads of things and could last a lifetime. Right. It's a traumatic experience that professionals have made to that person. Probably happens every day. And it's how do you stop that understanding of it. And I think probably at a higher level, there's got to be better policies in place to ensure that vulnerable people get appropriate services, I guess, that are trauma-informed."- Enzo

The above quotation represents a common pattern across participants of sharing clients' stories to reflect on their understanding of how trauma can show up for people, either to emphasise the need for TIC or to demonstrate how TIC can support an individual.

Some participants discussed the importance of accepting the inevitability of rupture and repair in client-staff relationships, naming this as a form of trauma that takes place within services. Acceptance was discussed as a necessary step in order to hold awareness in a trauma-informed approach, thus, how to build trust, offer a non-judgmental approach and maintain safe boundaries in order to support both clients and staff.

"Relational ruptures are gonna happen, they're inevitable in this line of work, but also they're a real opportunity for learning and growth like, and, so I think for the team to kind of hold that until and to share that with clients who, and when something's happened, it's kind of like actually we do want to work through that. […] We understand how relationships can be healing, including through

ruptures and repairs, and we recognise the importance to be thoughtful around endings, and for this happening in a planned way where possible." – Elliott

One participant referenced the homeless sector as a service which is 'sick', an analogy to express the dysfunction and deeply embedded structural issues that perpetuate experiences of trauma for all those who are involved in the system, e.g. clients and staff.

"…The idea of like the service being sick or the system being faulty and the impact that then that has on us too. So the way that creates its own sort of trauma…" - Arthur

Some participants discussed the idea of the homeless sector experiencing systemic trauma, whereby there have been collective traumatic experiences that have impacted the functioning and wellbeing of the sector as a whole. A specific example of COVID-19 as a systemic trauma is discussed in the quote below:

"…In the pandemic, we've been running like three hotels filled with homeless people. There was so much funding and we had zero people on the streets because there was a deadly pandemic going around and it was the right thing to do. And then the money stopped. And then the negative effects of the pandemic, obviously, around people's, you know, work and accommodation and things, the numbers just were higher than they were pre-pandemic. And I think that that kind of like traumatised the whole sector in a way." - Enzo

Discussion of trauma in different spheres within the homeless sector led some participants to name their perspective of TIC being needed as a response.

"I think it is that [the TIC] approach and understanding is probably needed now more than ever, let's be honest. […] The rough sleeping figures are going up and up and up and that is, you know, people in temporary accommodation is going up and up and up. You know, we're in the most probably the most difficult, challenging times in this sector today, in the 15 years that I've been in there." – Rhys

In sum, this subtheme highlights the need to address a traumatised sector through recognition of the widespread prevalence of trauma across the homelessness sector.

4.2.2 Subtheme 2: Experiencing Emotional Resonance with TIC

The second subtheme references participants' experiences of emotional resonance with TIC, whereby TIC evoked an emotional response that connected with their personal experiences. Participants shared that TIC is unique to each person and described methods of connection, such as experiential learning or connecting with previous knowledge.

Participants referenced having their own experiences of trauma and recognising some of the effects of trauma in themselves as provoking emotional resonance with TIC.

"My personal experiences. Also, I'm not trauma-free. So looking back and thinking about what would help me and what went wrong, it's more of a self-reflection and being self-aware, that also helps." - Ewa

"I would say it's more in the latter years really of my career that I've sort of become more trauma-informed. And I think that's happened on a personal level before it became a working part of my professional life." – Gemma

The above quotation highlights the personal nature of adopting TIC, emphasising that the journey began with personal resonance and understanding before transferring into professional practice.

Participants also spoke about experiencing a deeper, embodied, "visceral" response when explaining their connection to TIC. One participant expressed difficulty summarising it in words, instead referencing how it can feel when TIC is taking place:

"…other places I've worked, it's been, it's been a more like about the numbers, it's about the spreadsheets do you know what I mean, it's... Yeah, it's unless you work here. It feels it's very err, like, visceral, you can really feel the difference." - Lyle

There was an overall suggestion from participants that the definition of TIC is dependent on how it shows up for someone personally – it changes depending on who the client is, the clinician's own identity and experiences as well as the context of the work.

"it's not a one size fits all, really." – Annie

"To adapt them to individual needs because obviously everyone is different and everyone has their own experiences." – Bronwen

"When people get invested [with TIC], they're really interested because it's about looking at themselves, [...] I could see the click that happens with them." - Sahla

This perspective testifies to the importance of TIC being a personalised approach according to each individual's need, suggesting TIC works when it emotionally resonates with those involved in the process.

Further highlights of the importance of personally connecting to TIC was shown in participants' discussion on valuing experiential learning of TIC as an opportunity to go beyond the academic knowledge of TIC and experience personalised learning.

"I guess it's when you just do this job, it's just it's that's like a general understanding [of TIC] […] I suppose it's just the more you do it, the more you sort of understand"- Lyle

Considering the context of a traumatised sector discussed in the previous subtheme, it can be inferred that hands-on experience with TIC and seeing its alignment with the high prevalence of trauma strengthens its impact and resonance.

Participants drew upon knowledge of existing approaches in the helping sector to further discuss how they have made sense of their connection to TIC. Some acknowledged that TIC was not an entirely new approach, naming associated approaches such as PIE and person-centred care that bear similarities to TIC. Whilst this was named, participants did recognise TIC as a distinct, improved

approach overall.

"[TIC] It's a lot of what we've already been doing, but it helps us see that a lot better and understand that, and also give us some ways of doing some of the stuff better." – Rhys

Some participants spoke about their previous professional experiences in contrast to their current role within a TIC context as an eye-opening shift to the work, with some referencing how they would not be able to switch back into working in a non-trauma-informed manner.

"It was like somebody switched the light on." - Gemma

"It's like you can't unsee things now." - Annie

The commonly used analogy of an *"eye-opening"* and *"life-changing"* experience suggests that connecting to TIC has been a profound and transformative learning experience for participants. It's possible to consider that the introduction of TIC has provided shifts in perspective, whilst challenging existing knowledge, beliefs and methods of offering support in the homeless sector.

Overall, this subtheme depicts participants' emotional resonance with TIC, where personal experiences of trauma and experiential learning evoke a deep, transformative connection to TIC, emphasising its personalised and profound impact on their professional practice.

4.2.3 Subtheme 3: TIC Supports Me with the Challenges of the Work

This subtheme illustrates how participants have connected with TIC as a method of support whilst encountering challenges in work.

Some participants recognised that staff may experience trauma in the workplace, whether that might be through direct experiences, in the form of vicarious trauma or burnout. Consequently, experiencing these challenges requires support.

"We should be thinking about this all the time and how we work with people that have suffered trauma and ensuring that the staff also feel supported because, you know, vicarious trauma

and so on. It can, it can really affect a lot of people that come into this type of work. I think especially when you work with people that are rough sleeping […] it can really have an impact on the workers. So they need a lot of support." - Annie

Some participants emphasised TIC as supportive due to the approach offering a framework for reflection and enabling different perspectives to understand behaviours or situations that challenge staff.

"I'm coming at it like […] thinking, right, he might scream in my face and spit at me, but that's not, he's not doing that out of choice. […] It's, I guess, trauma-informed, I'm coming at it thinking there's a reason why." – Lyle

There was further discussion on how TIC encourages consideration of the context of behaviour, supporting staff in reflecting on what has happened for an individual:

"[TIC] is to understand that actually again, something led to that [behaviour that challenges], you know, this is not how this person is, or even if it is, how that person is all the time, there's a reason for it." - Nadeem

Participants further elaborated that TIC has been supportive in developing their sense of empathy and widened their understanding of how trauma may manifest for a client, as well as holding in mind the possibilities of re-traumatisation through services.

"And then there's the re-traumatisation aspect as well is thinking about this person's experience of trauma. If I even experienced trauma and it's around, I don't know, X, Y or Z and I walk into this project and it's bars on the window and the staff have got their keys jangling, you know what I mean? It can help you think. […] How would that make me feel? Would that be, could that be re-traumatising? So, you know, that idea as well, making you see things through a different lens." - Rhys

Some participants described some of the benefits they receive due to working in a trauma-

informed approach, including feeling rewarded when seeing the positive outcomes for clients.

"it feels more rewarding the work that you're doing because, you're actually understanding people and working with people rather than just constantly reacting to things that they're doing because you're able to pre-empt things." - Amelia

The work being rewarding suggests participants experiencing positive emotions alongside a sense of purpose and fulfilment. Some participants extended this in describing the trauma-informed approach as therapeutic and healing for themselves, suggesting it offers nourishment and sustainment for continuing to do their job.

"But I find it very therapeutic, doing the job I do and it kind of helps with that healing as well." - Sahla

The positive emotions were further described as a sense of feeling lucky for working in a TIC setting:

"Like I'm very lucky. It's like, it allows me to work in a way that is patient-focused as opposed to goal-oriented, organisational-focused." - Gemma

The above quotation also represents how some of the participants expressed an appreciation for TIC aligning with their personal values, such as working in a person-centred manner. It can be further inferred that participants recognise that working in such a manner may not be commonplace within the homeless sector, implying that TIC is not yet universal in this context.

In sum, the subtheme shows how participants connect with TIC as a supportive method for addressing work challenges, acknowledging trauma's impact on staff, providing a reflective framework, fostering empathy, enhancing understanding of client behaviours, and offering rewarding benefits aligned with personal values.

4.3 Theme 2: Relationships at the Heart of the TIC Journey

The current theme summarises participants' experiences of interpersonal connections and

interactions playing a central role in their TIC journey, effectively describing the importance of *"putting the relationships at the heart of what you do,"* as Rhys shared.

Participants discussed relationships with clients as guiding influences in how they engage with TIC, forming the first subtheme. The second subtheme represents participants' discussions of the benefits of coming together with colleagues, across teams, and across partnerships to support carrying out TIC, while the third subtheme named some of the limits they experience in attempts to join together.

4.3.1 Subtheme 1: Being Guided by Clients in the Journey of TIC

This subtheme illustrates how participants put their relationships with clients at the heart of the TIC process. They named their relationships with clients as important foundations, enabling them to have a central role in the TIC journey of a service.

Some participants discussed the importance of making space for client voices to be heard within TIC and enacting their feedback as key.

“Yes, I think we use clients in pretty much everything we do. So like all of our policies are overseen by a service user policy group that come together and often actually, you know, I have a client that does the policy group and says “half the time, I don't understand the policy, but I'm just there to say, actually I don't think that would be really fair on us because actually you've overlooked this bit or you know for me…” and actually they get more of that conversation. […] Sometimes I think people are seeing that service users are stupid and that they won't understand the difference when you talk about TIC.” - Amelia

The above quotation reflects the recognition from participants about the existence of stigma that clients have faced in their involvement in services, and a desire to tackle the stigma in order to build closer relationships with clients.

One participant discussed the value of working relationally with clients, utilising empathy to recognise the potential harm caused by services and recognising that time is required to build trust and closer connections with clients within a trauma-informed framework.

"I feel like we work relationally, we work to try to really acknowledge that people are furthest from services and a lot of people who [we] work with face, you know, multiple rejections in their life and their personal life, but also within services. And so they often are quite sceptical, with layers of mistrust of services. So a lot of the work is around building relationships with people in the first instance, you know, to build that level of trust so that they may be open to kind of accepting some sort of help. And so we work with people over kinda longer periods of time." – Elliott

Some participants emphasised the need for client advocacy to address the power imbalance between staff and clients. Advocacy was seen as a way to prioritise client needs and redistribute power.

"So it's equalising the power a little bit as well, uhm. I think like, our advocacy. You know, we, we advocate for people quite a lot as well. And in terms of our role, […] I think that also helps with generating that trust. You know, people feel quite disempowered and quite marginalised that their voices aren't heard." – Elliott

Existing language used in practice was reflected upon by some participants, and how their collective engagement with TIC enabled them to shift language to support re-balancing power dynamics between staff and clients. An example can be seen below in challenging the language of 'difficult to engage':

"And it's almost as a service we've not yet found a way to support that person. […] I don't think people are difficult to engage. I think they have been through trauma in their lives and they live quite chaotic lives and we need to find a way to engage them. What is it that's going to help them to engage with us?" – Annie

A few participants discussed the idea of keeping an 'open door' policy for clients to facilitate

relationship building, trust and support. Participants spoke about this mindset providing flexibility according to client need.

"We're going to talk about this and that, but then it's also always the door open of approaching at anytime when it's needed." – Rosa

Overall, this subtheme highlights how participants prioritise client relationships in the TIC journey through valuing client feedback, relational work, advocacy, language shifts, and an open-door policy to build trust and support.

4.3.2 Subtheme 2: Coming Together

This subtheme represents participants discussing their experiences of coming together with colleagues in teams, within a service and across partnerships to foster meaningful relationships. Participants discussed coming together as key for delivering TIC, describing different mechanisms that enable this such as shared values, trauma-informed collective spaces, training, psychological staff input and thinking about identity, as well as the impact this has.

One participant discussed how TIC lessened a sense of feeling alone, instead, providing a shared way of thinking together as a team:

"I don't feel alone anymore because it's almost, um, like we've got shared way of… of looking at maybe a clients' trauma and… [...], so, it's able to be in the same room thinking through that process." - Sahla

TIC was discussed as a mechanism that connects for the majority of people, therefore connecting those people together through the framework:

"It's almost something that that kind of connects with most people." - Arthur

Some participants also discussed how TIC was possible due to their existing close connections with colleagues, utilising peer support and informal conversational spaces as avenues for enhancing trauma-informed practice.

"I think within my team and organisation, they flag up and offer us support and help with work. We're quite a tight team. We support each other in the team, we have good management as well. So that really helps." - Jamie

Participants discussed how shared values within a team and an organisation can support trauma-informed working and collaboration.

"It's really good to have those shared values because yeah, everybody is sort of singing from the same hymn sheet then as well." - Sahla

"The team that I have right now, we're very fortunate because everyone is very compassionate, empathetic and it makes it makes my life a lot easier as well." – Nadeem

"We did a piece of work where we co-produced our values as a team and that felt like then we had this real safe, with this sort of place to come back to, where we had this core set of beliefs." – Elliott

Trauma-informed values named across participants' contributions included being strength-focused, being open, prioritising safety, being relational, kindness, compassion and wanting to fight against social injustice.

Most participants spoke about different forms of trauma-informed collective spaces enabling togetherness in the trauma-informed journey. Collective spaces were described as structured approaches such as reflective practice, supervision and team formulation sessions, as well as the value of unstructured, informal support.

"[Comparing previous non-TIC job to current TIC job] Here we have like reflective practice, case formulation, peer support, supervision […] all those things are for us and really helpful." - Elena

"The powers that be allow and recognise for that needs and allow that [reflective practice] to be part of our sort of fortnightly diaries because they could easily say no, you've got enough work to do, get on with it, but they don't. So they recognise the need for it which is good." – Lillian

The above quotation highlights how the participant views organisational support as key in being able to prioritise trauma-informed collective spaces. It was further expanded about teams needing tailored support according to their experiences, such as gender-focused reflective practice for female staff experiencing vicarious trauma relating to their female clients' experiences of gender-based violence.

Collective spaces were also described as key for de-compressing, challenging bias and ensuring clinicians were coming from the same understanding of a clients' needs, as demonstrated in one participant describing their experience of carrying out team formulations:

"When you start looking at formulations and get to the… nitty gritty of what their triggers are, what their past traumas are and, you know, working on their strengths, […] it's uplifting because it's like the penny drops and I see that now […] when we're having formulations, you know, within the staff team… It's good […] because with our clients, they are very ballistic to say things, and sometimes it's very hard to actually get to the… bare brunt of the truth of what's really happened." – Sahla

The quotation also implies the importance of utilising more than one clinician's perspective to develop a holistic understanding within TIC, deepening the emphasis on a relational approach within TIC.

Reflection was consistently discussed by participants as an avenue to enhance self-awareness, empathy, learning and collaboration in delivering TIC. Whilst TIC was named as a method of structuring reflection, it was also recognised that reflection was embedded in service delivery that provided space for TIC to flourish. Reflection was discussed by some participants as a method of

slowing down practice, in order to counteract reactive, quick responses that have had unintended consequences of causing harm to clients previously.

"We try and challenge ourselves in our team meetings. Where have we been trauma-informed this month? What could we do better? You know, we just keep it on the agenda all of the time. What successes have we had with our trauma-informed practice? What went wrong, and what was good? – Lillian

Participants discussed valuing engaging training as a method of unifying clinicians in their TIC journey. Training was also viewed as valuable in offering a space to think about themselves as clinicians in the TIC journey.

"And the training that I brought in […], but you know it was a fantastic training that that I was able to source and it was delivered over a few days and actually the staff feedback that it was the first training that they'd had been on where it was actually about them as well because quite often you go on training, it's about supporting our service users. […]. Actually, a lot of this was about them as workers and how they've experienced trauma, and how they deal with it and how they keep themselves well and look after themselves." – Annie

Overall, participants expressed a value in having multiple routes for collective spaces, recognising the unique benefits from each avenue to foster relationships and growth in the trauma-informed journey, thus ultimately serving the best outcomes for clients.

"So for here we have like reflective practice, case formulation, peer support, uh, they, you know, therapy sessions, um, all different kinds of group work, um, and all those things are for us to really helpful. […] …All these different things that we've got in place, that's what's helping us help the clients and that's why there's more successes." - Elena

Some participants spoke about valuing psychological staff input to support professional collaboration in the trauma-informed journey, stating that psychology-associated staff can help

develop an understanding of clients' presentations, support team formulations, provide reflective spaces, offer trauma-informed training, and consider how theory applies to practice.

"…they'd have psychology as well. And so I think that's definitely made a huge difference across services. …I think they are supportive of staff to work in a trauma-informed way and provided that reflective practice and clinical supervision and that can go to from with cases and discuss that. And I think that's really helped across the whole of the organisation in terms of working with people rough sleeping, having psychology just you know, that's something that I didn't see even just a few years ago, so it's really helped to be embedded in those outreach teams." - Annie

Psychologists were also discussed as an avenue for support for staff wellbeing when particularly difficult events happened, such as client deaths:

"And the thing in our service, we've had quite a few deaths as well, client deaths, which is quite common because quite a few of our clients use substances. And so that can be hard. And I've lost two clients. And, so your mental health and wellbeing, sometimes can take a little bit of a knock and, but that's where having a psychologist and having that reflective space really helps, because when I lost my first client, the psychologist in this service was amazing, and at first, I kept having 5000 things going around my head like "could I have done something different? You know what if we tried this, what if we done this, would that have prevented it?" And then when I reflected with the psychologist and then she made me look at it from a different point of view and made me acknowledge it, "actually, you were there through that clients' whole journey and you were the only person that was there" and it made me think actually, "yeah. OK, I think I don't blame myself no more like I did all that I could do so…" - Elena

Overall, this subtheme highlights the importance of collaboration among colleagues and across partnerships in the TIC journey. Participants emphasised the role of shared values, collective trauma-informed spaces, training, psychological staff support, and reflection in enhancing togetherness.

4.3.3 Subtheme 3: The Limits of Our Ability to Be Together

The present subtheme represents the limits of people's ability to be together in TIC. The absence of collectivism and associated difficulty further supports the notion of relationships as central to TIC.

Some participants spoke about the limits of collective trauma-informed reflective practice:

"I think with reflective spaces sometimes they can turn into sort of whingey spaces. I'm totally guilty of that myself, "ah it's absolutely everything is shit", you know."- Lillian

"And I think reflective practices is great, but it's not a solution to significant trauma." - Enzo

The above quotation highlights how further supportive input, in addition to reflective practice, is still needed to fully address the needs of staff and PEH.

Participants note there is sometimes resistance towards integrating trauma-informed practices.

"So we do reflective practice for staff groups and team formulations regarding complex clients, […] staff will say "ohh, I've got team formulation tomorrow and they're like, urgh ((rolls eyes))". And I think… Hmm, it's not... Maybe after they think "Ohh, that's good", but they're not willing either, which is hard." – Bronwen

Participants who spoke to resistance further acknowledged that the absence of collective investment in TIC had negative impacts for their own wellbeing.

Some participants spoke about their experiences of holding sole responsibility for supporting the transition of TIC within their service, implying a sense of isolation.

