Doctoral Thesis

Submitted in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology

The Experiences of Staff Working with Vulnerable Populations: Racism, Power, and Psychological Impact: A Qualitative Analysis

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Doctorate in Clinical Psychology

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Total Word Counts

	Main Text	References, tables, figures, and appendices	Total
Thesis abstract	298	-	298
Literature review	7999	6713	14712
Research paper	8000	5257	13257
Critical appraisal	3626	981	4607
Ethics section	5650	6481	12131
Total	25573	19432	45005

Thesis Abstract

This thesis is comprised of four sections: Section one: A systematic literature review that explored staff experiences of working in Domestic Violence (DV) shelters. With the use of thematic synthesis, nine papers were reviewed generating four analytical themes: emotional weight of the work, connecting with others, power versus empower, and making it through. Staff were found to face several challenges, including difficulties balancing resident wellbeing with their own, within a context of limited resources and wider systemic barriers. Findings highlighted a need for psychologically informed resources to reduce risk factors of burnout and Secondary Traumatic Stress (STS). Section two: An empirical research paper utilising a qualitative approach exploring staff experiences of racism within the homelessness sector. Seven female participants took part in the study and were interviewed using semi-structured interviews. Data was analysed using Reflexive Thematic Analysis (RTA) eliciting five themes: experiencing racism in blatant and subtle forms, powerlessness, feeling unheard and misunderstood, psychological impact, and perseverance and protection. The study highlighted the persistent nature of racism experienced by staff, including racial slurs, refusal to work with staff from ethnic minority communities, and a lack of acknowledgment of racism from those in senior positions. Findings illuminated a need for support for staff experiencing racism, along with raising awareness through interventions, such as training, for those without lived experience of racism. Section three: A critical appraisal offering an overview of findings, including bringing together the trauma impact staff experienced across both papers. Personal reflections discussed include the use of terminology selected, the impact of researcher insider status, along with discussion on clinical implications, strengths, and limitations of both studies. Section four: The empirical paper’s ethics application and supporting documents used in the process.

Keywords: Domestic Violence, DV, Intimate Partner Violence, IPV, staff experiences, shelter, racism, homeless, shelter, staff experiences

Declaration

The present thesis was conducted for the Doctorate in Clinical Psychology at Lancaster University, within the Division of Health Research. The thesis has not been submitted for any other academic award. All work carried out as part of the thesis is the author's own work, unless otherwise referenced.

Name: Sharon Lilian Sandhu

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I would like to offer my sincerest appreciation to the individuals that took part in this study. You have taught me so much.

To all my beautiful friends, I would not have made it through the trying times without you, you have my heart.

Finally, I would like to dedicate this thesis to my mum, Bhupinder. Thank you for all you do to encourage me, I love you.

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Section One: Systematic Literature Review

Staff Experiences of Working in Domestic Violence Shelters

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Abstract

Background: Staff working with individuals who have experienced trauma face varying challenges, including mental health difficulties (i.e., secondary traumatic stress). Research indicates such challenges are present within the Domestic Violence (DV) field. DV shelters offer an intensive environment whereby staff work to support residents to overcome barriers faced as a result of DV. Whilst some literature provides insight into the challenges shelter staff face, including high turnover, burnout, and funding difficulties, further understanding of shelter staff experiences is needed. Aim: To explore staff experiences of working within DV shelter environments. Methods: A total of nine studies were selected following a comprehensive systematic literature review and analysed using a thematic synthesis approach. Results: Four analytical themes were generated: (i) emotional weight of the work, (ii) connecting with others, (iii) power versus empower, (iv) making it through. Conclusions: Staff working in DV shelters experience a range of challenges, including working closely with trauma material, balancing a role that incorporates both providing emotional support and rule enforcing duties, and working with limited resources. This impacted staff wellbeing and resulted in experiences of Secondary Traumatic Stress (STS) and burnout. Psychologically informed resources can work to reduce staff distress and improve overall wellbeing.

Keywords: Domestic Violence, DV, Intimate Partner Violence, IPV, staff experiences, shelter

Introduction

There is no universally recognised definition of Domestic Violence (DV) (Burelomova et al., 2018). For some organisations, DV and Intimate Partner Violence (IPV) are used interchangeably to describe the abuse experienced by an intimate partner (National Coalition Against Domestic Violence [NCADV], 2016), whilst others define DV with a predominant focus on violence against women (World Health Organization [WHO], 2018). For the purpose of this review, DV can be broadly understood as one incident, or a pattern of behaviours, that cause harm to another within ’personally connected’ relationships, irrespective of gender or sexuality. These relationships include past and present intimate partner relationships and familial relationships. Children are also recognised as victims if they have directly experienced or witnessed any form of DV (UK Government, 2021). DV involves, although not limited to, acts that seek to gain physical, sexual, psychological, or financial control with the use of intimidating, controlling, and coercive behaviours (UK Government, 2021).

Statistically speaking, the Office for National Statistics (ONS) reported one in five individuals aged 16 years and above have experienced DV, with an estimation of 2.4 million adults (1.7 million women and 699,000 men) in the year ending March 2022 (ONS, 2022). In a systematic review assessing global prevalence rates of DV against women by male partners, the World Health Organisation (WHO) reported that 26% of women aged 15 and above had experienced physical and/or sexual DV at least once (WHO, 2018). The National Coalition of Anti-Violence Programs (NCAVP) highlighted lesbian, gay, bisexual, transgender, and/or queer (LGBTQ) individuals experience a similar number of DV incidents, if not higher than cisgender and heterosexual individuals, which is often not reflected in reported figures (NCAVP, 2017).