"It's really hard to be the only one. Not the only one, but, someone who is attempting TIC and then others are just not on board at all." – Amelia

"In a room of people that are not, I guess, on board the ship, […] and that can feel that, that's a real challenge." – Bronwen

It was also noted that when participants who held responsibility for TIC were asked about their wellbeing in the process, they tended to discuss staff wellbeing in place of their own.

"So, for me, I think that my role is to make sure that the services that I support and I work in feel equipped to work with this particular client group." – Annie

It's possible to consider this tendency may be understood by a few participants' contributions who named the absence of leader-specific supportive spaces for their wellbeing. One participant did share positive experiences with leader-specific spaces, recognising it had been helpful to connect with others who share similar positions:

"I also get a reflective space within [organisation] where the leaders attend that. So that's a separate space and yeah, […] just to offload and support each other." - Lillian

In sum, this subtheme depicts the limits of collectivity in TIC, emphasizing the need for additional support beyond reflective practice, the resistance towards TIC integration, and the sense of isolation felt by some of those leading TIC efforts.

4.4 Theme 3: Where There Is Challenge, There Is Also Hope

The present theme depicts participants' experiences of challenges in the TIC journey whilst also employing deliberate acts of hope to counter such difficulties. The first subtheme illustrates the types of systemic challenges experienced, such as oppositions, powerlessness and challenges that feel beyond the reach of participants' control. In response to these challenges, subtheme two depicts participants' actions to foster hope, including collaboration, creativity and celebrating little wins. The final subtheme depicts the lifelong journey of TIC, with ideas from participants on how they hope TIC continues to grow in the future.

4.4.1 Subtheme 1: Oppositions, Powerlessness and Challenges Beyond Our Control

Participants described experiencing challenges within different aspects of the homelessness sector on their journey of TIC. Challenges were perceived to be occurring at different levels of the

homelessness system: within staff teams; across a service; within the homelessness sector and in wider society. These challenges, understandably, have emotional consequences.

Participants described systemic challenges taking shape in different formats. Some participants discussed experiencing oppositions in service provisions to TIC, feeling powerless to implement service change, experiencing inconsistencies across the sector, working alongside people in other services who are at a different stage of their TIC journey, and experiencing difficulty when holding responsibility in TIC delivery.

Some participants talked about experiencing oppositions in services, whereby other service practices or service provisions are in conflict with TIC. An example discussed by several participants included the opposition of traditional key performance indicators (KPIs) to TIC:

"I think it's really hard to justify at times why you're not meeting those KPIs in the same way, because KPIs don't care about trauma-informed care in the same way, it's you can't, you can't make it a statistic, so that can be really challenging."- Amelia

Further topics positioned as in opposition to TIC included the medical model of understanding distress; focusing on policy & procedures; governmental funding and legal requirements of carrying out the work with people experiencing homelessness.

It was acknowledged that services demonstrate an understanding of TIC but there is further progress to be made in its implementation, as Enzo states: *"I think it's, there's understanding there, but by far not perfect."*

Some participants named that shifting a service's practice into a trauma-informed way of working can be slow in pace and require time. It was discussed that meaningful collaboration in the process can be met with additional challenges when combining efforts across partnerships, where there may be varying priorities or cultures in different services.

"But there's other organisations that may be wanting to move in that direction, but change is just really, really slow and they're quite bureaucratic, quite big institutions. And I think so, trying to, you know, manage that pace of how you work and take people alongside along with you is difficult when people are kind of much slower. That's probably about one of the biggest things."- Elliott

At a wider society level, participants discussed the contrast of carrying out TIC in a non-trauma informed society, thus leading to a limited effect of its benefits.

"Yeah, I guess that's something there's something big about system change, about having institutions that are completely on board and, and you know, I guess our politics needs to change, you know, substantially as well, you know, thinking about inequality in society and about how we treat minorities and all sorts of, all those aspects need a real shift in change, to think about it really critically." - Rhys

Further elaborating on the limits of TIC, most participants discussed experiencing a ceiling effect whereby limited finances, staff and resources restrict TIC growth.

"So, you know, in my service, that's not a trauma-informed approach, if actually you don't have the staffing ability to run that service. […] I think that and retention is important. I think it doesn't matter how many reflective practice sessions or post-incident sessions or employability support programs. Human beings will get burnt out if they're working relentless hours with the number of people going up. I think it's kind of common sense, isn't it? If the need is going up, you need invest in the resource and I don't think we've had that over the last ten years really." - Enzo

Participants offered reflections on their emotional experiences when restructuring practice into a trauma-informed manner and experiencing multiple barriers to the change. Participants named experiencing feelings such as powerless, defeated, frustrated and drained.

"I think it's emotionally draining and it can be really challenging to accept that, you know, the traditional view of justice or the traditional view of kind of what you can expect in the workplace

is really challenged by trauma-informed care, you know, a lot of my colleagues I think would struggle to tolerate some of the ways that I've been spoken to by some clients because I'm choosing to work in a trauma-informed way and overlook some of that to focus on that relationship and challenge it at a later date. I think it takes a lot of time." – Amelia

Overall, this subtheme demonstrates the numerous challenges face in the TIC journey within the homelessness sector, including systemic opposition, powerlessness, resource limitations, and emotional strain, all occurring at various levels from individual services to wider society.

4.4.2 Sub-theme 2: How We Show up in Light of Systemic Challenge

Participants described how they resist and respond to experiencing systemic challenges on their journey of TIC. This included equalising and re-distributing power, balancing priorities, collaboration, modelling TIC to others, carrying hope, optimism and courage, engaging with creativity and championing little wins. Overall, there was a pattern of recognising a challenge and acting in opposition to what the challenge was pulling them into.

Many participants discussed the analogy of 'balancing' when referring to responding to systemic challenge. For example, one participant referenced balancing the amount of care invested in the work, ensuring to care enough but not care too much to enable the long-term sustainability of this work.

"I think is finding this balance as well of is not that you don't care because if we wouldn't care, we wouldn't be here. But in the end, it's finding the balance of care enough for doing what you do, but not pain too much in order to actually function." - Rosa

Some participants discussed experiencing power imbalances from decision makers above them, such as commissioners, the local council and government which impacted on their sense of experiencing systemic challenge. As an act of addressing power imbalances in systems of care, some participants discussed the importance of acknowledging their own power as a professional as a

method of recognising how they may contribute to harmful mechanisms and offer an opportunity to themselves to choose actions that re-distribute power.

"I think it forces you to sort of think about your role and the dynamics and the power that you bring to the role and how that is seen by the service user possibly and perceived by them." – Jamie

Participants spoke about systemic challenges in the homelessness sector causing services to disconnect from one another, therefore placing an emphasis on intentional collaboration with other agencies outside of their service to correct this consequence. An interdependent process between collaboration and TIC was noted in the data: collaboration was discussed as a necessary step to implement TIC, whilst shared TIC principles enabled across-service collaboration. Participants spoke about different methods of collaboration across services, such as sharing trauma-informed training resources, having reflective professional support networks across partnerships and local TIC steering groups.

"It's about everyone learning from each other and giving each other that space and we, when we do a check-in, you know, we talk about something that we've learned or something that's happened within our service or something like that which I just think it's really interesting to hear what other people have been doing and things as well." - Annie

Modelling TIC was discussed as a method of coping with systemic challenge.

"My organisation is a client-focused organisation, yeah. At the local level authority, not so much. So therefore, it's like, they had very little understanding about the drug and alcohol recovery. So we showed them what that's about. We showed them how difficult it is to wake up someone at 7am and request information." - Ewa

Modelling was also referenced in terms of demonstrating transparency of not claiming to be fully trauma-informed in order to combat the term being used as a buzzword:

"I've seen so many organisations where like senior people and or even frontline workers say "we're trauma-informed" and I kind of go out of my way a little bit because we've got a reasonably good reputation, […] I will say "well, we're not like we're trying, but we're just not" like, so how can you confidently say that you are?" - Enzo

A cautionary note about modelling was offered by one participant, noting that modelling TIC starts within your own system first before sharing in wider systems:

"Practicing what we preach really. So if we can't do it in our office, how do we expect to go into other people's services and offices and implicate that there and model trauma-informed behaviour?" - Bronwen

Participants also spoke about holding certain psychological attributes such as hope, optimism and courage in response to systemic challenge:

"I remain hopeful if, you know, if we can be a good example of what it means and how it can work. And again, you know, that's my sort of optimistic, sort of hippie-ish, if you almost like, sort of thing, idea that, you know, if the trauma-informed framework here works the way it's supposed to work and we do it better at a sort of societal level, I think that could be a real shining example for everybody else of how things could work."- Rhys

Courage was also discussed as a required internal attribute in order to speak up against systemic practices not perceived as TIC.

"And that takes a bit of courage because you have to go against the local authority saying, I need time to get to know this person, because housing a person is not, it's not the problem. The housing is there, making sure that that person never comes out to the streets again, that's a success." - Ewa

Focusing on little actions, change and wins were discussed as important to support persevering with TIC delivery in light of systemic challenges*:*

"Well, as we fought, little wins because obviously the big things, it's easy to celebrate, but it's remembering that actually for a lot of people who have little wins are just as important." - Elliott

Participants also discussed recognising needs in the midst of systemic challenge and utilising creativity in their approach due to limited financial resource, either through taking perspective or generating resources for their service:

"we've had to really think about trauma and why that person is behaving in that way and what can we do? What can we learn about that from their behaviour? What is going to work for that person, for us to engage them, you know? So you have to be really creative and really think, alright, well actually you know, they don't like being woken up at that time or, they don't like that assertive approach, […] so you're working it all out, you know, so that you can get that person to engage." – Annie

This subtheme highlights how participants respond to systemic challenges in TIC by redistributing power, balancing priorities, fostering collaboration, modelling TIC, maintaining hope and courage, celebrating small wins, and engaging in creative problem-solving.

4.4.3 Sub-theme 3: A Lifelong Journey

Participants spoke about their views on the path forward for TIC, not only in the homelessness sector but also including considerations for wider society. Participants discussed beliefs of TIC as a lifelong journey, recognising that continuing to grow this approach is a commitment for the future for themselves, their clients and their service. A further hope was expressed in TIC being a universal approach due to the context of our current society being faced with increasing rates of trauma. Participants expressed a wish for growth in homelessness services, including the quality of training, pay and increasing the size of the workforce. Participants discussed how communities outside of services can support the growth of TIC in the sector. Finally, there was a wish for growing the evidence base of TIC in homelessness services.

Participants spoke about TIC being a lifelong journey, therefore envisioning a future where they continue to reflect, develop and grow TIC for themselves and their service.

"I think from my perspective, it's always a journey."- Amelia

"So I mean, I don't think there's ever going to be an end point." – Elliott

Most participants believed in the benefits of applying TIC universally across services, communities, and society. They argued for TIC's widespread adoption due to the universal nature of trauma, especially given the increasing potential for traumatic experiences in current societal contexts.

"So 100% bullet proof, is the right thing to do. It's just common sense to me. Like it's like every service should be operating in a trauma-informed way. So I think doing it just feels ethical. It's like we work with people who experience trauma, like why? Why wouldn't we all be like, putting time and effort into ensuring that our services are, you know, operating in that way." - Enzo

Some participants spoke about the existing structures in communities, such as local commissioning groups, religious groups and sporting bodies, offering support for TIC being implemented in the local area and how this positively supports TIC within the homelessness sector. Participants elaborated that these united approaches from the community may be a crucial path forward in supporting the growth of TIC.

"One of the things that we've really identified around that is the community. So actually sharing and incorporating a trauma-informed approach to the wider community […], we've recently partnered with [local] football stadium to donate food to us, and actually they wanted to understand more about what we did. So opportunities to educate in that way, so actually you can reach people and that, you know, society take a more trauma-informed approach to people so that actually people don't end up in homelessness services much, maybe would be the ultimate goal." - Amelia

Participants recognised the lack of research available on TIC and cited this as a challenge in carrying out the approach, particularly in the context of existing evaluation processes that emphasise a time-limited window which can be, at times, in conflict with TIC. Furthermore, participants spoke about a wish for set standards in evaluating the TIC approach in practice, as well as hoping for a greater evidence base to support their work.

"I think if there was something where you can't say that you are [trauma-informed] until you demonstrate it, I think that would be helpful because then at least you have like a standard of, this is actually what a good service or reasonable service looks like and you would kind of get away all the other stuff and say, no you're not, you've got to really trial it. And if that's applied in certain aspects like, you know, things like day centres or substance services, but also housing and local authorities as well, you would standardise what we would say was best practice rather than, you know, having an amazing service, but it's surrounded by poor partnership working. That client's journey will still be poor." - Enzo

Most participants discussed a wish for growth of services and the workforce to support the trauma-informed approach, highlighting that a bigger workforce would allow for longer-term input with clients with a relational, trauma-informed focus.

"Staff need to be paid better, to be trained better. Within the council, you need to have a bigger workforce so that people in other teams, not just ours, can work with people longer and adopt that trauma-informed practice rather than that, trying to do a care act assessment within 30 days and that sort of perspective, which is what they're on now, because they've got gigantic waiting lists and the pressure is enormous. So we need a bigger workforce, people need to be paid better and need to be trained better, and it needs to be central." - Lillian

Participants also discussed a wish for a revision on how funding is allocated within homelessness services.

"And I think yeah, I think massively just around changing the way that we allocate funding and that we view funding these services. Umm would be really ideal. So yeah, all right to the top."- Amelia

Overall, this subtheme demonstrates how participants view TIC as a lifelong commitment, emphasising the need for continuous growth, universal application, community support, increased research, and improved resources to enhance the effectiveness and reach of TIC.

4.5 Self-Reflexive Position

The analytical stage of generating themes had more stages and revisions than anticipated, which I think reflects on my process of attempting to look through the data with different interpretations and lenses. One particular draw had been analysing themes using a different systems-level analogy e.g. within teams, within services, within the sector, undoubtedly influenced by my own training and my own preferred lens in clinical work. Through discussions with my supervisors and use of a reflexive diary, I was able to temporarily put down the systems framework for describing overall themes to revise the final picture into deeper meaning. Consequently, I drew out meanings that existed across the different levels of the system to describe themes. Through carrying out the iterative process of RTA, I was able to reflect back on the systems-lens position and consider how this could inform my descriptions of themes and sub-themes to provide further meaning.

During the process of 'letting things go' and looking for universal meaning across levels of the system, I witnessed how when participants discussed challenges, they were often interwoven with discussions of hope. This influenced me to consider my own practice and ask myself how often do I find myself balancing challenge with hope in my clinical domain.

Throughout the write-up, I felt dedicated to accurately reflecting the rich data which had been kindly offered by participants. There were moments where it felt difficult to let go of certain contributions, as the whole data felt compelling to understand the meanings given. Utilising a

reflexive diary and reflective conversations has supported me to engage in the process of letting go, as well as understanding how my own experiences were impacting on what data was included or excluded. The process was key to ensure a balanced, reflective and succinct sharing of the findings.

Chapter 5: Discussion

5.1 Chapter Overview

This chapter will commence with a summary of the overall findings, followed by a discussion of the three themes identified in relation to existing theory and research. A critical appraisal of the current research will be presented, with reflections on the study's overall strengths and limitations. Recommendations and implications will be discussed for further research, clinicians, homelessness services, policymakers, and government.

5.2 Summary of Findings

The present study set out to explore staff experiences of transitioning to TIC in homelessness services. Through the findings, it became apparent that staff more closely reported their experience as a journey rather than a transition, leading to a title amendment which will be further discussed in 5.3.3. Using RTA (Braun & Clarke, 2022a), three themes and nine subthemes were developed from interviews with sixteen participants. The first theme, ‘Knowing TIC through trauma itself’, demonstrates that staff perceive trauma as not only a common experience for the people they work with but also something that pervasively affects the staff, influencing their engagement with TIC. The widespread trauma necessitates a structured approach to address its layers. Participants discuss the emotional resonance that TIC evokes, acknowledging it as a life-changing experience. This theme is underpinned by a deep understanding that the sector itself experiences collective traumatic events.

The second theme, ‘Relationships at the heart of the TIC journey’ emphasises relationships as central to the journey of TIC, both with clients, among staff and across agencies. Clients guiding the process are viewed as preferential by staff as this dynamic shapes the service delivery, making it more empathetic and client-focused. Furthermore, the importance of collaborative environments and shared values among teams is emphasised to enhance the delivery of TIC. However, the findings also address the limits of abilities to be together, such as leadership isolation in carrying out TIC and recognising the limits of trauma-informed reflective practice.

The third theme, ‘Where there is challenge, there is hope’, discussed challenges in embedding TIC across the homelessness sector, highlighting resistance from within and constraints imposed by external systemic factors like financial limits and KPI rigidity. The analysis presents a conflict between the ideals of TIC and the realities of operational constraints, suggesting that while TIC is philosophically aligned with the needs of the sector, practical implementation is frequently circumvented by factors beyond the control of individual practitioners. The findings capture a sense of cautious optimism among practitioners who, despite facing significant barriers, continue to advocate for and implement TIC. This hope is tempered by a recognition of the need for systemic change to fully realise the benefits of TIC, calling for enhanced support, training, and resources to sustain these efforts and expand their impact. The findings conclude with reflections on the journey of TIC, emphasising it as an evolving process that requires commitment, innovation, and community engagement to thrive.

While this study focuses on homelessness, its findings may offer valuable insights into applying TIC across various support sectors and inform broader organisational changes in the helping professions.

5.3 Relevance of Findings to the Literature

5.3.1 Theme 1: Knowing TIC Through Trauma Itself

Several studies have supported the findings of ‘a traumatised sector’. Firstly, the participants discussed assumptions that trauma has happened for everyone they work with due to the nature of experiencing homelessness being traumatic itself and individuals often experiencing multiple traumatic events leading to homelessness. Indeed, the discussion on prevalence of trauma for PEH in Chapter 1 supports participants’ reports, with a UK-based study surveying PEH experiences reported 96% of respondents had experienced at least one traumatic event in their life (Irving & Harding, 2022).

Secondly, participants acknowledged the prevalence of traumatic experiences for staff occurring whilst working within the homeless sector which has been supported by previous research. For example, Kerman et al. (2023) found 89% of 624 staff across Canada reported exposure to one or more traumatic events in the workplace. The authors further explored associations whereby staff who were newer to the sector, working with an adult population and spending more time providing direct input to clients had a greater risk of exposure to traumatic events and stressors (Kerman et al., 2023). In addition, Schiff et al., (2019) demonstrated a third of their sample of over 400 emergency shelter workers were screened as positive for post-traumatic stress symptoms. A smaller study of staff working with PEH in Texas reported that just under half had moderate-to-severe presence of secondary traumatic stress (Petrovich et al., 2021). The current study builds upon these findings by further recognising the existence of collective trauma amongst staff through events such as COVID-19 and how this has impacted the overall sector.

Within this theme, some participants eluded to experiencing trauma outside of the workplace which was associated as increasing emotional resonance with TIC. Prevalence of traumatic experiences outside of the workplace have been explored in previous research, as seen in Aykanian & Mammah's (2022) study who invited 136 frontline workers in homelessness services in Texas to complete the ACES questionnaire, finding at least 80% had experienced minimum one ACE and 38% reported four or more ACEs (Felitti et al., 1998). The authors reflected that the minimum prevalence rate was comparable to other studies of human service providers, whilst the multiple adversity finding was higher than others (Lee et al., 2017; Steen et al., 2021). Bryce et al.'s (2023) systematic review reported that familial dysfunction was common amongst individuals working in the helping profession, suggesting the career choice may support making meaning of one's own experiences through helping others who have experienced similar events or wishing to contribute to prevention of traumatic experiences. The present study, focusing on homelessness staff within the helping profession, supports Bryce et al.'s (2023) findings, as participants reported that their personal experiences contributed to a deeper emotional connection with TIC.

The findings offer an extension on the relationship between knowledge and trauma noted in Chapter 2's SLR. In particular, the presenting literature focused on the importance of staff having knowledge of trauma in implementing TIC through staff training and maintaining professional competency (Barry et al., 2013; Burge et al., 2021; Crawford, 2022; Kahan et al., 2019; Hetling et al., 2018; Schiff et al., 2019 & Sullivan et al., 2018). The current theme builds on this through recognising that staff may have an awareness of trauma through their own experiences, whether within or outside the workplace. This highlights the need for organisations to provide comprehensive support systems that address both the professional training and the personal trauma experiences of staff, ensuring a holistic approach to TIC.