The detrimental impact of DV on physical and mental health is well documented. This includes extensive bruising, injury to internal organs, high blood pressure, headaches, acute and chronic pain, and sexual and reproductive health difficulties (Campbell et al., 2002; Coker, 2007; Sedziafa et al., 2016; Sutherland et al., 2002). The vast range of mental health challenges includes stress, anxiety, suicidal ideation (McLaughlin et al., 2012; Mechanic et al., 2008; Pico-Alfonso et al., 2006; Sutherland et al., 2002), and Post Traumatic Stress Disorder (PTSD) which is commonly experienced in conjunction with other mental health difficulties, such as depression (Mechanic et al., 2008; Pico-Alfonso et al., 2006).

Given the immediate and ongoing difficulties of individuals experiencing DV, shelter services offer an essential resource (Johnson & Zlotnick, 2009). Typically speaking, shelters provide an immediate and safe location, have shared communal living spaces with other individuals experiencing DV, and commonly have set rules and regulations for residents to adhere to, such as curfews and attending in-house support meetings (Adisa et al., 2020; Gregory et al., 2017). Staff working at shelters provide a range of services supporting the varying complex needs of residents, including providing emotional support, safety planning, connecting individuals with any necessary information and resources, including legal information, and making referrals, such as mental health and addiction recovery referrals, along with offering support services to children (Bennett et al., 2004; Johnson & Zlotnick, 2009; Sullivan & Virden, 2017). Additionally, shelter work involves bringing a sense of power and control to residents, typically diminished as a result of DV (McGirr & Sullivan, 2016).

Providing emotional and practical support to vulnerable populations, particularly those that have experienced trauma, has been found to take its toll on staff members. In a meta-analysis exploring staff experiences of working with homeless individuals, a vulnerable population with a high prevalence of traumatic experiences (Taylor & Sharpe, 2008), Peters et al. (2021) found staff exposure to service user suffering, including listening to distressing stories, contributed to the challenging nature of the work. Such exposure to traumatic experiences has been highlighted as a risk factor for compassion fatigue, secondary traumatic stress (STS) (Figley, 1995), and vicarious trauma (VT) (Pearlman & Mac Ian, 1995), where staff responses include avoidance, nightmares, intrusive thoughts and images, hypervigilance, and changes in the view of the world, self, and others (Figley, 1995; Jenkins & Baird, 2002; Pearlman, & Mac Ian, 1995).

In relation to working with individuals with DV experiences, challenges have been documented in varying contexts. For example, hospital settings, where staff (e.g., nurses and doctors) reported difficulties managing personal responses to DV, limited time with service users, and feelings of helplessness when service users returned to the abuser (Colombini et al, 2013; Dawson et al., 2019). Various responses to hearing about DV experiences were found in counsellors with high DV caseloads (Iliffe & Steed, 2000). These included feeling physically sick, increased awareness of their safety, visual imagery intrusions, and desensitisation over time. Additionally, participants reported a sense of powerlessness when experiencing a strong commitment to supporting service users overcome their challenges within wider systems that staff felt did not have the same commitment, such as social and justice systems (Iliffe & Steed, 2000). Nevertheless, DV staff working in highly emotive and uncertain environments have found ways to alleviate work-related stress, including using self-care practices, peer support, regular communication within teams, training, and focusing on the strengths of service users (Ben-Porat & Itzhaky, 2011; Iliffe & Steed, 2000).

This research highlights the varying contexts and associated staff challenges of working with DV service users. However, less focus has been given to the perspective of staff working in DV shelters. This is likely due to research primarily utilising resident experiences and outcomes to better understand shelter experiences, including barriers to accessing services and shelter succusses (e.g., Eaton et al, 2022; Fisher & Stylianou).

In a meta-synthesis of women’s shelter experiences, Robinson et al. (2020) report challenges encountered by residents. For example, a sense of control enforced upon residents as a result of shelter rules and boundaries, fear of being asked to leave the shelter if they do not comply with the rules, and a loss of independence. Residents were also shown to have positive experiences, such as gaining a sense of safety within the shelter and feeling emotionally supported by staff (Few, 2005; Robinson et al., 2020). Furthermore, many studies that utilise staff perspectives do so to gain further understanding of resident experiences, including barriers faced by residents and service provision outcomes (i.e., Campbell et al., 2023; Grubb & Muftić, 2018; Yates et al., 2023).

Nevertheless, existing quantitative research offers insight into staff experiences. In a study assessing senior managers' views on DV shelter challenges, participants reported inadequate funding, limited space to meet the demands of shelter services, and high staff turnover (Liao & Yu, 2022). The data for the study was based solely on manager views, however, highlights the challenging environment of staff working directly with residents. Additionally, quantitative research has commonly focused on staff burnout, conceptually understood as the cumulative effect of job-related stresses, including emotional exhaustion, a sense of detachment from service users, and a reduced sense of competence in the role of helping others (Maslach & Jackson, 1982).

Utilising the Maslach Burnout Inventory (Maslach & Jackson, 1986), burnout was found to be particularly prevalent for staff members working frequently with DV service users (Babin et al., 2012). Brown and O'Brien (1998) reported moderate stress levels in relation to exposure to DV and residents returning to abusive partners, with overall exhaustion offset by supportive supervisors and personal relationships. Co-worker support and self-care were also found to be beneficial when experiencing fears of personal safety in relation to becoming a target of residents' abusers (Stout & Thomas, 1991). However, high levels of work-related emotional distress were found to be present outside of working hours (Dekel & Peled, 2000). In an additional study assessing burnout levels, Baker et al. (2007) reported that whilst some staff members experienced moderate levels of emotional exhaustion and low levels of personal accomplishment, enough to meet Maslach and Jackson's (1986) burnout criteria, staff were not burnt out overall.

Current quantitative research starts to build a picture of shelter staff experiences. Further investigation is required extending beyond manager perceptions of shelter challenges and the somewhat inconclusive evidence on staff burnout levels. A thorough analysis of existing qualitative literature will support a deeper understanding of the complex nature of shelter work. Therefore, a meta-synthesis approach was selected to bring together existing qualitative research to address the research question: What are the experiences of staff working in DV shelters?