5.3.2 Theme 2: Relationships at the Heart of the TIC Journey

The present study reinforces the importance of relationships in homelessness work, echoing previous findings that relationship building is essential in TIC (Cockersell, 2012). The SLR chapter further underscores the foundational role of relationships in trauma-informed care (TIC) (Barry et al., 2023; Burge et al., 2021; Crawford, 2022; Edwards et al., 2023; Hetling et al., 2018; Kahan et al., 2020; Schiff et al., 2019; Sullivan et al., 2018; Ward-Lasher et al., 2017). Theoretical approaches highlighted by participants like PIE (Keats et al., 2012), strengths-based practice (Saleebey, 2009), and person-centred care also highlight the importance of relationships, with guidelines often integrating relational methods (Council to Homeless Persons, 2023; Homeless Link, 2024). Consequently, a question is raised – what makes relationships influenced by TIC different from existing approaches?

A unique aspect of TIC is its focus on how trauma affects the ability to form connections. For instance, Padgett et al. (2008) found themes of mistrust and isolation among formerly homeless women due to trauma. Given the high trauma prevalence for PEH (Bellis et al., 2014), support must address how trauma impacts relationship-building and tailor approaches to facilitate healing through relationships. The present findings contribute to the literature by showing how TIC can enhance staff approaches to relational ruptures, expanding empathy and sustaining their work.

A subtheme within this theme, 'being guided by clients in the TIC journey' speaks to several examples in research that discuss the importance of considering and re-aligning power imbalances that can be inherent in services. Experiencing homelessness has been associated with isolation, marginalisation and social exclusion (Diaz & Valera, 2010). Thus, inclusion of people using homelessness services in co-designing the service they receive has been discussed as a necessary pathway to ensuring comprehensive support whilst healing from previous experiences of exclusion (Smith et al., 2021). Norman & Pauly (2013) discuss in their literature review how *"social inclusion and exclusion are two sides of a coin"*, emphasising the importance of inclusion as an active choice, upholding relationship principles that will facilitate this process.

The findings discussed factors that enable staff to come together in this sector. Key mechanisms identified include shared values, trauma-informed collective spaces (such as informal support, reflective practice, supervision, and team formulation), trauma-informed training, and the involvement of psychological staff. In comparison to research from outside the homelessness sector, Lauridsen & Munkejord (2022) found that a reflective restorative circle process helped social workers and nurses build self-awareness, compassion, trauma awareness, emotional safety among peers, and personal growth. While some evidence suggests that reflective practice is beneficial, other studies have noted that frontline workers experiencing burnout and secondary traumatic stress are less motivated to engage in reflective practice within a PIE framework (Schneider et al., 2022). Further research is needed to explore how different theoretical frameworks encouraging the application of reflective practice might influence its reception and effectiveness.

Whilst the benefits of people coming together were discussed in 'relationships at the heart of the TIC journey', limits of people's ability to come together were also noted. References in the present findings discussed how certain aspects of trauma-informed collective spaces may not be fitting for all needs, and the lack of leadership-specific spaces in TIC can lead to feelings of isolation. An underlying lesson with the above findings gestures towards the importance of tailored support

according to presenting staff needs. SAMHSA (2017) also recognise the potential for leaders to be isolated due to a lack of peers who understand the complexities of TIC, reinforcing the importance of a trauma-informed workforce and peer support networks amongst leaders.

5.3.3 Theme 3: Where There Is Challenge, There Is Also Hope

Systemic challenges in implementing TIC have been discussed across various service contexts. In Australian healthcare settings, managers reported issues like limited resources, ongoing vacancies, and difficulties integrating TIC into KPI-based funding models, which restricted budgets for TIC (Isobel et al., 2021). These challenges are echoed in the UK, where public services face a workforce crisis due to systemic challenges (House of Lords, 2022). This study's SLR also identified resource variability across organisations as a barrier to TIC implementation in homelessness contexts (Barry et al., 2023; Burge et al., 2021; Crawford, 2022). Financial constraints and staffing issues were common, with calls for better resource allocation. The current findings build on this by illustrating strategies staff use to navigate these limitations, such as considering power dynamics, modelling TIC behaviours, collaborating with other services, being creative with TIC delivery, and focusing on small wins. By showing how TIC can support staff in managing systemic barriers and enable hope, the study adds a unique perspective to existing literature.

Further sensemaking of the layers of systemic challenges can be seen through comparing participants' reports to Bronfenbrenner's (2000) ecological systems theory, which posits that an individual's development is influenced by the different types of environmental systems they interact with. These systems are structured in layers, ranging from immediate surroundings to broader societal contexts. The theory emphasises the interconnectedness of these systems and how changes or challenges in one layer can affect others (Bronfenbrenner, 2000). By applying Bronfenbrenner's ecological systems theory to participants' reports (Table 13), we can better understand how systemic challenges at every level of the sector interact and compound, affecting both the staff and the PEH within the homelessness sector. Table 13 further demonstrates participants' reports of supportive

mechanisms in TIC in light of systemic challenges within different levels of Bronfenbrenner's (2000) system.

Table 13

Bronfenbrenner's Ecological Theory and Current Study Comparison

Bronfenbrenner's system	Application to present study - challenges	Application to the present study - support
Microsystem: This is the immediate environment in which a person lives and interacts, such as family, school, peer group, and workplace. For staff working with people experiencing homelessness (PEH), the microsystem includes their direct interactions with clients and colleagues.	Staff difficulties with the immediate demands and emotional toll of supporting PEH. Within team differences reported to add further challenge at this level e.g. different stages of TIC journey, differing engagement with collective spaces such as reflective practice, holding TIC leadership responsibility in microsystem and encountering resistance.	Support at this level through shared team values, collaborative working with immediate colleagues, shared collective spaces e.g. reflective practice, supervision, training, team formulation.
Mesosystem: This level encompasses the interactions between different microsystems. For example, the relationship between a staff member's home life and work environment.	The stress of balancing personal life and work responsibilities is exacerbated by inadequate support systems.	When space is offered in terms of support through work to consider the intersection of personal and professional lives through TIC.
Exosystem: This involves the larger social systems that do not directly involve the individual but still impact them. For staff in the homelessness sector, this could include community resources, local policies, and organisational support systems.	Insufficient organisational support, lack of community resources, difficulty with partnership working and restrictive local policies create barriers.	Trauma-informed working across partnerships, agencies and seen in the local council policies. Space to share learning and reflect as trauma-informed networks.
Macrosystem: The broader societal and cultural context, including societal norms, laws, and economic conditions. Systemic issues such as insufficient funding for social services and societal attitudes toward homelessness are part of this layer.	Broader societal issues, such as stigmatisation of homelessness, ongoing societal trauma and economic inequality, further complicate efforts.	Advocating for PEH within social contexts, linking up with other agencies to influence social perceptions. Engaging in research to attract further support for addressing macrosystem level issues.
Chronosystem: This dimension adds the element of time, reflecting changes and shifts in	Over time, changes in political climates, economic downturns, shifting homelessness	Relief seen through COVID-19 'Everybody in

the individual's environment over time. For instance, long-term trends in housing policy or economic conditions that affect homelessness and the resources available to address it.	legislation, COVID-19 returning back to 'normal' or evolving public policies exacerbating these challenges reported by staff.	scheme' (Cromarty, 2021) during that time.

Within the current theme, participants described their engagement with TIC as a journey rather than a transition, leading to an amendment of the research title. Although the interview schedule included the term 'journey,' many participants elaborated on their experience of a continuous, evolving process of TIC development throughout their interviews, aligning themselves with the terminology 'journey'. Reflection on language led to a recognition that 'journey' encompasses the entire experience and implies an ongoing process of growth and adaptation, while 'transitioning' suggests a specific phase where change occurs. Naming TIC as a journey can be understood through reflection on our existing societal structures. Such structures often perpetuate and precipitate trauma occurrences, as seen in examples such as marginalised communities experiencing inequality and discrimination (Abrutyn, 2023). In environments where individuals have been repeatedly let down or harmed by societal systems, building trust and safety is a long-term process (Pemberton, 2016). Since societal structures and the issues they create are complex and ever-evolving, addressing trauma effectively requires a dynamic and continuous approach. Thus, becoming trauma-informed can be considered as having no endpoint because it is a continuous process of learning, self-reflection, and action in order to address such pervasive effects of our societal systems. A similar notion of an ongoing journey can be found in the anti-racist movement (Kendi, 2019). Anti-racism recognises that dismantling systemic and structural oppressive inequalities will require large-scale, collective work that is unlikely to reach an endpoint in our lifetime due to the nature of requiring healing from centuries of racism (Kendi, 2019). Experiencing individual and systemic racism constitutes a form of trauma; thus, integrating insights from both trauma-informed and anti-racist movements can be mutually beneficial in learning how to navigate a continuing journey.

5.4 Critical Evaluation

The present project has been critically evaluated using the CASP (2018) qualitative checklist in Table 14, holding my study to the same standards as the papers in the SLR. The present project was further reflected on using Tracy's Eight "Big Tent" Criteria for Excellent Qualitative Research (Tracy, 2010) to aid appraisal (Appendix AC).

Table 14

CASP Qualitative Critical Appraisal Checklist for the Present Study

CASP Criteria Items	Criteria (Yes / No / Can't Tell)	Evidence for meeting CASP criteria
Was there a clear statement of the aims of the research?	Yes	The present project aimed to explore staff experiences of transitioning to TIC in the homeless sector. Aims and objectives of the present study were given in Chapter 1.
Is a qualitative methodology appropriate?	Yes	Qualitative methodology is appropriate for exploring staff experiences of TIC because it allows for in-depth insights into personal experiences and perceptions. A qualitative approach provides the opportunity for the complexity and context of staff experiences with TIC practices, in which quantitative methods might overlook.
Was the research design appropriate to address the aims of the research?	Yes	Qualitative methodology was recognised as suitable for the current aims and objectives, allowing exploration through one-to-one interview settings and the use of open-ended questions. RTA supported flexibility and a non-linear approach in analysis to generate rich findings. Utilising trauma-informed research guidance compliments the study's aims to understand TIC.
Was the recruitment strategy appropriate to the aims of the research?	Yes	The current project explored multiple avenues of purpose sampling to recruit potential participants that were suitable to the study's inclusion and exclusion criteria. Recruiting through known mailing lists within the professional field supported engaging professionals and organisations. Further purposive sampling evident in contacting organisations either through existing relationships with a supervisor from the project or through contacting organisations based on information available on their website discussing TIC. A snowballing approach facilitated accessing participants through trusted connections.
Was the data collected in a way that addressed the research issue?	Yes	Conducting one-to-one interviews is a suitable method for understanding staff experiences of trauma-informed care, as it allows for in-depth, personalised discussions that can reveal nuanced insights. Additionally, this method provides the opportunity to create a safe experience for participants, tailored to their individual needs. Utilising a trauma-informed research perspective for data collection supported investigating TIC. Data collection methods are detailed in Chapter 3.
Has the relationship between the researcher and participants been adequately considered?	Yes	The relationship between the researcher and participants has been adequately considered through the use of a researcher reflexive diary and collective reflections within the research team. This approach ensures continuous reflection on the dynamics of the relationship, promoting transparency, ethical awareness, and responsiveness to any potential biases or power imbalances throughout the research process. Examples of reflexive diary entries have been incorporated into the present project to inform the reader.

Have ethical issues been taken into consideration?	Yes	Ethical issues have been reflected upon throughout the project, with particular focus in Chapter 3. Ethical approval supports the present project's claims of adhering to ethical principles. Discussion on following a trauma-informed research process has been demonstrated in this chapter to offer a further perspective on carrying out ethical research.
Was the data analysis sufficiently rigorous?	Yes	The data analysis was sufficiently rigorous. A systematic coding process was employed to generate and refine initial codes, which were then organised into themes, as discussed in Chapter 3. The analysis involved cross-checking with the research team to ensure consistency and robustness of the findings. Reflexivity was maintained through the use of a researcher reflexive diary, helping to monitor how my own identity and experiences were interacting with the data. The diary documented all decisions and changes during the analysis, enabling transparency. Rich, thick descriptions and detailed quotes from the data supported each theme, demonstrating deep engagement with the data.
Is there a clear statement of findings?	Yes	The discussion chapter offers a clear and concise summary of the findings of the present project.
How valuable was the research?	Yes	The study is the first of its kind to solely explore staff perspectives on transitioning to TIC in the UK context across different homelessness organisations utilising a qualitative approach. The present findings offer a new understanding of how staff connect to TIC through knowing trauma itself. Additionally, the findings offer insight into how relationships can support TIC and what limitations are experienced in those relationships. The findings further discuss the balance staff face of mitigating challenges and holding hope. Clinical implications for clinicians, services, policy and guidance are documented in the discussion chapter, supporting the claim of value for the research.

5.5 Strengths and Limitations

This is the first known study to have solely explored staff experiences of their journey of TIC within homelessness services in the UK utilising a qualitative approach. The landscape of existing knowledge highlighted in the introduction and systematic review demonstrates limited evidence discussing staff experiences with TIC, primarily focusing on perceived benefits of TIC for clients or experiences of work-related stress. Thus, this study offers a unique and meaningful contribution to the existing evidence base.

The project also demonstrates strength through its use of a trauma-informed research approach, which ensures the research process has been sensitive to participants' experiences and needs. This approach supports considerations of how to build a safe and supportive environment, encouraging honest and open sharing of experiences. This may have improved trust and engagement from the community who offered their time to this project.

A further strength can be seen in the use of an EbE in the present study to guide methodological decision-making and analyses. Fostering a strong working relationship provided an opportunity for authentic discussions on the project process. Additionally, EbE involvement can build trust and rapport with the community involved in the research (Rose et al., 2012). EbEs can offer innovative perspectives and solutions that might not be apparent to researchers without lived experience, potentially leading to more effective and applicable outcomes (Beresford, 2007). Whilst the use of an EbE was a strength, this may have been further enhanced if a team of EbEs were employed for the project. A single EbE’s experiences and interpretations may dominate the research findings, potentially introducing personal biases (Rose, 2014). There are possible ethical concerns about adequately representing the studied group with one EbE, as this may inadvertently marginalise other voices and experiences (Banks et al., 2018). Future research may benefit from a wider representation of EbEs within its process.

A limitation can be seen in the demographic makeup of the final sample. Whilst recruitment was open to several professionals, only one individual who identified as a psychological practitioner came forward. Given the study's findings implying the role of psychology in supporting, facilitating and leading TIC practices, further insight from individuals holding these positions may have been fruitful in understanding what enables them in their work with TIC. Additionally, the participant sample was predominantly individuals from white backgrounds. Given that one of the key trauma-informed principles is 'Cultural, Historical and Gender Issues' (SAMHSA, 2017), there may have been further learnings on what it is like to uphold this idea in services if there was a greater representation of individuals from varied cultural backgrounds.

5.6 Recommendations

5.6.1 Recommendations for Clinicians and Homelessness Services

Across themes, there was a sense of connecting with others in order to survive a traumatised system – whether that was noted by informal support from colleagues, through structured practices of support such as supervision and reflective practice or through across-agency collaboration. These practices of coming together gesture towards the importance of collective care being established as part of TIC guidance in teams and services. A definition of collective care has been offered by social justice advocates Mehreen and Gray-Donald (2018): *"Collective care refers to seeing members' wellbeing – particularly their emotional health – as a shared responsibility of the group rather than the lone task of an individual."* Adopting a collective care approach in homelessness services could significantly enhance the wellbeing and resilience of both clients and staff. Collective care and its emphasis on mutual support, shared responsibilities, and community-based solutions can foster a more inclusive and supportive environment (Reynolds, 2019). This approach aligns with the principles of TIC, recognising that trauma and adversity often require community-based healing to be more effective. Collective care can help to address the systemic and structural issues that contribute

to homelessness by promoting social justice and equity (Holman, 2023). Integrating collective care into homelessness services thus complements existing practices discussed by participants.

Psychological practitioners[8] were noted by participants as taking supportive roles in TIC implementation due to facilitating TIC training, reflective practice, training, supervision and team formulations. Some participants who did not have psychology backgrounds discussed how working alongside a psychological practitioner enabled them to develop skills to facilitate trauma-informed reflective practice, supervision and formulations themselves. Psychological practitioners have been slowly increasing in presence across homelessness services in the UK, with often variable representation due to the nature of local commissioning and differing service providers bringing different approaches to staffing structures (Pudaruth, 2022). The present study demonstrates evidence for the notion of increasing universal representation of psychological practitioners working in homelessness due to their skill sets. Namely, psychological practitioners uphold skills in formulation, utilising multiple psychological theories and translating them into practice (Johnstone & Dallas, 2013). Furthermore, psychological practitioners are usually trained in reflective practice and supervisory models, with further knowledge of implementing staff support within systems (Yousefzadeh & Farquharson, 2022). Further benefit can be seen through the utilisation of psychological practitioners' skill base in research and service development, which may further support developing an evidence base of TIC in homelessness services. Guidelines are available to support clinical psychologists (CPs) working in this field, supporting the notion of expanding this skillset in homelessness (Wells et al., 2023). Given that CPs are expected to participate in policy-making and decision-making at all levels of provision within their services (Division of Clinical Psychology, 2010), the current study's findings can help guide them in contributing to and leading the TIC journey within homelessness services.

[8] Psychological practitioners include psychological therapists, clinical psychologists, assistant psychologists and trainee clinical psychologists.

Interestingly, only two psychological practitioners participated in the present project. However, several other psychological practitioners supported the researchers in securing approval from their organisations and assisted with distributing recruitment information amongst their colleagues. Through discussions, it became clear that these practitioners believed it was more important for their non-psychology peers to have space to participate in the research. Given this, future studies should consider targeted recruitment of psychological practitioners to gather their perspectives on their journey with TIC, as the above discussion suggests they play a crucial role in facilitating TIC delivery.

A further recommendation for services includes increasing methods of evaluating TIC practice. Several participants in the present study discussed a wish to have supportive frameworks that would allow their team or service to reflect on how they show different aspects of TIC within their service delivery. With recognition that TIC was characterised as an ongoing journey in the present study, an evaluating framework that supports periodical review of TIC processes may be beneficial. The 'Roots' TIC framework is a reflective tool designed to help organisations implement and sustain trauma-informed practices (Thirkle et al., 2021). Structured around seven key domains—safety, language, social relationships, trauma-specific interventions, empowerment, whole system, and compassionate leadership—it promotes continuous improvement through mapping, planning, action, and review. Although Roots is not homelessness-specific, the tool offers promising support for services' TIC journeys. Strengths of the 'Roots' framework include its comprehensive and systematic approach, emphasis on continuous improvement, and adaptability to different contexts. However, potential limitations lie in its resource intensiveness, the need for extensive training and buy-in from all organisational levels, and the challenge of maintaining long-term commitment. Applying this framework to homelessness services may provide a structured approach to evaluating progress and development in applying TIC.

5.6.2 Recommendations for Policy Makers and Government

The present study explored experiences of staff's journey with TIC across the UK, highlighting variations in organisational and local council support based on locality. These disparities can hinder collaboration and lead to repetitive development and siloed operations. Participants identified this as a systemic challenge, reflecting broader organisational difficulties in trauma-informed change. Supporting this, Emsley et al. (2022) reviewed 24 policy documents and interviewed 11 service providers across UK healthcare organisations, revealing varied implementation strategies. Scotland and Wales have centralised government-driven principles, whereas England appears to be driven from the bottom up by relying on local leaders' initiatives, resulting in inconsistent TIC efforts. Government and policymakers could support a more centralised strategy across the UK, linking organisations to share best practices and reduce redundant efforts in trauma-informed policy, guidance, and research. This approach could also provide support mechanisms for TIC leaders.

Additionally, the present findings indicate the importance of 'being guided by clients in TIC', which can also be considered as implementing co-production at policy level. Co-production has been established as a mechanism to address inequities in health service provision by involving those who are often included to inform services (Williams et al., 2020). McGeown et al. (2023) detail several principles for trauma-informed co-production in their study working with women who have experienced complex trauma in Bristol, UK. The authors note principles of flexibility, transparency regarding power dynamics, close collaboration with partnership agencies and the necessity of long-term funding to support co-production in practice. Whilst these findings span women with various difficult life events and traumas, some participants report experiencing homelessness. Thus, the applicability of these recommendations may benefit the homeless sector, with guidance to support the process of how trauma-informed policies being co-produced can be carried out in a meaningful, safe and supportive manner.