Methods

Design

Qualitative research was collated using a systematic literature review process. To support a deeper understanding of direct staff experiences, an approach of synthesising data that is explicitly grounded in the original studies results was needed, therefore, a thematic synthesis approach was selected (Thomas & Harden, 2008).

Electronic Search Strategy

The SPIDER search tool (Cooke et al., 2012), presented in Table 1, supports the identification of relevant qualitative data and was therefore utilised to develop the search strategy. A comprehensive search strategy was then implemented with specialist support from a Lancaster University librarian. A sensitivity test was also carried out to assess the rigour of the searches.

[Insert table 1]

The systematic search was conducted on June 6, 2023. The EBSCO bibliographic databases of PsycINFO, CINAHL, Academic Search Ultimate, and MEDLINE were selected to ensure a manageable variety of meaningful databases and as recommended by Lancaster University review guidance. Search terms were derived from database subject terms and an exhaustive preliminary scoping search on existing data within the DV field (see Appendix 1-A). To further ensure an understanding of terminology, contact was made with Women's Aid, a charitable organisation working within the DV field. It was then decided that search terms relating to job titles would be excluded, given the likelihood of many national and international variations. Thus, reducing the chances of missing relevant research. Furthermore, given DV is commonly discussed in relation to heterosexual partner violence (Reuter et al., 2017), consideration was given to inclusive terminology, with search terms including those relevant to familial violence and violence experienced by LGBTQ_{+} communities.

To maximise the number of articles retrieved, no restriction was placed on the date of publication and doctoral theses and mixed-method research were not excluded. A total of 4868 studies were retrieved and exported to Endnote where 2215 duplicates were removed. The remaining 2653 studies were exported to the systematic literature review software, Rayaan, for screening. Following the removal of studies written in a language other than English, 2562 studies were screened by reading titles and abstracts, excluding 2359 studies. The remaining 203 studies were screened by reading the full text with articles excluded for reasons including focus on a different population, focus on a different topic (e.g., evaluation of an intervention), or no evidence of rigorous analysis. In total, nine studies were considered relevant (see Figure 1) in accordance with the inclusion and exclusion criteria (Table 2). Reference lists of key papers were reviewed to identify any relevant studies missed in the search with no additional outcomes.

[Insert table 2]

Study Characteristics

Of the nine studies included, seven were carried out in the US, one in Canada, and one in Israel, with publication dates ranging between 2010 and 2020. All studies aimed to capture the experiences of staff working in shelters, focusing on challenges faced, coping strategies, and the realities of working in shelters. One study focused on the impact of low barrier policies on staff practices. This initially appeared to be service delivery focused, however, findings focused on staff experience and was therefore included. In total, 270 participants took part in the studies. All participants either worked in shelters at the time of the interview or, in the case of one study, previously worked in shelters. Participant demographic details varied across the studies. However, job roles cited included frontline worker, children’s advocate, women’s advocate, psychologist, counsellor, supervisor, and case manager. Not all studies stated the demographic information of residents. However, three studies stated that participants worked in shelters for women.

Three studies used interviews to collect data, including one mixed-methods study. Two used solely focus groups, one utilised both interviews and focus groups, one study supplemented interviews with researcher field notes, and another used participant observation, interviews, and focus groups. The remaining study, a mixed method study, utilised a survey with open-ended questions for qualitative data collection. Methods of data analysis included thematic analysis, constant comparison method, content analysis, grounded theory, ethnographic description and analysis, and Moustakas modified Van Kaam method. All analyses included participant quotations to illustrate themes (see Table 3 for study characteristics of each study).

[Insert table 3]

Quality Appraisal

The Critical Appraisal Skills Program (CASP) checklist (CASP, 2018) is the most widely used quality appraisal tools for qualitative research (Long et al., 2020). Following a discussion with the research supervisor, this was deemed the most appropriate tool for critically evaluating the quality of the nine studies (see Appendix 1-B). The first two items on the checklist assessed the presence or absence of a clear statement of research aims and an appropriate methodology applied to the qualitative research. Duggleby et al. (2010) three-point scoring system was applied to the remaining eight questions. For each study, a score of one was given when little or no explanation was offered in relation to the eight items. A score of two was given when the item in question was mentioned yet provided little justification and explanation. Finally, a score of three was given when extensive justification and explanation were offered in relation to the item. Thus, the CASP has a minimum score of eight and a maximum of 24.

Initially, three studies were appraised by the researcher and research supervisor separately. Any differences in the scoring were discussed and adapted accordingly. This provided the basis for scoring the remaining studies by the researcher. The scores of the reviewed studies ranged from 12 to 20 (see Table 4). These scores were taken into consideration, with greater emphasis placed on studies with higher scores. Regular consultation with the research supervisor was maintained throughout the review process to maintain validity (Duggleby et al., 2010).

[Insert table 4]

Thematic Synthesis

The review employed a thematic synthesis approach (Thomas & Harden, 2008). As outlined in the method, the findings and/or results sections were extracted to form the data used within the review, including participant quotations and author interpretations. Thematic synthesis was selected over alternative approaches, such as meta-ethnography (Noblit & Hare, 1988), as it can be applied to a more diverse range of study designs, including qualitative surveys and those producing more descriptive data (Thomas & Harden, 2008).

The analysis was conducted in three stages. Firstly, inductive line-by-line coding was carried out, keeping in line with the meaning and content within the primary data as interpreted and reported in each study. The next stage involved grouping the codes to form ’descriptive codes.’ This involved grouping codes connected by meaning and content from across the studies. An overarching descriptive code was created to capture the meaning of each grouping. This resulted in a total of 19 descriptive codes. In the final analysis stage, a distinction was made between grouping existing meaning and content across the studies and generating new meaning within the context of the review question and aims. This involved continuous review and interpretation of the descriptive codes to form more overarching abstract analytical themes. Supported by regular consultation with the research supervisor, a total of four analytical themes were developed (see Appendix 1-C). All data was analysed using NVivo 12 software.

Results

The analysis generated a total of four analytical themes: emotional weight of the work, connecting with others, power versus empower, and making it through. Despite the varying language used in the papers, the term ‘resident’ is used for consistency purposes when referring to individuals living in shelters.

Theme One: Emotional Weight of the Work

This theme captures the diverse ways participants were challenged with more than the delivery of physical duties (i.e., emotional challenges that come with the role). This emotional nature of the work was captured across all nine papers.

In three of the studies, participants directly discussed the initial shock of working within shelter settings, including the realisation that working hours and work plans have an unpredictable nature (Merchant & Whiting, 2015) and feeling overwhelmed when initially meeting residents (Wu, 2008). Six studies highlighted the continued challenge of witnessing the nature of DV, including participants who struggled with seeing the physical effects of abuse. For example, one participant was “shocked” when witnessing a resident “not only had a black eye but her whole entire side of her face was swelled up” (Wu, 2008, p.69). Others commented on difficulties seeing the impact of DV on children (Peled & Dekel, 2010; Wu, 2008). The impact of resident abuse on participants was not confined to seeing physical effects but also through hearing resident stories. Stories included residents being “set on fire,” “run over” and “beaten, shot, and raped by numerous people in their lives” (Beckerman & Wozniak, 2018, p.478).

While seeing and hearing about the violence suffered by residents evoked compassion (Philyaw, 2021), participants spoke of its effect on their professional and personal lives. One participant stated, “I think that the greatest challenge that we encounter is trying to undo some of the mental trauma that the residents have went through” (Brown et al., 2020, p.550).

Although the passion for helping those experiencing DV was a clear motivator for working in shelters (e.g., Merchant & Whiting, 2015; Wu, 2008), in some cases, due to participants' personal history of DV: "Wanting to help others as I had been helped" (Merchant & Whiting, 2015, p.470), the emotional toll was evident. For example, Philyaw (2021) spoke of participants being "reminded of their personal stories" (p.75). An additional challenge participants encountered was residents returning to their abuser, which one participant described as "heartbreaking" (Merchant & Whiting, 2015, p.472). Another described their experience of learning about the death of former residents:

> I have picked up a piece of paper and seen a couple of our clients that have died […] been murdered [...] It is very traumatic [...] heart-wrenching. I can tell all over the shelter that there is a sense of sadness because we knew that person (Wu, 2008, p.73).

One participant described a sense of responsibility when residents choose to return: "I worry especially when they go back to the abuser…a lot of us get embarrassed or feel ashamed (Wu, 2008, p.73).

The exposure to shelter work continued to affect participants outside of work, with participants across three studies stating they had their eyes opened. Participants' comments included: "Since my work here, I do look at the world very, very differently," and "I could never imagine such evil existed in this world, and now I know it exists and it's everywhere" (Beckerman & Wozniak, 2018, p.479). Participants shared fears of being the target of the residents' abusers: "When I'm off duty, sometimes I think an abuser has followed me and knows where I live" (Beckerman & Wozniak, 2018, p.478).

Additional challenges included struggling to emotionally disconnect from work whilst at home. One participant commented, "I can think of several instances that I laid in bed and prayed or thought about a victim that needed help" (Philyaw, 2021, p.68). Furthermore, participants spoke of the impact on personal relationships, including reduced time spent with family and friends due to working overtime (Wu, 2008). One participant commented, "I think sometimes my point of view of the world has changed a lot […] I have this mindset that everyone is getting beat up," leading to cautiousness about their own and others' romantic relationships (Wu, 2008, p.80).

In addition to the detrimental impact of the work on personal wellbeing, participants also spoke of positive impacts. These included an increased understanding of the signs of domestic abuse allowing participants to share with others, outside of work, "what they can do so they will be safer" (Wu, 2008, p.83) and, as noted by Merchant and Whiting (2015), an "increased understanding and compassion for victims, family, and friends who stayed in violent relationships" (p.471).

Nevertheless, the psychological impact on participants remained at the forefront with one study specifically addressing STS (Beckerman & Wozniak, 2018), and responses such as emotional numbing, nightmares, a lack of ability to enjoy oneself, intrusive thoughts, avoidance of reminders of client stories, and overall exhaustion was present across five of the studies (e.g., Merchant & Whiting, 2015; Philyaw, 2021; Wu, 2008).

Overall, reconciling with the presence of abuse, both within work and outside, presented as a challenge for participants. While some positive factors of increased awareness were evident, an overall emotional toll extended beyond the initial shock of working with individuals who have experienced DV.

Theme Two: Connecting with Others

Whilst the 'emotional weight of the work' theme highlights the challenges of working closely with residents and their experiences of DV, building supportive working relationships remained an integral part of participants' experiences. This theme captures the varying ways in which participants experienced connecting with individuals who have experienced DV, barriers to connecting with others and building connections within the wider community. The central concept of connecting with others was present across eight studies.

Participants spoke of creating a safe space for residents offering compassion, empathy, a non-judgemental approach (Peled & Dekel, 2010), and an understanding that each resident’s experience is unique (Merchant & Whiting, 2015). In one study, participants considered “survivor-centred practices” imperative to building quality connections with residents (Nnawulezi et al., 2018, p.674), along with the reciprocal nature of sharing information to aid mutual connection, with one participant stating, “You have to give a little bit and be willing to share a little bit” (Wies, 2009, p.473).