A continuous, striking theme across research investigating TIC in the homelessness sector is the call for increased funding to support the sustainability and development of practice. A recent report 'Support for Single Homeless People in England' (Homeless Link, 2022) demonstrated that almost 24% of homelessness accommodation witnessed a reduction in funding since 2021, whilst 56% reported no changes in funding. The latter finding can be considered as a reduction given the economic inflation in the UK that has been witnessed in the last few years. Thus, increasing funding to combat the current climate may support service development in several ways. Funding was discussed as an avenue for increasing staffing levels in order to move forward from 'firefighting' within services and ensure all staff have time to reflect on their trauma-informed practice. Participants often spoke about the desire to engage in various elements of service development and additional supportive mechanisms such as reflective practice but finding that their service experiencing crises without enough staff limited their ability to engage in such activities. Increased funds was also discussed as a method for increasing pay for staff, recognising that the current pay standards are inadequate, particularly in the context of the UK cost of living crisis. In combination with the emotional demands of the work and not having enough staff, there were reports of high turnover of staff who leave the sector to increase pay conditions. Additionally, participants spoke about funding as a mechanism to increase training, whether that is through increasing skillsets within services to deliver training or outsourcing experts in the field to support development. There was a further notion of considering how funding can be increased universally in homelessness, as the current context of commissioning in the sector often leads to local bids with time-limited offers to meet particular outcomes or goals that ultimately increase service pressure (Blood et al., 2020). Hence, increasing funding may provide several supportive avenues for homelessness services to develop and maintain TIC.

5.6.3 Recommendations for Further Research

The present study collated viewpoints of staff at one particular time point of their journey with TIC. A longitudinal study with an opportunity to discuss the same staff's perspectives at different time points of their career utilising this approach may provide more in-depth information on several aspects. Firstly, revisiting the same individuals periodically could allow for patterns, challenges and successes that may not be initially apparent in a single snapshot. Secondly, the change process with TIC may be further understood by investigating what may be similar or different when inviting discussion with participants at different time points of their journey.

The decision to exclude the client perspective was considered in initial research planning, which led to reflections on the 'explicit' and 'implicit' understanding of TIC from clients' perspectives within homelessness settings. TIC has been theoretically generated by professionals and positioned as an approach to be known and upheld by professionals (Harris & Fallot, 2001). Consequently, the act of TIC has not always been explicitly named with clients. Whilst there has been emerging research incorporating clients into the delivery of TIC through co-production and hearing clients' views (McGeown et al. 2023); it was discussed and reflected on with participatory organisations that the current stage of implementation of TIC in the UK may not be fully explicit in client awareness and therefore requires a further development in the sector. There is a further complicating factor of two organisational change models in existence within UK homelessness services, namely PIE and TIC, which has caused confusion for clinicians themselves in determining their theory-driven approach, thus limiting accessibility in understanding for clients (Homeless Link, 2024). Future research exploring services educating clients on TIC and involving them in co-production of TIC delivery in homelessness specifically may aid development on this issue within the sector.

A final recommendation for further research includes the possibility of research being conducted within a geographical region that discusses the TIC journey at team, service, across services and council level. The importance of the layers of structural support for carrying out TIC was

eluded to by several participants, also noting differences whereby some services were located in an area with a council following trauma-informed framework, in contrast to some participants reporting TIC as solely a team initiative. An example of a trauma-informed system can be seen in the BNSSG trauma working group (2021), who propose guidelines for working according to TIC principles across different services and levels of support. A spotlight study exploring staff experiences across different sectors, professions and responsibility may provide important learning for the rest of the UK in developing their TIC provisions.

5.7 Dissemination

Dissemination ideas following approval of the final report will include distribution of findings in housing bulletins; a housing podcast and within homelessness organisations who offered organisational approval for participant recruitment. Participants were asked if they are interested in engaging in the dissemination process through the consent form and at the end of their interviews. With those who agreed, we will consider how to involve them in the above opportunities.

5.8 A Reflexive Ending

Looking back on the research journey, I have noticed several shifts in my perspective. I have often considered the privileges of what resources I have available - having a workspace, technology, time and supportive networks - in order to conduct the project. Hearing about staff experiences in the sector and the many demands pulling them in different directions highlighted how there is a drive for developing evidenced-based practice but the lack of available resources to do so. Holding a position of access to resources to do the project has emphasised the importance of ensuring this project was carried out with dedication, credibility and rigour to honour the staff who offer so much through their work.

Whilst my present project has focused on staff experiences, I have ensured to take points to pause and ask myself “What would someone experiencing homelessness think of the work we are doing?” I feel this has been crucial for keeping what is important at the core, as there were times it

felt tempting to walk down different roads of possibilities for making decisions in research, thus requiring an anchor to ensure the research remained centred on what the participants care about the most – the people they work with.

I have seen growth in myself in several domains within this project: as a clinician, as a researcher and as a human. Similar to my participants, I have come across systemic challenges in my clinical work and hearing how they choose hope in light of these difficulties has supported me to consider how I continue to ensure I am actively leaning into hope. I found it particularly enlightening to hear how the source of navigating challenges came back to connectedness with one another and ensuring our humanity always has a place in the work. My clinical work has seen me introduce more ideas on reflecting on staff wellbeing in placements and sharing the idea of collective care to encourage the relational approach to sustaining ourselves in the helping profession.

I have also been able to think about when I have felt I have carried out more 'trauma-informed' research and when that has felt less so. Considering how to carry out trauma-informed interviews came naturally, perhaps influenced by my position as a clinical psychologist-in-training. However, I have noticed that there were times where I felt I was not a trauma-informed researcher in relation to myself, putting my needs as the last priority in order to get the work done. This experience mirrors a tale healthcare workers know all too well and what some of my participants alluded to in the project. There were times I was caught off guard by my own personal struggles, finding it difficult to name what I was experiencing with other professionals in my network. Engaging in this research gave me courage to share those struggles with others that I work alongside, allowing vulnerability and my own humanity to be expressed in order to receive support and to allow myself always to be open to connection that fosters healing.

5.9 Conclusion

The present project has explored staff experiences' in their journey with TIC within the homelessness sector. This study has contributed to our understanding of how staff connect to TIC

through their recognition of the landscape of trauma pervading every level of systems. Furthermore, it has highlighted a new perspective on engaging with TIC, recognising it as an ongoing journey for staff. The study has amplified the importance of coming together and harnessing collective power, providing recommendations that provide the people we work with platforms to guide clinicians and have choices in TIC work. The findings demonstrate the ongoing negotiation and balance that staff find themselves facing in regards to systemic challenges and fostering hope. The practical implications from this study advocate for internal collective resources, centralised TIC systems and greater sector funding to support staff in their continuous efforts to deliver the most comprehensive, holistic support for PEH.

Ending this thesis feels most fitting to summarise the ethos through a contribution by Gemma, a participant:

"And we should be helping find people, bring people home, […], homelessness is not external, like it starts internal, everything collapses and people leave their internal home before they become homeless externally. And I think what I want is the people to be brought back home to themselves."

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Appendices

Appendix A. Reflexive Diary Excerpt on My Professional Relationship To My Topic

Beginning my journey with the present topic led me to reflect on my professional experience of what has constituted 'home' for the people I have worked with and their experiences of trauma. Initially working in an older people's complex care inpatient ward, I encountered individuals who had never had ownership of a 'home'; ultimately being moved by the state between different facilities, wards, hostels and accommodations for the majority of their life. I noticed they had often experienced trauma which had led to significant and enduring mental health difficulties. From my experience, I felt that the byproducts of trauma often took autonomy away from an individual, including decisions on where they live, what they can do with their own bodies and how others treated them.

Working in adult mental health services where there was a requirement for 'stable housing conditions' to receive psychological therapy left me curious about those individuals who faced continuing changes in housing. I was unable to meet these individuals due to the bounds of our service structure, which highlighted to me how psychological support, at times, maintains gatekeeping where only those with privileges may access such an intervention.

Shifting into a neuropsychological rehabilitation field, I met people who lost their home after a significant neurological event. At times, these events were due to physical assault, biological in nature, and accidents. To me, all these events appeared traumatic and life-changing. These experiences further signified to me how often trauma can precipitate significant life shifts such as changing a home environment, which in turn, can lead to experiencing further trauma through destabilisation of one's grounds. Evidence supporting this notion is seen in Tsai et al's study (2020), where they found that 14.1% veterans with a history of homelessness reported homelessness as their worst traumatic event, which was associated with five times greater likelihood of a current experience of PTSD.

Meeting people across all professional fields who have experienced trauma demonstrated to me that an individual can respond and cope with trauma in a variety of ways. Societal commentary on surface level presentation of trauma-responses, as seen in the stigmatisation of borderline personality disorder (BPD) (Ring & Lawn, 2019), highlights that services have yet to develop a universal, comprehensive, empathetic and appropriately responsive approach to supporting individuals who experience trauma.

The present project has provided me on the opportunity to reflect on the assimilation of factors important to me in pursuing the psychological profession: increasing psychological support for those with fewer privileges; growing an individual's self-ownership and power; enhancing societal understanding of the varied effects of trauma on a person and ensuring basic human rights are met, such as stable housing. While the present study's scope lies within developing knowledge of trauma-informed care in homelessness services, I hope that there are lessons that can extend to further contexts and fields of support.

Appendix B. Library Search Planning Form

Search Planning Form

Question :

What does the existing literature tell us about trauma-informed care in a homelessness context? →

What does the empirical literature tell us about trauma-informed care in the homelessness sector?

First attempt at search term generation

Identify the main concepts of the question (use as many as you need)

Concept 1	**Concept 2**	**Concept 3**
Trauma-informed care	**Homelessness**	Empirical *(judge through inclusion / exclusion screening)*

List alternatives keywords, terms and phrases below

Concept 1	**Concept 2**	**Concept 3**
"trauma-informed care"	"homeless*"	
OR "trauma informed care"	OR "homelessness"	OR
OR "trauma-informed approach"		OR
OR "trauma informed approach"	OR	OR
OR "trauma-informed practice"	OR	OR
OR "trauma informed practice"	OR	OR
OR	OR	OR

Step 1: Use OR to combine ALTERNATIVE search terms together.

Step 2: Use AND to combine different concepts together.

Final attempt at generating search terms

Concept 1 **Trauma-informed care**	**Concept 2** **Homelessness**	**Concept 3**

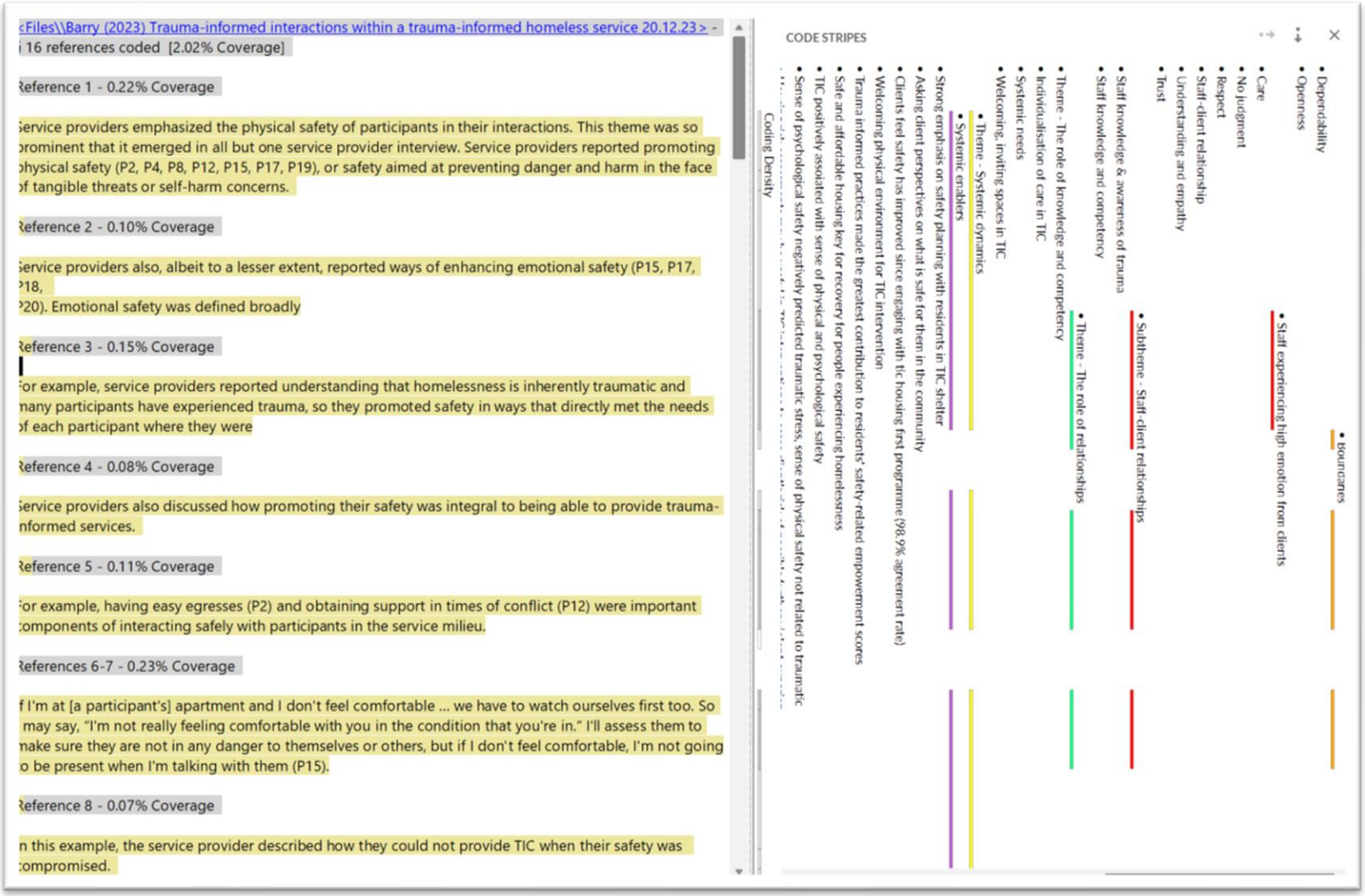
List alternatives keywords, terms and phrases below

Concept 1	**Concept 2**	**Concept 3**
"trauma-informed*"	"homeless*"	
OR "trauma informed"	OR "housing"	OR
		OR
	OR	OR
	OR	OR
	OR	OR
OR	OR	OR

Step 1: Use OR to combine ALTERNATIVE search terms together.

Step 2: Use AND to combine different concepts together.

Appendix C. Excerpt of Coding for Thematic Synthesis



Appendix D. Mapping Descriptive Themes Into Analytical Themes

Descriptive themes:

- Peer and social relationships for clients in TIC
- TIC Engagement Principles
- Flexibility and tailoring to clients
- Collaboration
- TIC service needs and gaps
- Staff knowledge, education and training
- Research and evaluation needs
- Client psychoeducation & awareness of trauma
- Client wellbeing: mental health, physical health and cognition
- Staff experiences of trauma and wellbeing

Analytical themes: *Colour code matching to descriptive themes*

Alternative	**Subthemes**
Knowledge of trauma	• Client awareness and psychoeducation • Staff training, knowledge and competency
The role of relationships	• Collaboration • Peer and social relationships • Staff-client relationships
Systemic dynamics in TIC	• Systemic safety • Systemic needs • Systemic limits
Wellbeing in relation to TIC	• Client wellbeing • Staff wellbeing

Appendix E. First-order and Second-order Data Reflections for the SLR

Reviewing data and codes to assess first-order and second-order data input into analytic theme generation

	The role of knowledge and education	Wellbeing in relation to TIC	The role of relationships	Systemic dynamics
Sullivan et al (2018)	Yes (2^{nd})	Yes (1^{st} / 2^{nd})	Yes (2^{nd})	Yes (1^{st} / 2^{nd})
Schiff et al (2019)	Yes (2^{nd})	Yes (1^{st} / 2^{nd})	No	Yes (1^{st} / 2^{nd})
Ward-Lasher et al (2017)	Yes (1^{st} / 2^{nd})	Yes (1^{st} / 2^{nd})	Yes (1^{st} / 2^{nd})	Yes (1^{st} / 2^{nd})
Barry et al (2023)	Yes (1^{st} / 2^{nd})	Yes (1^{st} / 2^{nd})	Yes (1^{st} / 2^{nd})	Yes (1^{st} / 2^{nd})
Crawford (2022)	Yes (1^{st} / 2^{nd})	Yes (2^{nd})	Yes (2^{nd})	Yes (1^{st} / 2^{nd})
O'Connor (2023)	No	Yes (1^{st} / 2^{nd})	No	Yes (2^{nd})
Edwards (2023)	Yes (2^{nd})	Yes (1^{st} / 2^{nd})	Yes (1^{st} / 2^{nd})	Yes (1^{st} / 2^{nd})
Kahan (2019)	Yes (1^{st} / 2^{nd})	Yes (1^{st} / 2^{nd})	Yes (1^{st} / 2^{nd})	Yes (1^{st} / 2^{nd})
Hetling (2018)	Yes (1^{st} / 2^{nd})	Yes (1^{st} / 2^{nd})	Yes (1^{st} / 2^{nd})	Yes (1^{st} / 2^{nd})
Burge (2021)	Yes (1^{st} / 2^{nd})	Yes (2^{nd})	Yes (1^{st} / 2^{nd})	Yes (1^{st} / 2^{nd})

Appendix F. Reflexive Diary Excerpt on the Systematic Literature Review

4th May 2024 – Systematic literature review themes analysis

Reflecting on themes for the systematic literature review with a colleague enabled a conversation on how we maintain the sense of a 'scientific' method when carrying out such pieces of work independently. I recognised that qualitative analysis is inherently subjective due to the reliance on my interpretations of the data, increasing the need for reflective spaces – with colleagues, supervisors or reflective logs – to minimise biases and preconceptions.

We recognised together a process of 'undoing' the idea of scientific methods, thinking back to how this is rooted in learning quantitative methodology primarily in our undergraduate days with considering predominantly 'positivist' approaches. With that as my starting point, I have recognised why alarm bells may ring for me in my current research process when there is a history of understanding science differently. Previously, there was no room for 'self' in those research methodologies in the same way, whereas now I am the channel that 'science' is occurring through. Naming that feels like a heavy weight to bear, which has led to different coping responses – immersing myself and analysing, avoidance of the research, wanting to detach and not feeling the sense of responsibility for the work. Being aware of the ebbs and flows allows me to attend to my needs accordingly so I can maintain the most consistency possible.

Aligning with a critical realist perspective means I get that while my take on things is subjective, there's still a real world out there that I'm trying to understand. Critical realism is all about balancing the idea that our views are shaped by our experiences and contexts with the belief that there's an objective reality we can know, even if it's not perfect. This outlook helps me stay grounded, knowing that while my perspective matters, I'm also trying to dig into the deeper truths and structures behind what I'm studying.

I have also realised that qualitative analysis needs inconsistency – I have taken breaks in reviewing analytic themes across days, waking up one day to look at a previous days' work and instantly seeing things in a different light. Inconsistency grows a diversity of perspectives, allowing consideration of the best fit perspective for the research aims and hopes.

An example - a conversation with a colleague when trying to explain a theme 'client healing' enabled me to recognise I was pulled towards explaining all client wellbeing through the word 'healing', only used in one paper. I realised I wanted trauma-informed care to be healing, otherwise this research might all feel pointless. Having this pause enabled me to step back to see that there were mixed associations, where actually trauma-informed care was not healing all the time in all included papers, or perhaps wasn't discussed as 'healing'. Taking this time to re-consider language and re-align with the papers' wording supported representing the most papers across the systematic literature review.