Participants also shared various challenges they encountered when attempting to connect with residents, present across six studies. For example, “When your job is to help clients and I don’t have any clients that want my help” (Merchant & Whiting, 2015, p.471). Participants rationalised this as being due to residents not feeling ready for help (Merchant & Whiting, 2015) or unwillingness to participate in available support (Wu, 2008). Participants stated feeling conflicted when faced with mother-child dynamics within the shelter that differed from their ideal, such as not setting clear boundaries for children (Peled & Dekel, 2010). Additionally, participants noted times they sensed they were being taken advantage of. For example, when asked to do something they felt participants could do themselves, creating an additional barrier to connecting with residents (Merchant & Whiting, 2015). However, one participant spoke of offering trust to move forward with the working relationship, stating, “We’re gonna trust that what you’re saying to me is the truth and we’re gonna roll from there” (Nnawulezi et al., 2018, p.673).

Some participants spoke of residents refusing to work with staff from ethnic minority communities, as highlighted by one author: “Denise, an Asian American, noted that some of her clients would not ‘look at you or even acknowledge that [she was] there’ to work with them” and “Kim experienced her clients' negative attitudes due to her being a young African American woman” (Wu, 2008, p. 70-71). A participant commented, “domestic violence victims are just like anyone else, they may not like you because of your skin complexion” (Philyaw, 2021, p.82). The challenges born in a lack of understanding of cultural differences was also noted by Wu (2008), who stated “Emily, a Caucasian caseworker, also experienced challenges and had to find ways to earn trust and cooperation from her African American client” (p.71).

The need to be more inclusive was discussed both in relation to connecting with residents living at the shelters and potential service users. For example, one participant stated, “Cultural differences can be a major problem in our services [...] some of the advocates only speak one language, which makes it hard when we have someone that is Latino or Hispanic.” Additionally, they gave an example of a woman who called the shelter for help “who only spoke French fluently,” stating “We had to call the hotline to just understand what services she needed” (Philyaw, 2021, p.67). Furthermore, in two studies, participants spoke of hopes for greater inclusivity in relation to men accessing shelter services. For example, one participant felt “more male advocates were needed to help support more programs geared towards men” (Philyaw, 2021, p.78), whilst another commented on the need for facilities that allow staff to connect with straight and gay men without jeopardising women residents’ wellbeing (Brown et al., 2020).

Another aspect of connecting with others involved building quality relationships with the wider community. For example, working well with other agencies, such as housing, “almost always involved dealing with specific individuals with whom they [staff] had built solid relationships over time" (Burnett et al., 2016, p.528), which helped participants support residents to feel more connected (Philyaw, 2021). In contrast, when participants felt a lack of understanding from the community, thus a lack of connection between the residents and the community, they felt the chances of residents returning to their abuser increased (Brown et al., 2020). Therefore, connecting with key community members (e.g., police officers) was considered vital to moving away from "victim blaming" to a more understanding, compassionate, and welcoming approach (Brown et al., 2020, p.547; Philyaw, 2021).

Theme Three: Power Versus Empower

The first two themes incorporated the challenge of balancing participant and resident wellbeing. Burnett et al. (2016) surmised this was "most certainly confounded by the broader system context of resource insufficiency, lack of coordination, and the spectrum of day-to-day challenges that come with delivering shelter services" (p.527). This theme encompasses the power dynamics that inevitably play a part when working to 'empower' others. The theme is present across all nine studies.

Participants spoke of hopes of empowering residents, for example, supporting mothers to support their children instead of shelter staff taking on the role of motherly care (Peled & Dekel, 2010). However, participants felt there was a "fine line" between empowering and enabling that can risk taking away someone's chance of building self-confidence by doing too much for the resident (Merchant & Whiting, 2015, p.473). Encouraging residents to make their own choices was considered another form of empowerment (Brown et al., 2020). As described by Peled and Dekel (2010), here lies the "paradox of empowerment" work, particularly apparent when working with already disempowered individuals. Peled and Dekel (2010) point out that placing oneself in the empowering role, automatically places another in an "inferior, controlled position" (p.1233).

Participants felt a sense of disempowerment not only for residents but also for themselves. This was noticeably apparent when working within organisational structures and values that did not reflect participant values (Merchant & Whiting, 2015). To elaborate, shelter policies varied across participant workplaces, with some shelters advocating a "survivor-centred approach" where engagement in support programmes was by participant choice only (Nnawulezi et al., 2018, p.674). Other shelters endorsed a more rigid approach whereby "residents who were not meeting the demands of their empowerment plan […] were often asked to leave the shelter" (Merchant & Whiting, 2015, p.473). Participants whose values did not match the latter felt that "forcing survivors to engage in programming were disempowering, dehumanising, shame-inducing, oppressive, and controlling" (Nnawulezi et al., 2018, p.673). Additionally, sharing personal information to create a safe space, as previously mentioned, and utilising faith as a tool to support residents, was dependent on shelter rules for participants (Wu, 2008). Some shelters considered sharing in this way to be overstepping a professional boundary (Wies, 2009).

Participants spoke of wearing "many hats," including acting as "validators" (Burnett et al., 2016, p.525), "kitchen staff", and "were often tasked with enforcing rules" (Merchant & Whiting, 2015, p.471-472). Participants regularly spoke of the difficulties this presented. For example, "It's tough to spend one day having a heartfelt conversation with a resident and then the next day having to approach her about an allegation that she stole her roommate's phone" (Brown et al., 2020, p.547), which can create an "us versus them" mentality (Merchant & Whiting, 2015, p.472). Participants also commented on how enforcing rules and boundaries "can feel eerily like the situation they just came out of" (Merchant & Whiting, 2015, p.472). One participant commented on the unique setup of shelters whereby "you almost live with them [residents]," leading to "the fear of how much I am infringing on the privacy of a person" (Peled & Dekel, 2010, p.1229). Furthermore, physical boundaries, such as separate living spaces for participants and working spaces for staff, were also noted as creating an evident power divide between residents and shelter staff. Nevertheless, enforcing rules and boundaries was also considered necessary to maintain safety within the shelter (Nnawulezi et al., 2018) and allow participants to separate "personal lives from their professional advocacy" by maintaining social boundaries (Wies, 2009, p.469).