Appendix G. Dowding (2021) Trauma-Informed Research Checklist Reflections

Checklist item	**Trauma-informed principle**	**Checklist reflections**
Before Interview		
Participant preferences have been considered when choosing the physical or online venue	Choice	I discussed this with the research team regarding choice of interview setting and I opted for online interviews to promote accessibility for staff across UK to participate as physical interviews would limit choice of participation for a wider pool of staff. Online interviews were also considered as more adaptable in providing choice for time and place for the interviewee to engage.
Any accessibility needs are known and have been met collaboratively	Voice	I offered the opportunity prior to participants confirming consent if any needs were to be considered to support them accessing the opportunity. I enquired at the beginning of the interview if they had any needs to be held in mind throughout the process.
If you will be discussing sensitive topics, participants have had an opportunity to see the questions in advance	Collaboration	I did not share the questions in advance with participants but I did give an overview of the topic areas we would be asking about. I also gave choice in the language of my questions in terms of allowing staff to choose if they wanted to share information on sensitive topics.
Participants have received accessible information about facilitator(s), the purpose & what to expect, where & when the session will be happening, & if there are refreshments	Trust & Transparency	I informed the participants of my role as a researcher, the aims of the project and what participation entails through the information sheet prior to confirming consent. We agreed on participation according to their availability and due to the nature of the interviews taking place online, refreshments were not offered but invited to take breaks if they needed to meet their own needs.
Participants have been offered the chance to meet with the interviewer ahead of the session if subject matter is potentially triggering	Trust & Transparency	I offered participants e-mail correspondence to answer any questions they may have and offered pre-interview meetings if required. This was only taken up on two occasions by participants. I also attended team meetings to recruit participants which provided a further opportunity to ask questions on participation.
Whether the session will be recorded is decided, alongside how you will ask for consent to record	Trust & Transparency	The information sheet contained information informing participants the session would be recorded and sensitively stored. I advised participants that I would be the only individual accessing the data and this would be deleted upon project completion. I asked participants at the beginning of the study if they consented to recording and pre-warned when the recording was started. I also informed participants when I stopped recording.
Interview questions are checked to ensure each question helps you	Safety	I reviewed the interview questions through discussion with the research team to reflect on the aims of each question, reduce duplication and ensure safety of the participants. We further reflected on the

meet a specific aim - that you are not asking people to share any sensitive information unnecessarily		nature of questions gathering only relevant, necessary information to inform the study's aims. I conducted a pilot interview with a research consultant to further verify safety of interview questions.
Plans are in place if anyone becomes distressed in the session and needs to take a break	Safety	Protocol for beginning the interview included making a collaborative plan with the participant on their preferences if they become distressed and expressed the opportunity for taking as many breaks as required. We also reflected on how to carry out this conversation in a relational manner through refining this process in the pilot interview e.g. checking in on how the participants' day was going at the beginning of the interview, allowing a space to acknowledge if there was anything presenting for them prior to interview.
During Interview		
Introductions, the purpose of the interview, and confidentiality issues explained with opportunity for questions	Trust & Transparency	I ensured to introduce my name, role and purpose of study via initial e-mails, information sheet and at the beginning of the interview. I advised of our confidentiality protocol and re-iterated what was stated in the information regarding upholding participant confidentiality. I also gave an opportunity to anonymise any demographic characteristics or to choose an alias for their data to uphold confidentiality at the beginning of the interview.
Participants will be asked whether they are comfortable with being recorded, & will be made aware that they can retract anything they share later on	Choice	Participants were informed of the recording and advised they were able to withdraw their data anytime before data analyses commenced at the beginning of the interview.
Participants will be told their options in advance in case they feel overwhelmed & they would like a break	Safety	Participants were given an overview of their choices at the beginning of the interview, as well as offered a check-in throughout the interview e.g. stating how many questions were left, acknowledging how much time had passed and enquiring if they wished for a break
Participants will be made aware of where recording devices are & when they are turned on & off	Choice	Participants were asked for consent to record and warned before this commenced. Participants were also advised when the recording had stopped.
The interviewer has planned to meet participant's basic needs throughout, including toilet breaks and water	Safety	We discussed the opportunity for participants to attend to their own needs at the beginning of the interview and emphasised the importance of taking breaks given the interview was online.

The interviewer is aware and prepared for their role in bringing out a person's story, without filling silences or removing focus from the person being interviewed	Voice	I reflected on my role as a researcher within the pilot interview with the research consultant and how to attend to the responses from participants e.g. allowing time, taking pauses and summarising what they have said in order to ensure their intended meaning was fully understood.
The interviewer plans to pay attention to non-verbal cues or discomfort and address them appropriately	Trust & Transparency	Further reflections in the pilot interview on how to consider non-verbal cues through an online interview. Emphasis at the beginning of the interview to participants to take breaks a required and a check-in at the end of the interview on how they felt the interview went was important to assess for any possible discomfort.
After Interview		
Interviewees are told about opportunities to add anything they feel is important before the session closes, and notified if they can continue to contribute after the interview	Choice	A part of the interview schedule included an open-ended question to give participants the opportunity to add any further thoughts on the topic of trauma-informed care within the homelessness sector. I informed participants they were able to reach out to me via e-mail if anything further arose that they wanted to share or have documented as part of their participation.
The interviewer goes through any notes made at the end with the interviewee (and keep notes visible throughout)	Trust & Transparency	I opted to not take notes throughout the interview due to the recording and automatic transcription through using the Teams app. I felt it was more pertinent to direct my full attention towards what the participant was saying.
Participants have been thanked for their time & energy	Trust & Transparency	I ensured to thank each participant for their contributions and effort towards supporting the project gain an understanding of staff experiences in TIC.
Signposting materials & debriefing options have been shared for anyone who may be impacted by the contents of the session	Safety	I devised a debriefing sheet that was sent to all participants post-interview in order to provide guidance on where to access support if they experience any distress following the interview. Sending this via e-mail also provided another opportunity to thank them for their time and give space for them to respond with any lingering thoughts or queries.
Participants have been given an opportunity to comment on any draft reports, or to be informed when a final report is made available	Voice	I have chosen not to member-check in the present study for reasons including: participant burden – these staff members have incredibly busy working lives and asking for further time may prove difficult for some. Given the initial difficulty with recruiting, I was concerned any compulsory member-checking would exclude participants consenting to take part. I was further concerned that optional member-checking would not have a full representation of staff due to further time required, particularly if this requires re-visiting information several months later. A further reason is due to the

		complexity of interpretation – I immersed myself in each participants' experience to understand shared meaning, patterns and themes. The data collected hosted a diversity of views and there was a possibility that not all staff members would opt-in to member-check, which could potentially mean any contributions through member-checking may bias the final findings towards a particular view and lessen the presence of views which were not entirely matching. Instead of member-checking the findings, I gave all the participants an opportunity to opt-in to be informed when the final report is available and if they would like to be a part of the dissemination process.
Participants have been given the opportunity to feedback on the process of being interviewed in person or via email, during or after the session	Voice	At the beginning of the interview, I asked participants to let me know if any queries arose during the questions. At the end of the interview, I asked for feedback on how participants found the interview and also advised them to reach out via e-mail after the interview ended if any further thoughts arose.
The interviewer has created a dedicated space to reflect on the group & to continuously develop trauma-informed practices within interview settings	Trust & Transparency	I have reflected on the interview process with my research team and through creating reflexive diary entries to consider my process, consolidate any learnings and further highlight any possible developments for my trauma-informed research approach.

Appendix H. Reflective Diary Excerpt Using Isobel's (2021) Trauma-Informed Research

17th March 2024 - Data analysis and dissemination reflexive diary using Isobel (2021) prompts for trauma-informed research

Isobel (2021) reflective questions	**My thoughts**
Am I protecting the safety of the participants' words and experiences through all stages of the analysis?	Throughout this project, my knowledge of TIC has grown, and if I were to choose one word to represent the approach, it would be safety. It can mean so many things depending on the person, time, place and space. Contextual safety has been important, not only in interviews but thinking about how participants have left me with their words and experiences without their physical presence in analyses. Participants offered vulnerability through sharing some of their own experiences, so I have tried to consider how I have honoured that by choosing which parts of their words represent their intended meanings the most.
Have I considered all required aspects of de-identification?	At each stage, I have attempted to think about de-identification, asking about particular characteristics and job titles but agreeing with participants about anonymising certain features in the write up to ensure their confidentiality. Whilst I have wanted to honour organisations, I have also kept them anonymous to further uphold de-identification.
What else may be impacting upon the participants' experiences, words and my understanding of them?	I have often asked myself the question, "Where am I at today?" With RTA, the 'scientific' tool is me—the words and experiences are synthesised through me; therefore, whatever I hold will undoubtedly influence that process. There have been times when I have not been in the right frame of mind to carry out analyses, so taking a step back or taking breaks has been key to honouring the process. At the same time, I have also asked myself "Where are these words wanting to take me?" In any research, participants will have different ways of speaking and conveying their points. There have been times where I have particularly connected with a particular phrasing, so it has been important to ask myself about where that is coming from – do we have similarities in our identities that makes this connect? Are they representing an idea that is already important to me? These check-ins have been important to stay grounded with an oversight of all contributions.
Have I considered the role and dynamics of power or disempowerment in the narration, collection and analysis of these experiences?	I've thought a lot about the role of power and disempowerment while gathering data and analysing to generate findings. When talking to staff, I made sure they felt comfortable and safe to share their stories without feeling judged. I reflected regularly on my own biases and assumptions throughout the analysis, considering where the pulls were taking me. It's been important to think about my power in analysing data without direct input from participants alongside the process – they have put trust in me to represent their views. Using frequent quotes and ensuring all voices were represented in quotes feels important to empower, rather than dis-power.

Has my analysis remained grounded in the data and experiences?	The answer to this question has been incredibly fluctuating throughout the analyses. There have been times I felt it has really connected to participants' intended meaning, and other times I have looked at the analysis, feeling it has lost its way. I think the process of 'letting go' has challenged its grounding, so the re-shaping and refining so far has felt destabilising at points. The codes felt the most connected at first, so losing some of those nuanced points was difficult because I knew they were representing something important to a participant. Re-centring on key meaning, going backwards from the final 'top themes' to the codes again will be important as part of my analyses to ascertain grounding.
How would I feel if I was one the participants and I read these findings?	I have often sat and visualised my participants taking on board the findings at different stages of the analysis journey so far. Would they pick this word? Does this phrasing summarise that story's meaning? Have I heard them how they intended? Re-visiting the interviews in video format has been key for keeping participants' essence within analysis, helping me to connect to their positioning and how they may digest findings. I have also weighed up the dilemma of how participants had very different views to one another, meaning some may not see themselves in all the meaning discussed. I have been curious about how this may land for some. Ultimately, I decided against member reflections due to participants having possible different interpretations or recalling events differently, which could lead to discrepancies between their reflections and the research findings. I was concerned that if not all could do member reflections (and two participants told me about circumstances that meant they wouldn't be accessible later down the line), then it would not be an equal representation in the reflections and potentially bias towards certain points of views.
What mechanisms of dissemination may ensure findings provide some benefit to the communities and individuals?	Discussions with participating organisations and participants has made me think about the importance of accessibility – whilst the project is handed in within a 30,000 word format, this won't be accessible to the majority. I have had conversations about what feels most accessible, with ideas around briefing papers to be disseminated in participating organisations; offering lunchtime bite-size talks about the findings in organisations – essentially, finding ways to go directly to the people it applies to support accessibility. A further idea also includes attending a popular housing podcast, given many workers are often on the road travelling between visits, may support them to access the findings within working time. I also discussed at consent about participants being involved in supporting dissemination, which some consented to do so. There is a lot of richness to be offered through hearing from

Appendix I. Research Consultant Contract

Agreement for Volunteers & Lay Members Involvement In Research

Agreement to be completed between trainee and any volunteer or consultant to research

AGREEMENT FOR VOLUNTEERS & LAY MEMBERS INVOLVEMENT IN RESEARCH

Doctorate in Clinical Psychology research study:

Title: Staff experiences of transitioning to trauma-informed care in homeless services: A thematic exploration

This research project is a study based at the University of Hertfordshire. The researcher is Clare Weston and the internal project supervisor is Dr Kirsty Stubbs. The present study aims to understand the staff experiences of transitioning to trauma-informed care within homelessness services. Whilst trauma-informed care has been in existence since 2001, implementation within homelessness services is still in its infancy. There has been previous research exploring the impact of trauma-informed care that looks at outcome seen in services, such as level of knowledge of staff, compassion fatigue and perceived organisational changes. However, there is little known about the in-depth experience of transitioning to trauma-informed care is like for staff. We recognize that organisational change can be complex, and we are interested in learning what it is like to work in a trauma-informed care approach within homelessness services. We are also curious about the experience of moving away from a particular way of working and transitioning into trauma-informed care.

Payment will be made to volunteers and lay members of the public for their participation in meetings and other research involvement activities. The project will finish on 01/09/2024.

This form must be completed by the participating volunteer before payment can be made. Any queries concerning this Agreement should be referred to the relevant Head of Research Centre at the University of Hertfordshire

Between: **The University of Hertfordshire**

and

Name: Ellen Grieves **(The "Participating Volunteer")**

Address: **[Removed for confidentiality]** **Tel No:** **[Removed for confidentiality]**

Email address: **[Removed for confidentiality]**

ACTIVITY Volunteer for Doctorate in Clinical Psychology research study

The **Participating Volunteer** has agreed to assist the University by voluntarily taking part in the research **Activity**.

1. The Activity to be undertaken is described below and it is the Activity for which you have given your consent/agreement.

Attend meetings to discuss recruitment, study progress, findings and how to share our results. Review participant information and materials as a Participating Volunteer Give his/her views to inform the research process and direction.

There will be no requirement for the participating volunteer to attend all meetings or take part in all activities. The participating volunteer can opt-out at any point in the project.

CONFIRMATION OF ATTENDANCE

2. The Researcher will confirm the Participating Volunteer has attended the Activity outlined above.

PAYMENT

3. The Participating Volunteer will receive a participation payment in the form of vouchers for completion of the activities described above. Payment will not be made for any activities in which the Participant did not participate at all.

RELATIONSHIP BETWEEN THE UNIVERSITY AND THE PARTICIPATING VOLUNTEER

4. The University does not regard the Participating Volunteer as an employee of the University nor as a worker, and the payment made to the Participating Volunteer for the participation is not made with respect to any employment relationship with the University.
5. The Participating Volunteer is advised that it is their personal responsibility to declare any payment for participation to HM Revenue & Customs under Self-Assessment, if that is appropriate to their personal circumstances. The University will not deduct income taxes from the payment.

SIGNED FOR AND ON BEHALF OF THE UNIVERSITY

The signatory for the University confirms they have authority to enter into this agreement on behalf of the University e.g., Principal Investigator

SIGNED	**[Removed for confidentiality]**
PRINT NAME	Dr Kirsty Stubbs
POSITION AT UH	Associate Tutor
DATE SIGNED	10/07/2023

SIGNED BY THE PARTICIPATING VOLUNTEER

I acknowledge receipt of a copy of this agreement and accept it's terms.

SIGNED	**[Removed for confidentiality]**
PRINT NAME	Ellen Grieves
DATE	03/07/2023

Appendix J. Research Poster

Appendix K. Introductory Document to the Research Project

University of Hertfordshire UH

An Opportunity to Participate in Research in the Homeless Sector

My name is Clare Weston, and I am a third-year Trainee Clinical Psychologist studying at the University of Hertfordshire. I am reaching out to share an exciting opportunity to participate in my research project, titled: 'Staff experiences of transitioning to trauma-informed care in homeless services: A thematic exploration'.

The project has ethical approval from the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee (Protocol number: LMS/PGT/UH/05370(2)).

What are we hoping to do?

We are conducting a qualitative study to hear the views of staff members who work in homelessness organisations that are implementing or transitioning to trauma-informed care. We would like to understand the in-depth experiences of staff members in this setting, including your perspective on how trauma-informed care is going in your service; what you find is working well and any complexities you may have found in the process.

Can I participate?

- Do you work in an organisation that supports people experiencing homelessness?
- Is your organisation currently implementing trauma-informed care?
- Or is your organisation transitioning to a trauma-informed care approach?

We recognise that trauma-informed care may also be referred to using other terms in organisations. We welcome discussions via e-mail to help you consider if trauma-informed care is currently an approach being used in your service.

What does taking part involve?

The opportunity will involve a single one-to-one interview with the project lead, lasting approximately 60-90 minutes over Zoom to hear your views. The interview can be set up to take place at your convenience. There is a further opportunity to be involved in sharing findings once the project is complete, but this is entirely optional.

As a thank you for your time, we will offer all participants a £20 love2shop online voucher.

How do I find out more?

If you are interested, please reach out for further information to Clare Weston at: [e-mail address redacted for confidentiality]

Many thanks for your time and consideration.

With kind wishes,

Clare Weston (she/her) - Trainee Clinical Psychologist
Project team: Clare Weston, Dr Kirsty Stubbs, Dr Rachel Brown and Ellen Grieves

Appendix L. Eligibility Guide for Participation

Guide for eligibility for potential participants

Thank you for your interest in participation in the present study. We have written the below information to help you identify if you are eligible for participating in the study.

Our definition for the present project for trauma-informed care pertains to the Homeless Link (2017) briefing:

"Trauma-Informed Care is an approach which can be adopted by organisations in order to improve awareness of trauma and its impact, to ensure that the services provided offer effective support and, above all, that they do not re-traumatise those accessing or working in services.

TIC is an approach which is widely used across many sectors in the US and elsewhere, and is growing in popularity here in the UK. There is a wealth of literature online about TIC and how to implement it.

The Substance Misuse and Mental Health Services Authority (SAMHSA), a branch of a federal government agency in the US, developed the National Centre for Trauma Informed Care in order to share good practice and promote the approach. They have developed a comprehensive toolkit around the approach and its implementation. Trauma Informed Care can be adopted by an individual project, by an organisation or across a whole system.

SAMHSA (2014): detail that those adopting the approach:

- Realise the widespread impact of trauma and how people might recover
- Recognise the signs and symptoms of trauma in those involved in the system
- Respond by using the knowledge of trauma to improve and change practice
- Actively avoid and prevent re-traumatisation"

Is this project for you?

We are looking for candidates to speak to whom have:

- Minimum experience of working within the homeless sector for 6 months
- Contact with people who experience homelessness on at least a monthly basis (e.g. management, administration, support workers, psychologists, case workers, psychotherapists, occupational therapists, dieticians, social workers, nurses etc.)
- Work within a homelessness organisation based in the UK that is currently transitioning to trauma-informed care or utilising trauma-informed care

You may not be suitable if:

- You have not heard of trauma-informed care
- You have heard of trauma-informed care but this is not an approach being implemented within your team or organisation at present
- You work in an organisation based outside of the UK

If you have any queries; would like to discuss any of the above or express interest in participation then please email the project lead, Clare Weston, at [e-mail address redacted for confidentiality]

Thank you for your time.

Appendix M. Recruitment E-mail Template

E-mail subject title: An Opportunity to Participate in Research in the Homeless Sector
Attachments: Eligibility guide and Research Poster
[E-mail content below]

Hello all,

My name is Clare Weston, and I am a second-year Trainee Clinical Psychologist studying at the University of Hertfordshire. I am reaching out to share an exciting opportunity to participate in my research project, titled: 'Staff experiences of transitioning to trauma-informed care in homeless services: A thematic exploration'.

The project has ethical approval from the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee (Protocol number: LMS/PGT/UH/05370(1)).

What are we hoping to do?

We are conducting a qualitative study to hear the views of staff members who work in homelessness organisations that are implementing or transitioning to trauma-informed care. There has been previous research exploring the impact of trauma-informed care that looks at outcomes seen in services, such as level of knowledge of staff, compassion fatigue and perceived organisational changes. However, there is little known about the in-depth experience of transitioning to trauma-informed care is like for staff.

We would like to understand the in-depth experiences of staff members, including how you have found the transition, what difference the approach has made, and what is helping or hindering you in this work.

Can I participate?

- Do you work in an organisation that supports people experiencing homelessness?
- Is your organisation currently implementing or transitioning to trauma-informed care?
- Have you worked in the organisation before and during the transition?
- Have you worked in homelessness services for a minimum of 6 months?

We have attached a guide to this e-mail with further detail to help you consider if you are eligible to participate in the study.

We recognise that trauma-informed care may also be referred to using other terms in organisations. We welcome discussions via e-mail to help you consider if trauma-informed care is currently an approach being used in your service.

What does taking part involve?

The opportunity will involve a single one-to-one interview with the lead researcher, lasting approximately 60-90 minutes over Zoom to hear your views. The interview can be set up to take place at a time convenient to you. There is a further opportunity to be involved in sharing findings once the project is complete, but this is entirely optional.

How do I find out more?