An additional layer of disempowerment experienced by participants, mentioned in six studies, related to a lack of funding and resources available to better connect residents with the support required, with participants regularly commenting, "Demand is exceeding our ability" (Burnett et al., 2016, p.526). This included limited time and trained staff members, along with limited resources to support the varying complex needs of residents, such as mental health needs (Philyaw, 2021). Furthermore, participants felt a lack of insight, on a systemic level, into the needs of the individuals experiencing DV was evident, along with government departments and agencies working in silos with "conflicting approaches to addressing violence against women" (Burnett et al., 2016, p.526). Consequently, participants described a sense of "powerlessness" in supporting residents as they felt they should be supported (Merchant & Whiting, 2015, p.472).

Working with such uncertainty with scarce resources resulted in participants often "stretching their meagre resources beyond what was intended", including utilising office space as bedrooms to accommodate more residents needing shelter (Burnett et al., 2016, p.522). This left participants feeling "overworked," "underpaid" (Philyaw, 2021, p.69), and "de-valued" (Merchant & Whiting, 2015, p.474), with participants commonly citing burnout as the reason for high turnover rates within shelters (Burnett et al., 2016).

Theme Four: Making it Through

The previous themes capture the varying challenges faced by participants, including the detrimental impact on participants' mental wellbeing, working within limited means, and feeling overworked and underappreciated, along with low pay. This theme captures what kept participants working at the shelters despite these challenges. It brings together internal and external and professional and personal coping resources utilised by participants. This theme was present across eight of the studies.

Participants placed importance on personal attributes when working within DV shelters, including dedication to working within human services, particularly as "the money is not all that good," a need to be "open-minded" (Philyaw, 2021, p.82-83), having the "emotional capacity" to be "comfortable with uncertainty" (Nnawulezi et al., 2016, p.674), and requiring a level of flexibility and creativity when approaching the work (Burnett et al., 2016). Others cited getting through by having "tough skin," which the participant explained stemmed from the realisation that you "cannot save people" (Philyaw, 2021, p.82). These ways of surviving the job are closely linked to the "emotional weight of the work" theme, however, participants also cited ways in which the stress of the job was relieved.

Professionally speaking, participants discussed managing their expectations, as one author reiterated, "Rose and Charity voiced their realisation of their personal limitation; they could not say 'yes' to everyone who asked for their help, and they needed to take care of themselves physically and emotionally" (Wu, 2008, p.86). Such focus on self-care was echoed by others with one participant stating, "Having self-care techniques helped them better cope with workplace stress" (Philyaw, 2021, p.72). Additionally, Merchant and Whiting (2015) commented on participants recognising "that going back [to abusive relationship] was not a reflection of their advocacy skills but rather the victim's readiness to leave the relationship" (p.472).

In addition, importance was placed on coping strategies that involved team support and an overall supportive culture. For example, “receiving support from co-workers helped advocates feel less alone” (Merchant & Whiting, 2015, p.471). One participant commented on the challenge of working with a pregnant woman: “That person was probably the hardest one I have had to deal with, a situation that I couldn't deal with at that point and time in my life” (Wu, 2008, p.69). They went on to explain that referring the resident on to her co-worker relieved what otherwise would have been a very stressful experience. Others spoke of enjoying work due to having a “close-knit team” to bounce ideas off (Wu, 2008, p.69).

Participants noted the importance of regular support from supervisors and management, commenting that without an overarching supportive culture endorsed across all levels of the team, the risk of burnout increased (Merchant & Whiting, 2015), along with “staff blaming […] and second guessing each other’s decisions” (Brown et al., 2020, p.551). Conversely, with supervision participants were given “the chance to review some of these horrible stories and then try to look at them more professionally,” alleviating the emotional weight of the work (Beckerman & Wozniak, 2008, p.480).

In relation to additional professional coping strategies, getting promoted “breathed life into exhausted employees and provided an opportunity to implement new procedures to improve and advocate self-care” (Merchant & Whiting, 2015, p.475). However, as the authors noted, introducing change was commonly met with resistance from upper and lower level employees, resulting in further exhaustion.

On the other hand, training was presented as another form of staff growth that “helps advocates understand barriers DV victims face, cultural differences, safety planning” (Philyaw, 2021, p.84), and supports understandings of resident mental health challenges (Wu, 2008). For new staff, training supported easing into the role, a component commonly cited as vital for anyone working within shelters (Wu, 2008).

Making it through also involved hearing success stories of residents: “Those are the things that get me through the days when they go back into a very dangerous situation” (Wu, 2008, p.75), indicating a need to offset the traumatic stories with the less discussed, positive changes to residents’ lives. Participants also employed several personal coping strategies, including maintaining humour, taking time off work, keeping busy after work, and doing things they enjoyed (Philyaw, 2021; Wu, 2008). Letting “off a little steam” after work with co-workers was also considered vital to coping with the emotional demands of the work, with one participant commenting, “After hearing how vulnerable these women were […] we have a group of workers that have all taken up boxing and self-defence, so we feel a little less vulnerable.” (Beckerman & Wozniak, 2018, p.480)**.**

In summary, participants utilised several coping strategies, relying on co-worker support, both within and outside of work, a supportive management and supervisory structure where available, along with personally maintaining self-care needs that incorporated understanding participants’ limits and reduced self-blame.

Discussion

Through a process of synthesising relevant qualitative data, with the use of thematic synthesis, this review explored staff experiences of working within DV shelters. An overarching finding of the review was the continuous challenge staff faced balancing personal values, hopes, and overall wellbeing, with the needs, decisions, and wellbeing of residents, within the context of shelter values and policies, all whilst working to overcome barriers presented by the wider structural and societal system. Thus, highlighting the complex nature of staff experiences.