If you are interested, please reach out for further information to Clare Weston at: [e-mail address redacted for confidentiality]

Many thanks for your time and consideration.

With kind wishes,

Clare Weston (she/her)
Lead Researcher & Trainee Clinical Psychologist
Project team: Clare Weston, Dr Kirsty Stubbs, Dr Rachel Brown and Ellen Grieves

Appendix N. Initial Draft of Stages of Traum-informed Care Journey

[Initially drafted with research team and not used to keep scope of recruitment broad]

Thank you for your interest in participation in the present study.

We are asking individuals to self-identify where they may be at within their trauma-informed care journey in order to gather views across the spectrum of implementation of the approach.

We have a guide below to help you consider how you may categorise your position within your trauma-informed journey.

	Category	**Indicators for the category**
1	Not started yet	• You have not heard of trauma-informed care • You have heard of trauma-informed care but this is not an approach being implemented within your team or organisation at present
2	Beginning the journey	• You have attended at least two trauma-informed care sessions, whether this is in the form of reflective practice, post-incident debriefing sessions, training or a supervision session focused on the trauma-informed care approach • You are aware of trauma-informed care and what it means, however, you are still learning about how it is implemented
3	Developing	• You have attended more than two trauma-informed care sessions e.g. supervision, training, reflective practice, case discussions, post-incident debriefing sessions • You have carried out reading on TIC • You have been able to offer insights occasionally with a trauma informed care lens within meetings • You feel you have some knowledge of trauma-informed care and you can give some examples of how it works in your organisation but you are still learning about it's approach
4	Advanced	• Your organisation is considered to have trauma-informed care embedded within it's approach and this is evident within policies and guidance • You have attended multiple meetings and opportunities (5+) that involve consideration of trauma informed care e.g. supervision, reflective practice, case meetings • You feel confident in discussing trauma-informed care and how it applies in your work
5	Leadership	• You are a named trauma informed care champion, or a designated leader of TIC within your organisation • OR You hold a form of responsibility for the implementation of trauma-informed care within your organisation e.g. offering trauma-informed supervision, providing training on trauma-informed care, facilitating trauma-informed reflective practices or facilitating trauma-informed post-incident debriefings

You will be asked during the initial stages of agreeing participation where you feel you are best placed within the above categories (1-5). We recognise it may be difficult to select an area, so please feel free to discuss with the project lead.

Appendix O. Study Information Sheet (Qualtrics)

University of Hertfordshire - Staff experiences of trauma-informed homelessness services

Start of Block:

You have been invited to participate in the study 'Staff experiences of transitioning to trauma-informed homelessness services'

The current survey provides pre-participation information: you will be taken through the information sheet, consent form and demographics information. Please take time to read carefully through the information sheet before providing your consent to participate in the study.

The study participation will involve approximately a 60-90 minute interview arranged at your convenience following completion of this survey. Please find further information on the next page.

The survey will take approximately 10 minutes to go through. Thank you for your time in advance, we greatly appreciate it.

Page Break

University of Hertfordshire
Information Sheet
Staff experiences of transitioning to trauma-informed care in homelessness services

1 Introduction

You are being invited to take part in a research study looking at 'Staff experiences of transitioning to trauma-informed care in homelessness services'.

Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University's regulation, UPR

RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link:

https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs (after accessing this website, scroll down to Letter S where you will find the regulation)

Thank you for reading this.

2 Who am I?

My name is Clare Weston and I am a Trainee Clinical Psychologist studying at the University of Hertfordshire. As part of my Doctoral studies, I am conducting the present study.

The project is being supervised by Dr Kirsty Stubbs, an Associate Tutor at the University of Hertfordshire, and Dr Rachel Brown who works in homeless services, both Clinical Psychologists.

3 What is the purpose of this study?

The present study aims to understand the staff experiences of transitioning to trauma-informed care within homelessness services.

Previous research has demonstrated that people who have experienced homelessness are more likely to have experienced trauma in comparison to the general population. Trauma-informed care is an approach which shifts the focus from “What’s wrong with you?” to “What’s happened to you?” Trauma-informed care seeks to recognize the signs of trauma within clients, families and staff; realise the impact of trauma; integrate trauma theory into practice, policies and procedures, as well as actively avoid re-traumatisation.

Whilst trauma-informed care has been in existence since 2001, implementation within homelessness services is still in its infancy. There has been previous research exploring the impact of trauma-informed care that looks at outcome seen in services, such as level of knowledge of staff, compassion fatigue and perceived organisational changes. However, there is little known about the in-depth experience of transitioning to trauma-informed care is like for staff. We recognize that organisational change can be complex, and we are interested in learning what it is like to work in a trauma-informed care approach within homelessness services. We are also curious about the experience of moving away from a particular way of working and transitioning into trauma-informed care.

4 Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw up to two week after interview without giving a reason, withdrawal isn’t possible beyond this timeframe as the data analysis will have commenced.

5 Are there any age or other restrictions that may prevent me from participating?

I am looking to speak with anyone who identifies as a staff member within a homelessness service

that is currently transitioning to a trauma-informed approach, or in the process of transitioning to trauma-informed care within their organisation.

If your organization is not currently transitioning to trauma-informed care, then this will restrict you from participating. If your organization is located outside of the UK context, this will further act as an exclusion for participation. If you have worked in a homelessness organization for less than 6 months, this is another restriction for participation.

6 How long will my part in the study take?

If you decide to take part in this study, you will be involved in it for 60-90 minutes in total for the interview to take place. We are happy to plan the interview according to your availability and what works for you. If you are interested, we will get back in touch to arrange a time.

7 What will happen to me if I take part?

The first thing to happen will be an e-mail contact from the lead researcher, Clare Weston, who will send you information such as the present information sheet, consent form, eligibility criteria sheet and demographics information form via a Qualtrics survey. If you are satisfied with the information, you will be asked to return a signed consent form and completed demographics information form. Once these have been returned, we will get back in touch via e-mail to organize your 1:1 interview with the lead researcher at a time convenient to you. The interview will be 60-90 minutes long. You can opt-in to be contacted if the study is published and the findings are disseminated via other methods, such as on a podcast or housing bulletin. You are also welcome to share in the interview if you would like to be actively involved in dissemination of results.

8 What are the possible disadvantages, risks or side effects of taking part?

We recognize that discussing trauma-informed care could potentially bring up difficult experiences regarding trauma for you, which maybe related to your professional and/or a personal context. We will not be asking you to directly discuss your own experiences of trauma, but you are able to share in your responses if this is something you wish to do.

9 What are the possible benefits of taking part?

You will be able to contribute your views about transitioning to trauma-informed care within a homeless service and help us to understand what some of the complexities of change may be, as well as what your perspectives are about what is helpful, or is going well about the process.

We hope this will inform further development of trauma-informed care within homeless services and provide thoughts on how to best support staff with the process, and perhaps wellbeing.

10 How will my taking part in this study be kept confidential?

At the point of transcription, you will have a choice to provide a pseudonym to be allocated to your information or one will be given to you. All identifying information and details will be destroyed at the end of the project to ensure confidential participation. Information will be kept anonymous in

the report write up.

The data collected within the study will be encrypted and password protected in a University of Hertfordshire data cloud. The data will only be accessed by the investigators of the project. The data will be transcribed, reviewed and analysed to generate themes from across the interviews. The data will be deleted after the researcher has been awarded their Doctoral degree in line with the University of Hertfordshire's data management policy.

The data will not be used in further studies.

11 What will happen to the data collected within this study?

The data collected within the study will be encrypted and password protected. The data will only be accessed by the investigators of the project. The data will be transcribed, reviewed and analysed to generate themes from across the interviews. The data will be deleted after the researcher has been awarded their Doctoral degree in line with the University of Hertfordshire's data management policy.

Anonymised data will be analysed and written up into a Doctoral thesis. The findings will also be written into an article in order to submit to an academic journal for potential publication. The project hopes to explore other methods of dissemination, including discussing findings via a housing podcast and providing infographics to housing sector bulletins summarising findings. I may use direct quotations from the interviews within the study write up, in publications, podcast and infographics. I will ensure there will be no identifiable information to ensure confidentiality in any subsequent write-up. You will be asked at the end of your interview if you are interested in engaging in the dissemination process as an optional process. You have a choice to opt-in post-interview to give time for consideration. At agreement, we will collaboratively consider methods for your involvement, such as co-creating dissemination materials such as infographics and the podcast.

12 Will the data be required for use in further studies?

The data will not be used in any further studies.

13 Who has reviewed this study?

The University of Hertfordshire Health, Science, Engineering & Technology Ethics Committee with Delegated Authority

The UH protocol number is: LMS/PGT/UH/05370(2).

14 Factors that might put others at risk

Please note that if, during the study, any medical conditions or non-medical circumstances such as unlawful activity become apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

15 Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with me by email: Clare Weston (Trainee Clinical Psychologist) at [e-mail address redacted for confidentiality] You may also contact the project supervisor, Dr Kirsty Stubbs, at [e-mail address redacted for confidentiality]

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

Page Break

Appendix P. Demographics Information Form

Demographic Information

We are interested to understand the demographics within the present study. Below, we have left the categories as open-ended as we are interested to hear your wording in how you would describe your identity. We would be grateful if you can fill in all fields, and if there is anything you are not comfortable with completing, please write 'Not disclosed' for that section.

Many thanks,
Clare Weston
Trainee Clinical Psychologist

Gender Identity:

Examples include 'non-binary', 'female', 'male', 'transgender woman', etc. Please note, these examples are not an exhaustive list.

_____

Ethnicity:

E.g. Examples include 'Black British', 'Chinese', 'Pakistani', 'White and Black Caribbean', 'White English', 'White Scottish', etc. Please note, these examples are not an exhaustive list.

_____

Age:

_____

Is there anything else you feel is important for us to know in terms of describing your identity?

Examples may include level of ability; class; religion or if you have experienced homelessness yourself. Please only disclose what you feel comfortable doing so.

_____

Please describe the service you work for AND your role:

E.g. Support worker, case worker, administrator, clinical psychologist, etc.

_____

End of Block

Appendix Q. Consent Form

University of Hertfordshire
Staff experiences of transitioning to trauma-informed care in homelessness services study
UH Protocol Number: LMS/PGT/UH/05370(2)

Consent Form

I, the undersigned [please give your name in the below text box]

_____

---

hereby freely agree to take part in the study entitled 'Staff experiences of transitioning to a trauma-informed homelessness service: A thematic exploration'

Please give contact details here, sufficient to enable the investigator to get in touch with you, such as a telephone number or email address:

_____

---

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

2 I have been assured that I may withdraw from the study at any time prior to interview without disadvantage or having to give a reason. I am aware that I am only able to withdraw up to two week after interview without giving a reason, as withdrawal isn't possible beyond this timeframe as the data analysis will have commenced.

3 In giving my consent to participate in this study, I understand that voice, video or photo-recording will take place and I have been informed of how/whether this recording will be transmitted/displayed.

4 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

5 I understand that if I share any information that involves a risk to my safety or someone else's safety during my engagement with the project, that the project team will discuss this with me outside of the interview setting.

6 I understand that if there is any revelation of unlawful activity or any indication of circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

7 I consent to my words being used in other methods of dissemination, such as in a podcast or infographic to represent the findings from the study. I am aware that there will be no identifying details included.

8 I agree that the research project has been explained to me to my satisfaction and I agree to take part.

Q8 Signature of participant below:

Q14 Please enter the date today e.g. (DD/MM/YY)

_____

Q10 Please select your preferences below by selecting your answer:

Q11 I would like to receive a summary of the completed report

- ○ Yes (1)
- ○ No (2)

Q9 I would like to be informed if the study is published

- ○ Yes (1)
- ○ No (2)

Page Break

Appendix R. Interview Schedule

Interview introduction prompts:

- *Welcome – ask how they are, introduce self if meeting for the first time (importance of relational building with the topic being discussed)*
- *Give an overview of the setting for today – I will be asking questions, recording but will be anonymised*
- *Demographics and consent form double check*
- *Recognise their experience in the sector named in demographics form – name focus on trauma informed care in homelessness services*
- *Ask if there is anything to take into consideration for making them comfortable during the interview e.g. are they someone who needs breaks, etc.*
- *Building up the processes of trauma-informed care e.g. Provide prefixes like if you are affected or the interview feels too much, you don't have to answer, if you need to take a break. Trauma lives in all of us in different ways (care giving space at interview)*
- *State they are able to exit the interview at any point or ask for their interview data to be removed up until data analysis commences*
- *Any questions before beginning the interview?*

Inform of recording beginning - HIT RECORD ON TEAMS & ZOOM

Questions

1) How do you define trauma-informed care?
2) Since trauma-informed care is a process, as opposed to an end result, I'm curious how you would describe where you are at presently in your trauma-informed journey?
3) Can you describe your personal experience of the transition to trauma-informed care in your workplace?
4) What difference has using trauma-informed care made to your work?
5) What do you think has been beneficial about using the trauma-informed care approach in your workplace? What have you personally appreciated about it?
6) What has supported your integration or adoption of a trauma-informed approach?
7) What do you think have been barriers or hurdles whilst transitioning to trauma-informed care?
8) What have you found challenging about the transition to trauma-informed care?
9) What do you think may help move past the barriers, hurdles and challenges you shared?
10) How has your emotional wellbeing been supported in the process of transitioning to trauma-informed care? What, or who, has helped?
11) Do you have any hopes, ideas or wishes for the future of trauma-informed care in the homeless sector?
12) Is there anything you would like to add about this topic area? Is there anything you would like to ask me?

- Snowballing Question: Is there anyone you know who may be interested in the above project?

Appendix S. Debriefing Information Sheet

Debriefing information

Thank you for your participation in the project 'Staff experiences of transitioning to trauma-informed care within homeless services'.

We recognise that discussing trauma-informed care may have led to consideration of trauma within both professional and personal contexts which may cause distress.

If you would like to further discuss what was shared in the interview, you are welcome to reach out to the principal investigator, Clare Weston, at [e-mail address redacted for confidentiality] to further speak. You may also contact the project supervisor, Dr Kirsty Stubbs, at [e-mail address redacted for confidentiality]. If you feel you require support for your emotional wellbeing, we recommend you discuss with your line manager or named trauma-informed care leads within your organisation. Spaces such as reflective practice and supervision within your work may also be suitable for accessing further support.

If you feel you need other support options, please do not hesitate to speak to your GP or their out of hours. Additionally, some helpful contacts include:

- NHS 111 option 2 (mental health crisis line)
- Samaritans on 116 123

If you feel it is urgent, please do not hesitate to go to A&E.

Thank you again for your contributions to this project.

Clare Weston
Trainee Clinical Psychologist

Appendix T. Participant Agreement for Remuneration

AGREEMENT FOR VOLUNTEERS & LAY MEMBERS INVOLVEMENT IN RESEARCH

Doctorate in Clinical Psychology research study

Title: Staff experiences of transitioning to trauma-informed care in homeless services: A thematic exploration

This research project is a study based at the University of Hertfordshire. The researcher is Clare Weston and the internal project supervisor is Dr Kirsty Stubbs. The present study aims to understand the staff experiences of transitioning to trauma-informed care within homelessness services. Whilst trauma-informed care has been in existence since 2001, implementation within homelessness services is still in its infancy. There has been previous research exploring the impact of trauma-informed care that looks at outcome seen in services, such as level of knowledge of staff, compassion fatigue and perceived organisational changes. However, there is little known about the in-depth experience of transitioning to trauma-informed care is like for staff. We recognize that organisational change can be complex, and we are interested in learning what it is like to work in a trauma-informed care approach within homelessness services. We are also curious about the experience of moving away from a particular way of working and transitioning into trauma-informed care.

Payment will be made to volunteers and lay members of the public for their participation in meetings and other research involvement activities. The project will finish on 01/09/2024.

This form must be completed by the participating volunteer before payment can be made. Any queries concerning this Agreement should be referred to the relevant Head of Research Centre at the University of Hertfordshire.

Between: The University of Hertfordshire

and

Name: Insert your name here **(The "Participating Volunteer")**

Address: Insert work address

Tel No: Insert work telephone number

Email address: Insert work e-mail

ACTIVITY Volunteer for Doctorate in Clinical Psychology research study

1. The **Participating Volunteer** has agreed to assist the University by voluntarily taking part in the research **Activity**.

The Activity to be undertaken is described below and it is the Activity for which you have given your consent/agreement.

Attend a 60-90 minute interview online with the lead researcher to share their views in the research study. There is no requirement for the participant to attend any further obligations. Participants will be made aware they are able to withdraw their interview data any time prior to the commencement of data analysis and this will not affect the receipt of the gift voucher.

CONFIRMATION OF ATTENDANCE

2. The Researcher will confirm the Participating Volunteer has attended the Activity outlined above.

PAYMENT

3. The Participating Volunteer will receive a participation payment in the form of vouchers for completion of the activities described above. Payment will not be made for any activities in which the Participant did not participate at all.

RELATIONSHIP BETWEEN THE UNIVERSITY AND THE PARTICIPATING VOLUNTEER

4. The University does not regard the Participating Volunteer as an employee of the University nor as a worker, and the payment made to the Participating Volunteer for the participation is not made with respect to any employment relationship with the University.

5. The Participating Volunteer is advised that it is their personal responsibility to declare any payment for participation to HM Revenue & Customs under Self-Assessment, if that is appropriate to their personal circumstances. The University will not deduct income taxes from the payment.

SIGNED FOR AND ON BEHALF OF THE UNIVERSITY

The signatory for the University confirms they have authority to enter into this agreement on behalf of the University e.g., Principal Investigator

SIGNED	
Print Name	
Position at UH	
Date	

SIGNED BY THE PARTICIPATING VOLUNTEER

I acknowledge receipt of a copy of this agreement and accept its terms.

SIGNED	**Please insert your signature here**
Print Name	**Please print your name here**
Date	**Please enter the date here**

Appendix U. Ethical Approval Notifications

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Clare Weston
CC	Dr Kirsty Stubbs (Primary Supervisor), Dr Rachel Brown (Secondary Supervisor)
FROM	Dr Rebecca Knight, Health, Science, Engineering & Technology ECDA Vice Chair
DATE	14/07/2023

Protocol number: **LMS/PGT/UH/05370**

Title of study: Staff experiences of transitioning to trauma-informed care in homeless services: A thematic exploration.

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

no additional workers named

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 14/07/2023

To: 30/09/2024

Second ethics approval notification following first amendments request

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	**Clare Weston**
CC	**Dr Kirsty Stubbs**
FROM	**Dr Rebecca Knight, Health, Science, Engineering and Technology ECDA Vice Chair**
DATE	**28/09/2023**

Protocol number:	LMS/PGT/UH/05370(1)
Title of study:	Staff experiences of transitioning to trauma-informed care in homeless services: A thematic exploration

Your application to modify and extend the existing protocol as detailed below has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

No additional workers named

Modification:

All modifications as requested on the EC2

Original protocol: Any conditions relating to the original protocol approval remain and must be complied with.

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 28/09/2023

To: 30/09/2024

Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.
Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit a further EC2 request.
Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A or as detailed in the EC2 request. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.
Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

Third ethical approval notification following second amendment request

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Clare Weston
CC	Dr Kirsty Stubbs
FROM	Rebecca Knight, Health, Science, Engineering and Technology ECDA Vice-Chair
DATE	24/10/2023

Protocol number:	**aLMS/PGT/UH/05370(2)**
Title of study:	Staff experiences of transitioning to trauma-informed care in homeless services: A thematic exploration

Your application to modify and extend the existing protocol as detailed below has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

No additional workers named

Modification:

All modifications as detailed in the approved EC2 application

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Original protocol: Any conditions relating to the original protocol approval remain and must be complied with.

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 24/10/2023

To: 30/09/2024

Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.
Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit a further EC2 request.
Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A or as detailed in the EC2 request. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.
Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

Appendix V. Organisational Approval E-mails for Advertising Participation

Redacted to preserve anonymity

[redacted]

To: Clare Weston [Student-LMS] Fri 08/09/2023 13:01

[redacted] I think we can go with a yes please proceed. Sorry it hasn't been as easy as I hoped.

Im on leave from [redacted] so please take this as confirmation as consent to proceed.

Best of luck

[redacted]

[redacted]

To: Clare Weston [Student-LMS] Mon 16/10/2023 15:41

Cc: [redacted]

This Message contains suspicious characteristics and has originated outside your organization.

Hi Clare,

You're fine to proceed now we've received the MoU; with regard to advertising in [redacted] also, I would ask that [redacted] checks with the team leader there first – she can tell them the research team has given the project the go-ahead, but it's up to local services to decide if they have capacity to support.

Best regards

[redacted]

Appendix W. Reflexive Diary Excerpt on Interviews

10.11.23 – 11th interview

Throughout the interview today, it was clear that trauma-informed care was really important to the participant. The participant had come with notes which highlighted to me that it was important for them to be able to share what they have learned about trauma informed care and what their experiences have been. I noticed myself wanting to be drawn to encouraging all of their experiences to be included in the interview. Also, I noticed that I didn't have to ask as many follow up questions as the participant was able to prompt themselves from their list to be able to share further about practises they felt were key and demonstrating trauma informed care. At times the participant was caught off guard by my questions, in particular, about their own wellbeing and some of the challenges of trauma informed care. I noticed this felt a bit more difficult for them to turn towards and it made me think about how perhaps, holding a position of a manager, you have to be the representative of trauma informed care to champion it and to be able to spread that word. It made me wonder how much time is given in services to think about the challenges of trauma informed care when you're trying to be the one pioneering it. Consequently, this taught me that my research is providing people with space to perhaps stop and think, whereas in services, they're not having as much time to process.

I also noticed I was drawn to wanting to reassure that it was OK that this individual had not thought yet about some of the challenges and how their emotional wellbeing is looked at. I also noticed that I had this pull to want to ask or suggest further supporting services when they named their emotional wellbeing has not been supported. This highlighted the difference between being a clinical psychologist in practice versus in research. I had to think carefully about how I suggested support once the interview had ended considering that I'm not a member of their team or their service.

I started to notice there feels like a theme of heroism in championing trauma-informed care. Even the choice of the word ‘hero’ and ‘championing’ highlights this further for me as I wrote this out. There's something about self-sacrifice that comes with delivering systems change and something further about having to work extremely hard to be able to implement something different. I am noticing as I'm conducting my own research that I am wanting to really honour the hard work and sacrifice that my participants are showing. I have a real urge to get things right to fully understand and develop something meaningful that will support their practise. These traits shown by myself and my participants are common features and the NHS and 3rd sector organisations. I think it will be important to hold in mind in my analysis how I think about these concepts, as it will be important for me to balance these pulls to remain unbiased.

I’ve also noticed how I’ve ended up with greater reflections on this interview, mirroring the rush of information shared by the participant.

Appendix X. Reflexive Diary Excerpts on Coding

21st January 2024 – Coding

Beginning the coding process, I noticed that I was drawn to initially picking out codes that helps me understand trauma informed care. I had to really consciously pull myself to hold in mind what does this contribution tell me about this individual's experience or their perception of other people's experience in the system they exist in. I am noticing my curiosity to understand the overall phenomenon of trauma informed care can pull me away from understanding staff experiences as a particular lens.

I have been trying to balance out what was interpretation of experience alongside directly summarising what was stated in coding. I have noticed that there are some things that feel unsaid in the interviews. For example, when talking about their own emotional experiences, there can be a tendency to contribute less and perhaps speak more on what they notice in other people's experiences as fellow staff members or clients. This has made me wonder about how the profession has further attracted individuals who are so focused on the work that they limit that space for themselves, demonstrated through participating in the interview that was about their experience but not naming some of their own singular experiences. In particular, I tend to speak even less about their own emotional experiences and instead focusing on the staff that they are responsible for. There appears to be a greater sense of get on with things. Additionally they speak about drawing more on personal resources to do their job rather than something that's provided within the service. This makes me wonder about possible future directions to hold in mind the implications of my study.

Reflecting on my impact on the work, I'm aware I have been thinking about the environment I'm in when I'm coding and how this impacts on my perspective. For example, I have noticed that short bursts of focus with coding in silence with a big screen, has helped me to immerse myself into that person's experience when I am coding. I have also noticed that taking time to check in with my own mind, my own body and my own thoughts have supported me to be aware of what stuff is mine, and what stuff comes up from carrying out the coding process. I've noticed I have been visualising my participants' faces as I code to help me re-connect to their experience and their narrative as I review written information. It's been lovely to enact that sense of sitting with them again, and ask myself: What are they wanting me to take from their words? What do they want me to understand?

24th January 2024 - Coding

I've notice during coding that I have been drawn to using 'ing' words to describe staff experiences. I noticed that asking myself about what are they feeling, what are they thinking, what are they saying and what are they hoping for me to understand about their experience from their verbalizations as important for coding. This has led me to reflect on what words I can be drawn to in describing an experience, for example, using the word 'feeling…', 'wishing…' 'reflecting…'. This style of coding has helped me align to considering their experience of TIC rather than the pull towards wanting to pull together components of making sense of solely TIC itself.

There are moments where I notice I feel overwhelmed by the amount of initial codes coming up, but balancing this with wanting to really capture everything in the data in order to honour my participants' time and efforts. I feel like I'm being led on a journey by the data, and that gives me a gut instinct that I should continue to follow noting everything that jumps out which tells me about their experience.

25th January 2024 – Coding

Carrying out coding today has left me with the feeling of uncertainty in terms of the direction of where the data will take me. Thematic analysis feels like a long winding journey, which sometimes means having to go back down the road to just go further ahead again. It's not a linear process. That uncertainty of nonspecific steps has made me reflect on how I usually show up in uncertainty, and therefore wonder how I am showing up in coding my data.

When it comes to uncertainty, I double down in effort to work out certainty. I have perfectionistic tendencies, which means I go into weighing up multiple perspectives to find the most fitting, and thus I can be over cautious with what perspective I commit to. Today I felt a bit overwhelmed with the number of initial subcodes so far (649), but I recognised this has related to my tactic of being cautious, tipping into labelling something when I am not sure whether to or not, giving different wording to capture any nuance instead of directly linking into a previous code. Naming this with myself has given me the opportunity to consider – do I continue to lean into how I manage uncertainty? Do I feel this gives me the best method of honouring my participants' contributions? Does this fit with my values and epistemology? Taking an opportunity to discuss this with another trusted individual allowed me to consolidate that I feel this is the best fitting approach for me and my research. Allowing myself a moment of reflection, in a similar vein to my participants pausing and reflecting on their practice, gave me a sense of how I am mirroring what some of my participants speak of doing in their clinical practice. Thus, there has been a moment of reciprocal influence.

Appendix Y. Reflexive Diary on Theme Generation

Below documents several excerpts selected out of the reflexive diary to show my thought processes shifting throughout theme generation

25th February 2024 – Subthemes / themes analysis

Today I have been experimenting with reframing my codes and sub-themes into different overall thematic categories. I notice there were different layers of experience that people were talking about in the interviews going from within their internal experiences, to the client-to-themselves relational experiences, to team experiences, service experiences, within the sector, and within society.

Whilst it's been helpful to consider how the experiences show up in these different manners, there have been essences of meaning which transcend across each domain. I am noticing how there are certain beliefs / values which show up within each domain, wanting to pull me back into my original framing of subthemes. I am aware I am quite a value-focused practitioner in my clinical work, therefore identifying underlying values / beliefs in research associated with TIC feels a closer lens to my usual experience. I have also learnt a lot about society in my Doctorate under the umbrella 'context', which has certainly shaped how I have worded / viewed the language of bringing together wider societal reflections in participants' contributions.

I am also noticing that I am being influenced by the research in how I am understanding their knowledge, therefore shaping what I know of TIC. I have been connected to staff's difficult experiences, reflecting on the underlying meaning and how it connects to some of the tensions I have experienced in NHS work. This has led me to ponder – what is new in the data that is unique to homelessness? What is the same in all helping sectors in the current landscape we live in?

26th February 2024 – Subthemes / themes analysis

It clicks! The euphoria when you notice you are sitting with a different perspective and things are starting to make sense. Sitting with making sense of domains of experience when thinking about 'within me', 'within me and client', 'within team/service' and breaking things into system levels has supported unifying some key relating themes. It's enabled me to bring some relationships together. I have noticed that I am drawn from my training to think about different systems levels, which has undoubtedly influenced this frame of analysis, at present feeling like it makes more sense to me. I am left with questions about how this may look different if I had trained elsewhere in a different Doctorate, or at a different time in life.

Reflecting on this, critical realism really ties into how I'm approaching this. Critical realism is all about recognising that there's a real world out there, but our understanding of it is always through our own perspectives and contexts. This helps explain why my training and background are so influential in how I see things. It's not just about the data sitting there in a vacuum; it's about how I, with my specific training and experiences, interact with that data.

I am left with questions about – are emotional experiences purely within someone? Can they also exist between people? How is this captured in the data? What about my own experiences makes me consider moving emotions into the 'within me' experience – particularly when some subthemes show that they do not feel able to bring emotional experiences into wider layers of the systems. How has the data also shaped my analysis in this way? If I were to consider themes in another service, or a non-helping context, would it remain the same? Is there something about our society shaping where we view emotions as sitting?

These questions really resonate with a critical realist perspective. It's about understanding that emotions and experiences are real and exist, but how we perceive and interpret them can vary widely depending on our context. Critical realism helps me think about how different layers of reality—like personal experiences, interactions between people, and larger systemic influences—interact and shape each other. It makes me more aware of how my interpretations are shaped not just by the data but also by my own background and the broader societal context.

So, recognising these influences helps me to be more reflective and critical about my analysis. It pushes me to think deeper about why I'm seeing things a certain way and how I can consider alternative perspectives. This way, I can make my analysis more robust and grounded in a more nuanced understanding of reality, blending both subjective experiences and objective structures.

4th March 2024 – Sitting with themes

I have been able to sit with my current themes and feel a sense of contentment with where it has landed. I have noticed I have followed my physical gut instinct throughout data analysis and allowing that to shape where I feel things land. Coming to a place where I am noticing the coherent narrative weave through the themes has enabled the sense of approaching the finishing line with data analysis.

I've enjoyed revisiting the interview data to verify how it connects with the narrative currently presented. I have been thinking—would participants be happy with the narrative being shown? Do they see themselves somewhere here? Will they feel connected to the research? Asking these questions has enabled me to connect the final presentation to the starting points, ensuring all is well weaved and connected throughout.

Additionally, it's been important to sit with the idea of what participants may potentially disagree with. All participants did not present the same view, therefore there will undoubtedly be parts where perhaps people do not see themselves in the data. I have spent some time thinking about some of the potential narratives missed, and what this may mean for the final presentation. Through this process, I have been debating member checking as a method of reviewing themes. As there is no equal way to sit with everyone's feedback, particularly as not all would participate, has made me sway towards not choosing member checking. I would be asking people for more of themselves and with no guarantee in how that takes shape – do I then privilege the few who would give feedback or reflections? What narratives may be lost when they are giving feedback on how it connects with their own experiences?

As a result, I have decided reviewing themes with my research team and my research consultant, who shares identity features with participants, may be the best way of reviewing themes before proceeding. We have all sat together with all the data, therefore awareness has been held of different narratives woven throughout the research.

10th March 2024 – Further supervision and revision of analyses

Today has been going back to the drawing board. I met with my primary supervisor which was helpful to have an in depth sitting with the meaning of analyses and how she responded to it. I appreciated being challenged to identify the thread from quotes to codes to sub-themes to themes within the existing structure. Whilst I have re-visited quotes before to consider codes and sub-themes, re-visiting them again after our meeting has certainly helped me consider the language held in the analysis and how this all fits. I have recognised I have been drawn to making sense of some of the aspects of analysis through language that has helped me make sense of the data e.g. depicting

journeys, roads, travel… Thinking about this language enabled me to reflect back on how the research project is so closely linked to my own journey of qualification, and how this has undoubtedly shaped how I connect with the project and mirror a journey in what I see.

Additionally, I have noticed that summarising information in similar words is helping me to make sense and find meaning in what feels like a vast amount of data. Catching this out and going back to quotes will enable me certainly to remain close to my participants words.

In the midst of this re-jigging of themes, I have felt a little uncomfortable with letting go some of the nuance to reduce the quantity of sub-themes and themes. Naming this has allowed me to step back and sit with the wider meaning. The uncomfortable nature speaks to a continued value of honouring participants, and hoping they can all see themselves in the final result.

23rd March 2024 – Revising analyses

An unexpected part of the analysis journey has included noticing anger arise in the process. I have spent some time wondering where this has come from and concluded that perhaps I am mirroring some of the processes of my participants. To expand, I have been sitting with the data and meanings where they discuss feeling things beyond their control, experiencing challenges, and having limited options at times. I wonder how this has transferred to me during the process, where I've struggled to engage with thinking beyond further meaning. I notice that I am also in some similar positions to participants – working on a placement in a difficult system with systemic challenges, witnessing trauma, and having my own personal experiences of trauma. It's been hard to re-read about some of the symptoms of burn out that participants talk about whilst experiencing it myself. Perhaps I have felt angry as the process of sharing and illuminating staff experiences where they have struggled in a doctorate process that has made me struggle, too. It feels like a never-ending cycle, and I'm feeling some of the frustration my participants feel, too.

Whilst some of my themes represent hope, I recognise I have struggled recently to connect to any radical hope and determination. I have felt in a middle ground while under resourced, and I wonder if my own current wellbeing is impacting how the analysis process is taking place.

I'm recognising I have also been grappling with the idea of being good enough with what will show up – which has meant going back in several iterations with analytic theme summary, whilst also struggling to let go of nuance or shift wording. Noticing this is important, recognising perhaps a step away is needed to enable further movement in the analyses.

1st April 2024 – Writing up the analyses

I have found today challenging to bring together the succinct story of the analyses. I was expecting to be in a place where the analyses would be complete prior to writing up – oh how I was wrong!

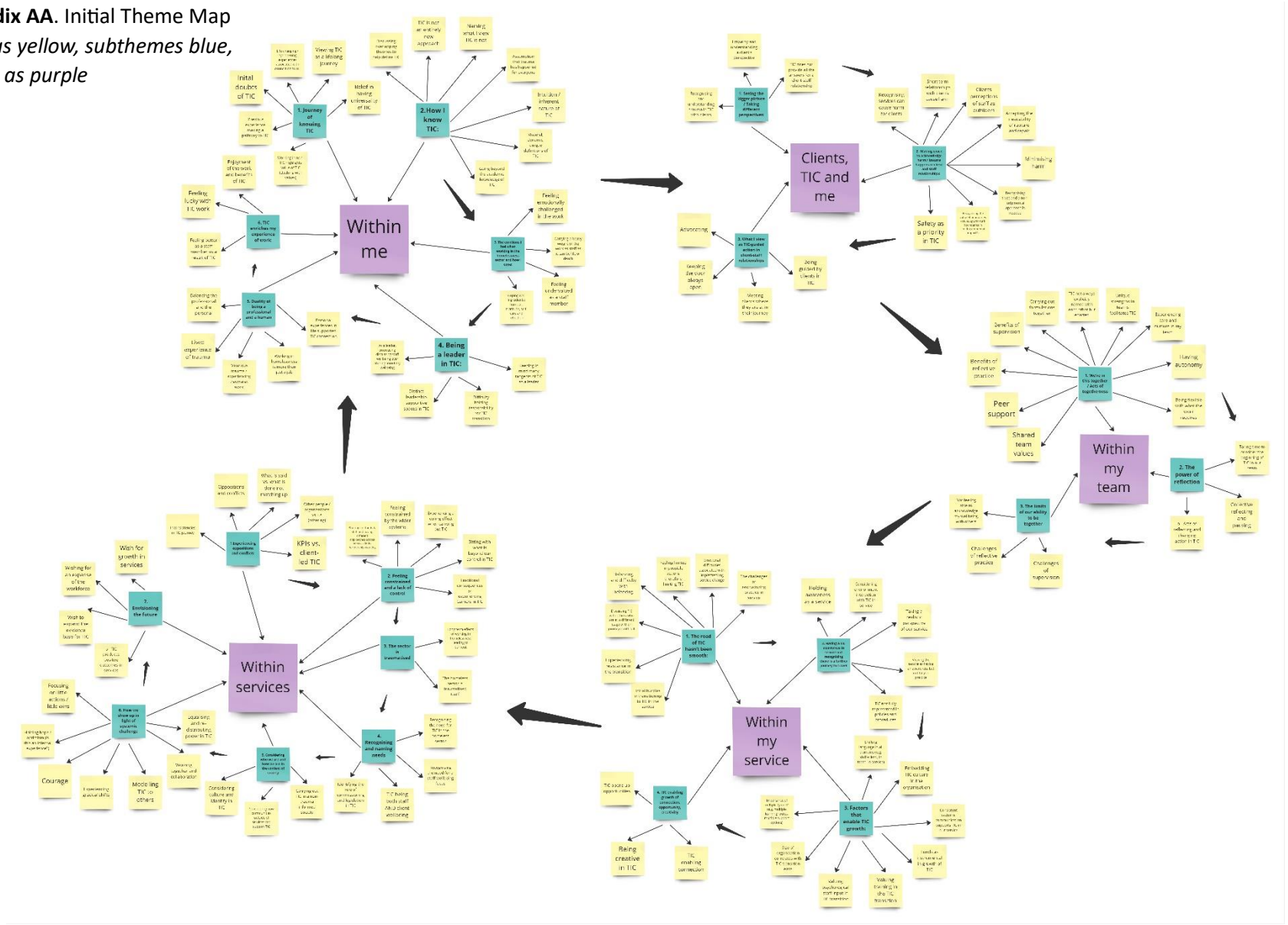
Sitting with the reflexive thematic analysis process has taught me truly about the meaning of it's what you make of it, and how you influence the data leading to it's interpretation. My own difficulty seeing the story has led to surface-level engagement with describing the data at times. I have noticed I have stepped back into looking at quotes, considering participants' tones and intentions in order to connect back to the collective meanings and patterns. Today, I went back to listening to some of the audio to enable this process. Again, finding myself leaning on visualising the clients is supporting me to consider what would they hope to see in the findings.