Firstly, the findings indicate an inevitable exposure to both the physical and emotional consequences of DV when working within shelters. Consistent with previous findings on counsellors working with individuals with traumatic experiences (e.g., Jenkins & Baird, 2002), and specifically DV counsellors (Iliffe & Steed, 2000), participants experienced a range of responses, including nightmares and intrusive thoughts. However, both studies specifically focused on those providing therapeutic interventions, whereas the present review, whilst included counsellors and psychologists (e.g., Beckerman et al., 2018), highlights a similar response to trauma exposure across varying roles within a shelter setting.

Additionally, when working with traumatic material, research suggests workers may experience changes in views about themselves and the world, including changes in their sense of safety and trust in others (McCann & Pearlman, 1990). In the present review, participants discussed feeling less trusting of personal relationships, experiencing a shift from being unaware of the severity of DV to sensing DV everywhere, along with a fear for their own safety. Though a fear for safety is well founded (Kanno & Newhill, 2009), it also indicates changes to participants' worldviews. Overall, mapping onto STS (Figley, 1995) and VT (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995) trauma models. Furthermore, participants with personal histories of DV commented on being reminded of their own experience, which may narrow the gap between working with DV and experiencing VT (McCann & Pearlman, 1990).

The review also supports existing quantitative research on burnout in DV shelters (e.g., Brown & O'Brien, 1998; Babin et al., 2012). When reviewed against components commonly utilised to assess burnout, such as emotional exhaustion and low levels of personal accomplishment (Baker et al., 2007; Jackson et al., 1986), burnout was evident. More specifically, emotional exhaustion resulted from the high emotional demands of the work, resource deficiency, and the absence of feeling valued and appropriately paid. Furthermore, coupled with a clear desire to support residents both emotionally and practically, a sense of responsibility for making changes to residents’ lives was present. Thus, when encountering clients choosing to return to unsafe environments and/or when residents faced wider systemic barriers, participants experienced these as a lack of personal accomplishment. However, the depersonalisation component of burnout, representing a removed approach to the work and residents (Jackson et al., 1986; Newell & MacNeil, 2010), although present, was limited within the review. Instead, participants expressed increased compassion and continued effort to provide support and resources for residents, often stretching beyond their means. Thus, within the present review, the combination of exhaustion, feeling helpless, and the continued drive to meet resident needs increased levels of burnout, which participants considered a leading factor in high staff turnover rates as noted in quantitative shelter research (e.g., Liao & Yu, 2022).

This review offers further understanding of challenges shelter staff face when working to connect with residents, one of which is experiences of racism. Existing literature on racism within DV shelters, whilst limited, offers insight from the resident perspective. For example, resident experiences of microaggressions, a subtle form of racism that can be expressed verbally and non-verbally (Sue et al., 2007), were found in resident interactions with staff and shelter services (Nnawulezi & Sullivan, 2013). However, research attending to shelter staff perspectives appears scarce. Given the findings from wider healthcare settings reporting staff experiences of racism, including service users refusing to work with staff from ethnic minority communities (Snyder & Schwartz, 2019), having a detrimental impact on staff wellbeing (Goto et al., 2013), this review brings attention to both a difficult and potentially a primarily hidden aspect of DV shelter staff experiences.

In addition, the present findings highlight the varying power dynamics participants experience. For example, as noted in DV literature, working to empower individuals whose sense of control has been taken due to DV, is considered the foundation of DV work (Cattaneo & Goodman, 2015). However, as suggested by Peled and Dekel (2010), this inevitably brings forth an uncomfortable element of power to those in a position to 'empower.' This was notably experienced in relation to implementing shelter rules. Interestingly, as found in the meta-synthesis of residents' shelter experiences (Robinson et al., 2020), participants in the present review felt this diminished resident power and posed potential similarities to the residents' experiences of being in an abusive relationship. This added another layer of complexity and challenge to shelter work, given participants were also providing emotional support. However, it was the contradiction between participants' values and shelter policies that heightened participants' sense of powerlessness.

A further fundamental aspect of powerlessness found in the review relates to the lack of adequate funding, resources, and cohesion between relevant organisations tasked with supporting residents. Consistent with previous research (e.g., Iliffe & Steed, 2000; Liao & Yu, 2022), such powerlessness resulted in increased burnout and staff turnover, a lack of consistency in staff hopes for their work and what is possible, and commonly led to staff stretching their emotional and physical capabilities.

In addition to developing an understanding of the challenges faced by staff working in DV shelters, a prominent finding of the review was the varying ways in which, despite the difficulties faced, staff managed work-related stress and maintained their commitment to the role. Newell and MacNeil (2010) note that working with vulnerable populations is challenging and requires support from co-workers, supervisors, friends and family, and partaking in hobbies outside of work. This is reflected in the present review with participants strongly advocating for team support, decreasing a sense of isolation, and supervision, allowing for reflection on work experiences, both cited as reducing the emotional strain of the work. Therefore, consistent with existing research indicating that peer support and supervision are likely to reduce burnout (e.g., Velando-Soriano et al., 2019). Understanding participants' own expectations and limitations of their role was also found to manage stress, a finding mirrored in research assessing challenges of varied trauma-related counselling (Ling et al., 2014).

Strategies including self-care and socialising with friends and family were perhaps equally critical given the challenges participants faced separating work from home life. Nevertheless, as found in this review, social bonding with colleagues outside of work can also alleviate work-related stress (Hills, 2019). This was further emphasised through co-worker activities, such as taking boxing lessons to feel less vulnerable. Specifically, as noted in VT literature, self-defence activities are commonly used to offset the decreased sense of safety experienced in response to working closely with individuals that have been physically harmed (McCann & Pearlman, 1990).

Finally, staff training has been found to reduce work-related stress (Ben-Porat & Itzhaky, 2011; Iliffe & Steed, 2000). This was found in the present review through training focusing on increasing staff understandings of residents' experiences (e.g., mental health challenges and cultural differences).