Appendix Z. Example Coded Transcript

Transcript – Interview 12 *[coded on NVivo - an example has been put into a table to aid clarity for the reader]*	Codes
Interviewer: As I said that question again, what difference does trauma-informed care make to your work? Is there anything else that comes to mind, [Participant name]?	Having autonomy and flexibility in approach supports TIC
Participant: Yeah. I mean, I think also like you know the team, the team feel trusted by me. So they're quite, they're very autonomous. I think that's quite important. And so you know to be able to tell practitioners, you can just go out. There's no agenda. And you know, they we have a client budget that we can use to facilitate engagement. People are kind of trusted in terms of how they kind of use that and we often find think about doing activities alongside people initially. So rather than just kind of getting somebody into, like, quite uncomfortable, maybe intense situation of like we're sitting in a room having a one to one, which is just can be really overwhelming, we quite often be like what, what sort of things do you like to do or you like, you know, you like to go for walk and wherever you like to go to the gym, we'll go to the cinema. You know, we try and do things alongside people initially. Also like there's a bit of a reciprocal thing and this is, I suppose, where you thinking about power which is like actually we we wanna get to know you, we wanna establish that trust but you we want you to be able to get to know me as well.	Having funds to be able to facilitate engagement through activities or interests is TIC Having autonomy in the team as TIC Considering environments is key for TIC Working alongside clients in TIC Being reciprocal in relationship building to establish trust
Interviewer: Mmmm.	
Participant: So it's like a reciprocal thing there. When you're doing activities alongside, that really generates that and we do things together and there's opportunity to get. It's kind of, yeah.	
Interviewer: Mmm.	Holding in mind power dynamics is TIC Being an advocate for clients in TIC
Participant: So it's equalizing the power a little bit as well, uhm. I think like, our advocacy. You know, we, we advocate for people quite a lot as well. And in terms of our role, you know, and that I think that also helps with generating that trust. You know, people feel quite disempowered and quite marginalized that their voices aren't heard.	Advocating for clients supports trust in staff-client relationship TIC as empowerment of clients
Interviewer:	

Mmmm. **Participant**: And so we try and find platforms for them to kind of amplify those voices, whether that be just for them to be heard or whoever it is more about us being able to kind of promote the kind of contextual information that we just that we talked about earlier around, you know, people's behaviour, people's the way people present is often, you know, there's a whole story behind that and actually understanding that story makes a huge difference to how people respond. **Interviewer**: Yeah. **Participant**: So obviously quite often our advocacy might be around providing some context around, you know, there's that sort of whether it be about trauma or just around like to try and understand like why, why somebody might need some a flexible kind of approach or different, you know, one of the ways we do that is we do, we organize team formulations. **Interviewer**: Mmhmm. **Participant**: So we and yeah, so, our psychologist predominantly will facilitate them although the team have been upskilled to sort of do these but, um, so that would be to invite lots of different people who are working around a person to come and kind of really share. Part of that is about trying to understand a fuller picture, and but it's also trying to think about what might have happened to the person to to come to where they are. And yeah, the feedback from people has been has been really powerful in terms of their understanding of the person and how they now respond to the person. **Interviewer**: Mmm. **Participant**: And but I think fundamentally as well like it, one of the things is just about allowing people, the team, the space to reflect. I think it's really, really important, um, and try and learn, you know? Because, yeah, like I talked about earlier. Like you get really caught up with the day-to-day work, with the relations with peoples, you know, real troubled lives. Um, our caseloads, OK, those are really manageable sizes. They're up to 10 people per 10 clients per worker, so they're not huge, and part of that is so that we can kind of have the space for the relational approach for the certain engagement approach. And part of that is to allow people to chance to set a step back - like what is anything we could be doing differently?	Finding platforms to amplify client voices Being an advocate for clients in TIC Understanding presentations beyond face value Team formulations as part of TIC Having a psychologist supports understanding what is happening for a client in the homeless sector Bringing professionals together in TIC to share formulations Understanding presentations beyond face value Reflection as a method of carrying out trauma informed care Making sure there is space for reflection Reflecting on the best method to build relationships in a trauma-informed manner Staff holding responsibility for building relationships in TIC

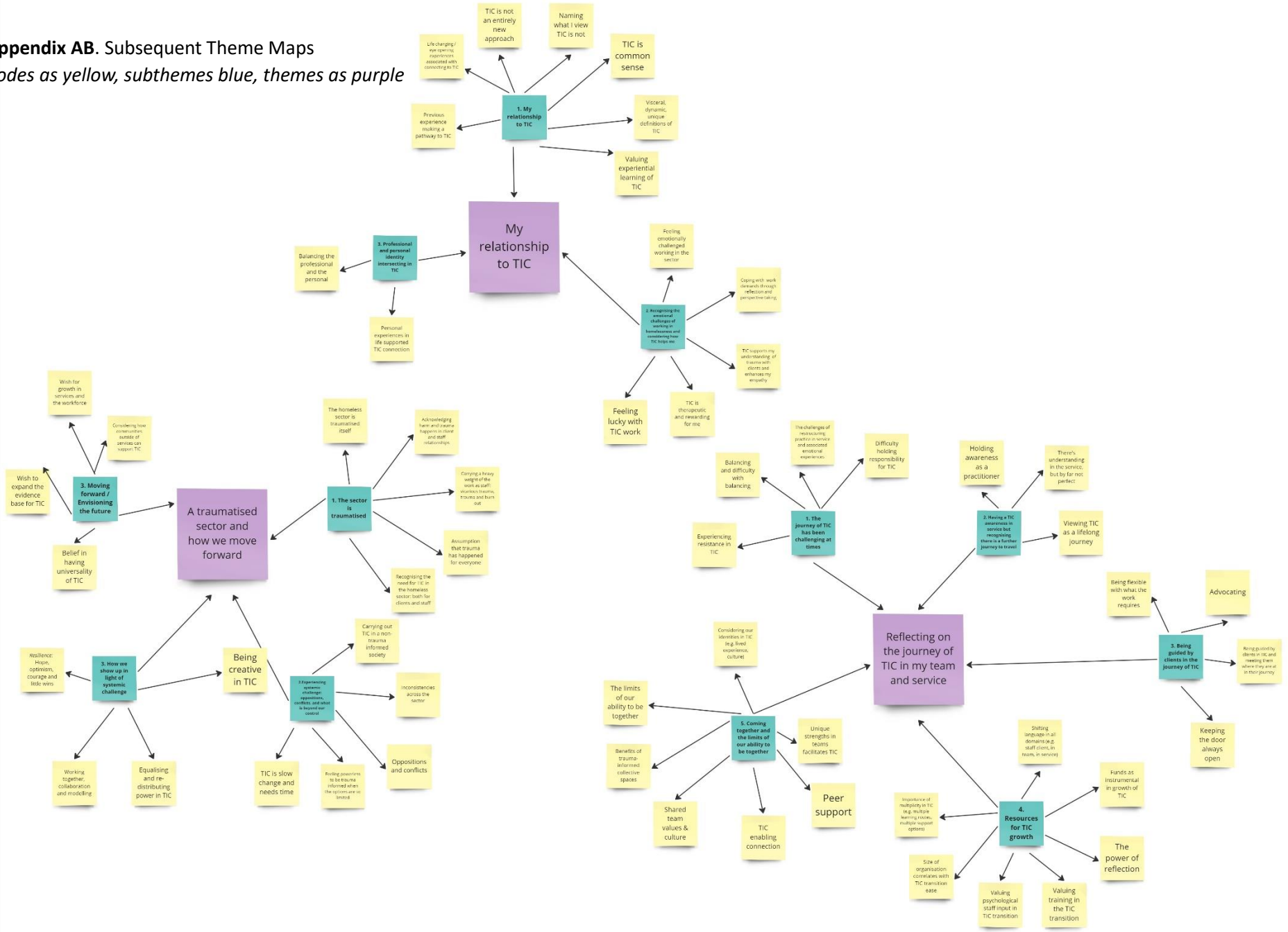
Appendix AA. Initial Theme Map
Codes as yellow, subthemes blue, themes as purple

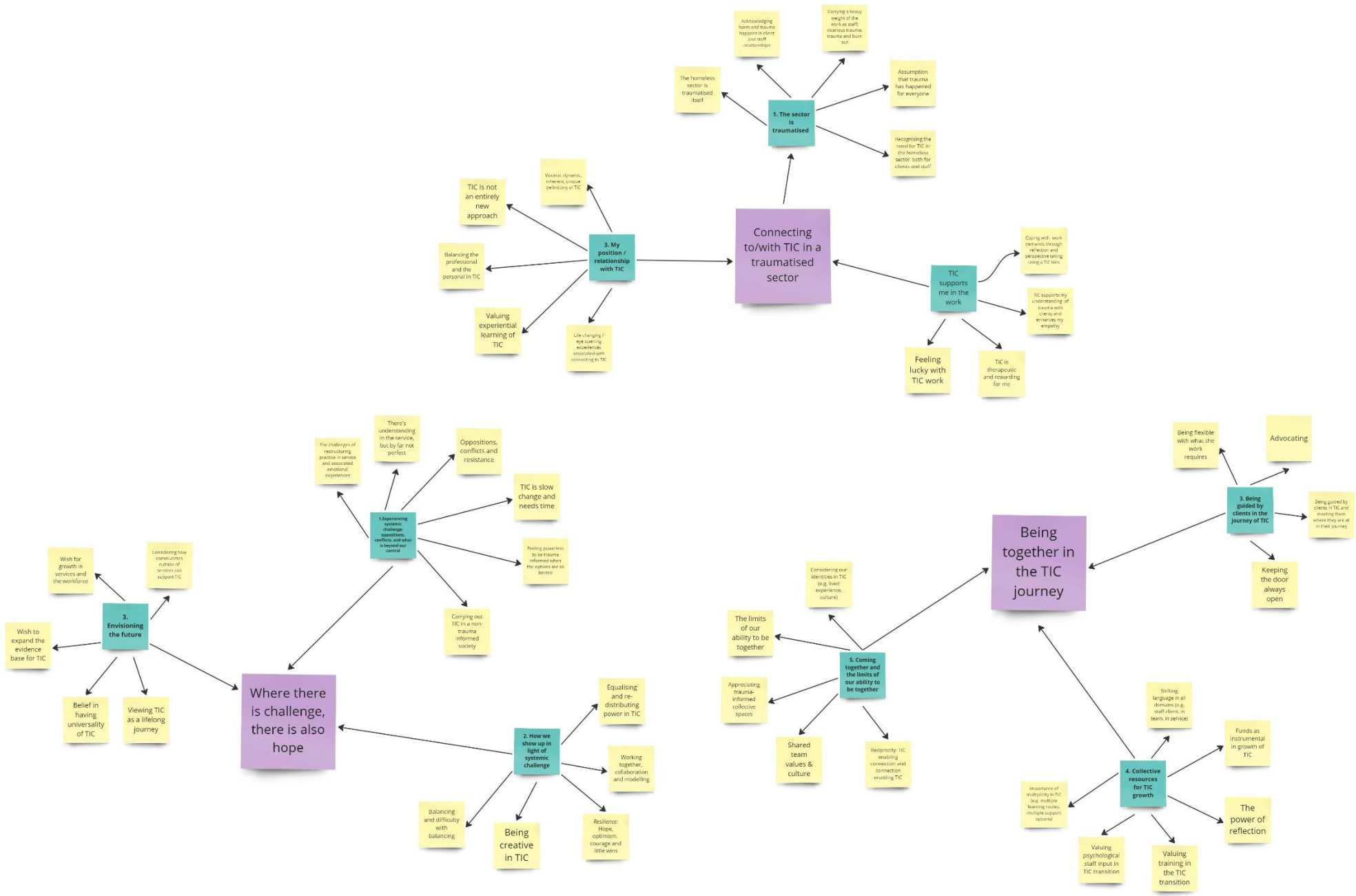


S

Appendix AB. Subsequent Theme Maps

Codes as yellow, subthemes blue, themes as purple

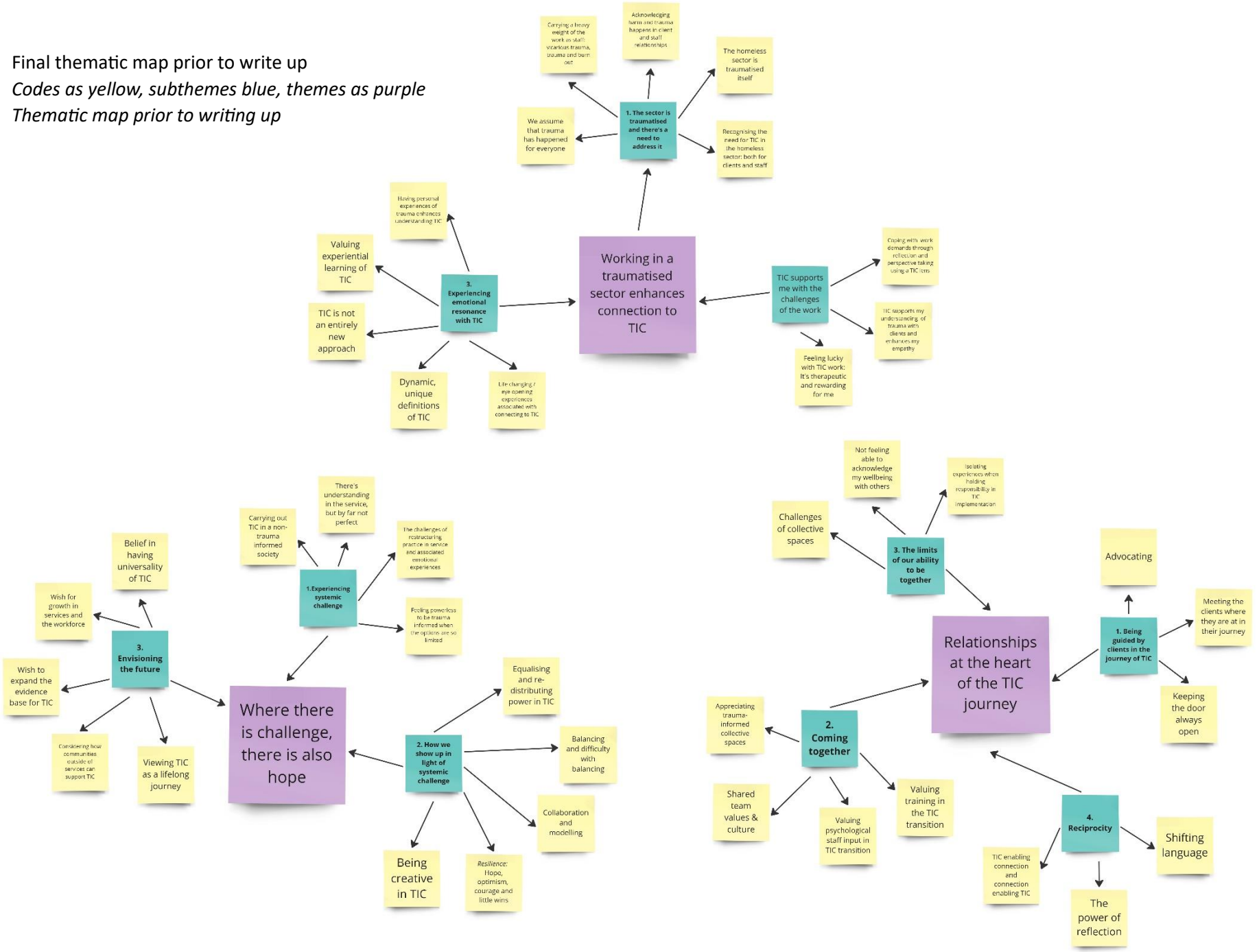



Connecting to/with TIC in a traumatised sector
1. The sector is traumatised
Acknowledging harm and trauma happens in client and staff relationships
Carrying a heavy weight of the work as staff: vicarious trauma, trauma and burn out
The homeless sector is traumatised itself
Assumption that trauma has happened for everyone
Recognising the need for TIC in the homeless sector both for clients and staff
3. My position / relationship with TIC
Visceral, dynamic, inherent, unique definitions of TIC
TIC is not an entirely new approach
Balancing the professional and the personal in TIC
Valuing experiential learning of TIC
Life changing / eye opening experiences associated with connecting to TIC
TIC supports me in the work
Coping with work elements through reflection and perspective taking using a TIC lens
TIC supports my understanding of trauma with clients and enhances my empathy
Feeling lucky with TIC work
TIC is therapeutic and rewarding for me
Where there is challenge, there is also hope
1. Experiencing systemic challenge: oppositions, conflicts, and what is beyond our control
The challenges of restructuring practice in service and associated emotional experiences
There's understanding in the service, but by far not perfect
Oppositions, conflicts and resistance
TIC is slow change and needs time
Feeling powerless to be trauma informed when the options are so limited
Carrying out TIC in a non-trauma informed society
2. How we show up in light of systemic challenge
Equalising and re-distributing power in TIC
Working together, collaboration and modelling
Balancing and difficulty with balancing
Being creative in TIC
Resilience: Hope, optimism, courage and little wins
3. Envisioning the future
Wish for growth in services and the workforce
Considering how communities outside of services can support TIC
Wish to expand the evidence base for TIC
Belief in having universality of TIC
Viewing TIC as a lifelong journey
Being together in the TIC journey
5. Coming together and the limits of our ability to be together
Considering our identities in TIC (e.g. lived experience, culture)
The limits of our ability to be together
Appreciating trauma-informed collective spaces
Shared team values & culture
Reciprocity: TIC enabling connection and connection enabling TIC
3. Being guided by clients in the journey of TIC
Being flexible with what the work requires
Advocating
Being guided by clients in TIC and meeting them where they are at in their journey
Keeping the door always open
4. Collective resources for TIC growth
Shifting language in all domains (e.g. staff-client, in team, in service)
Funds as instrumental in growth of TIC
Importance of multiplicity in TIC (e.g. multiple learning routes, multiple support options)
The power of reflection
Valuing psychological staff input in TIC transition
Valuing training in the TIC transition

Final thematic map prior to write up

Codes as yellow, subthemes blue, themes as purple

Thematic map prior to writing up



Appendix AC. *Tracy's Eight "Big Tent" Criteria Critical Appraisal of the Current Study*

The present project was further reflected on using Tracy's Eight "Big Tent" Criteria for Excellent Qualitative Research (Tracy, 2010). The model provides eight prompts for key areas of qualitative best practices, which has been discussed as fitting for assessing the coherence of reflexive TA research (Braun & Clarke, 2022b).

Criteria	**Discussion on how the present study meets criteria**
Worthy topic	The present project has offered timely, relevant findings for the homelessness sector in the UK given the current context of increasing use of TIC within this context. Existing evidence discusses the impact of working in homelessness for staff and their experiences in specific relation to supporting clients, with a call to develop staff support. The current findings discuss the varied existing structures of support for staff whilst also illuminating further pathways for development in relation to staff needs. Additionally, the findings provide further context towards the underlying mechanisms involved in the journey of trauma-informed care from a staff member's perspective, offering new insights pertaining to the dilemmas, negotiations and hopes that staff face or hold.
Rich rigour	Rich rigour has been demonstrated through a detailed discussion of the methodological process within this project, allowing for transparency and supporting understanding of the reader in terms of the processes followed in conducting the study. Consideration of decision-making of each stage of the project has been offered throughout the present study to support the reader's ability to assess rigour in research decision-making. Evidencing the stages of the analytical process in the methodology and appendices further allows the reader to digest the findings in context, including examples of stages of data analysis, e.g. coding excerpt, reflexivity entries, and theme map iterations. Reflections with the research team throughout data collection and data analyses have been supportive of ensuring a rigorous process.
Sincerity	I have carried out a reflexive diary throughout the process to support sincerity claims within this research process (Appendices F, G, H, W, X and Y). I have been considerate of my motivations, strengths and the shortcomings of my position as researcher and within this project through reflective discussions with my research team and reflexive diary. From the outset, I have been acutely aware of my 'outsider' researcher position, particularly in regard to not having experienced homelessness or being a staff member within the field. I have considered how this has brought strengths and limitations to my analysis, ensuring to reflect with my research team and speaking with experts in the field to consider my potential blind spots. I have ensured to consider how to deliver trauma-informed research to uphold myself to a similar process as what my participants are experiencing, reflecting on our similarities and differences to understand how this may interact with the analytical process. (Appendices G and H)

Credibility	The present study has exhibited credibility by ensuring a coherent narrative in reporting findings utilising extracts which support a 'show rather than tell' approach. Engaging in reflections with the research team throughout analyses has supported identifying any blind spots in the findings, allowing me to "let go" of any set ideas to support credibility (Braun & Clarke, 2022a). I have further reflected on the unspoken within the interviews and findings in order to support my analytical process to weigh up what else is beneath the surface and articulate these discoveries within interpretations in the findings.
Resonance	Whilst difficult to ascertain the ability of the research to affect an audience, I have considered through my presentation of the results how to ensure a coherent, rich narrative that conveys all themes and their overarching ties to one another. I have attempted to achieve 'aesthetic merit' (Tracy, 2010) by including evocative quotations, explanations and interpretations woven throughout the summary of the findings. To support this process, I have reflected on my own emotional responses to reading through the findings to support me in considering how emotional resonance may be achieved for the reader. Whilst the present study's findings relate to the homelessness context, it is possible there are learnings for universal concepts relating to utilising trauma-informed care in any supportive sector, whilst offering insights into wider attempts at organisational change in the helping sector. Thus, this supports claims of resonance through transferability of findings.
Significant contribution	The research makes a significant theoretical contribution by extending the understanding of staff experiences with TIC in the context of homelessness. Recognising TIC as an ongoing journey offers guidance to services to consider their internal structures and processes to facilitate their positioning with TIC. Through spotlighting some of the challenges and balances that staff engage with, the multiple layers of implications and recommendations support claims for significant contribution. The study also opens new avenues for future research in this area.
Ethical	The present research has ensured to maintain ethical consideration throughout it's process. I have adhered to procedural ethics, such as confidentiality, avoiding deception, informed consent and holding in mind power dynamics through research team reflections. Furthermore, relational ethics in light of the sensitivity of the research's topic have been held in mind, with consideration from the researcher on maintaining mutual respect and connection between the researcher and participants (Ellis, 2007). Utilising a trauma-informed research approach (Dowding, 2021; Isobel, 2021) has further enhanced my reflections on upholding safety, minimising harm, centring participants' voices and choices (Appendices G and H).
Meaningful coherence	Holding in mind the research question and aims throughout the project has supported addressing the meaningful coherence criteria. I have ensured the methodology, analyses and narrative of results have remained tied to the set purpose of the project. I have held a critical lens throughout engaging with the project to reflect at each stage "What would the participants think about this?" to support guiding meaningful coherence.