Clinical Implications

Findings highlight that staff working in DV shelters experience a range of complexities, including balancing staff and resident wellbeing and facing systemic barriers. This resulted in burnout and experiences of STS for participants. Therefore, dedicated support addressing these challenges is deemed necessary. This can be done by implementing Psychologically Informed Environments (PIE), as utilised within a growing number of homeless sector settings (Schneider et al., 2022). Furthermore, the presence of a Clinical Psychologist (CP) is considered a key factor in increasing psychological ways of thinking, found to decrease staff distress and burnout when working with individuals with complex mental health needs (e.g., Ebrahim, 2022). Therefore, PIE should be implemented with support from an on-site CP.

To address staff burnout, CPs can provide person-centred interventions utilising cognitive behavioural and mindfulness therapeutic techniques aimed at reducing emotional distress. More specifically, techniques involving self-awareness of burnout signs, challenging thoughts around self-blame, and promoting self-care strategies have been found to reduce burnout in healthcare staff (Askey-Jones, 2018; Awa et al., 2010). However, solely focusing on person-centred interventions risks overlooking major causes of burnout, such as high job demands and resource deficiency (Morse et al., 2012), as found in the present review. Therefore, CP roles incorporating climate surveys and service evaluations assessing staff wellbeing and burnout are needed to support change at an organisational and policy level (Beacham et al., 2023).

CPs can build upon existing self-reflection practices by implementing Reflective Practice (RP) sessions found to build self-confidence and support emotional regulation when working with vulnerable populations (Peters et al., 2021). RP can support staff to become more aware of personal experiences and challenges impacting their work and wellbeing (Curry & Epley, 2022). Training sessions and resources can also support to raise awareness of burnout and VT responses, and self-care practices. RP and training sessions can be offered on a regular basis and be guided by Trauma-Informed Care (TIC) principles, including ensuring a sense of safety, collaboration, and empowerment through choice and skill building (Harris & Fallot, 2011). CPs utilising TIC principles for one-to-one support may also prove beneficial for staff who find reflective practice challenging due to personal histories of trauma (Yip, 2006).

In addition, the presence of mental health support, including CPs, within DV interventions is limited (Adisa et al., 2020; Chapman & Monk, 2015). Therefore, DV staff shoulder the responsibility of providing consistent emotional support to residents. To alleviate such demands, incorporating resident support within the CP role is needed, enabling staff to refer residents for psychological support when required.

Furthermore, access to supervision that adheres to TIC principles, including creating a non-judgemental space to discuss workplace challenges, can support staff to reflect on their practice and bring staff success stories to the forefront. As found in the present review, this works to reduce burnout and VT (Berger & Quiros, 2014). Implementing policies ensuring regular supervision across all shelters could support this further.

Strengths, Limitations, and Future Research

When this study was conducted, no other reviews looking at shelter experiences from the staff perspective were published. Existing research typically focused on shelter service provision and resident experiences, including resident experiences of living in a shelter (Robinson et al., 2020). Nevertheless, some literature indicated the challenging environment of shelters for staff. For example, by highlighting high staff turnover, funding issues, and difficulties working with individuals that have experienced trauma. Therefore, the present review adds to current DV literature by providing the staff perspective and offers a deeper understanding of the challenges and high turnover rates of shelter staff. Thus, highlighting the complexity of working in shelter specific environments. This is important for developing interventions to improve staff wellbeing and create more sustainable working environments. Another potential benefit is this review only included studies where staff experience was at the forefront. This was particularly key given that staff involvement in DV research often relates to assessing service provision impacting residents. Whilst useful, this can dilute understanding of the impact on staff directly.

A limitation of this review lies in the varied roles included within the studies. Whilst effort was made to ensure most participants in selected studies were frontline workers, some supervisors, managers, and directors were included in the review. Thus, the review did not allow for the narrow focus on frontline staff only. It is also possible that experiences may have been diluted due to varied data collection methods (i.e., not all studies specified if focus groups for frontline staff and directors were separate). A further limitation is the review included studies that had a specific focus, such as perceptions of mothering in shelters (Peled & Dekel, 2010), and STS of counsellors (Beckerman & Wozniak, 2018), potentially removing from the consistency of the review studies. Nevertheless, given the limited research on staff experiences and challenges, these were considered relevant for the review. It is also important to note that the small number of studies does not allow for the generalisation of findings outside the review settings.

This review highlights a need for future research focusing on the wellbeing of staff working within DV shelters. Future research may explore the challenges highlighted in this review with the use of a mixed methods approach. For example, incorporating The Work-Related Quality of Life (WRQoL) scale (Van Laar et al., 2007) would offer further understandings of the sense of control staff feel they have at work, work-related stress, and general wellbeing. Therefore, supplementing understandings gained from interviews. Future reviews could also aim to explore frontline workers only. In addition, qualitative methods (i.e., interviews) with DV shelter staff that have experienced discrimination would offer insight into an under-researched area. This may illuminate further challenges faced by staff. Finally, research exploring interventions for staff wellbeing could include a co-evaluation approach. For example, evaluation of RP, training, and long-term evaluation of having a CP onsite that incorporates service user (i.e., staff) perspectives.

Conclusion

The aim of the present review was to explore staff experiences of working within a DV shelter. Findings highlight the varied difficulties faced by staff including the challenges of working with trauma material, limited resources, and the complexities of working within a shelter environment, such as the interplay of power dynamics between staff, residents, and the wider system. Subsequently, having a significant impact on staff wellbeing. Therefore, a focus on building upon staff support strategies is needed.

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Tables

Table 1

SPIDER Search Components and Descriptions

SPIDER Component	**Description**
Sample	Staff working in domestic violence shelters
Phenomenon of interest	Experiences of working within domestic violence shelters
Design	Qualitative methodology
Evaluation	Interviews, focus groups, open-ended survey, case study
Research Type	Qualitative analysis (e.g., thematic analysis, grounded theory) on self-reported data

Table 2

Inclusion and Exclusion Criteria

Inclusion criteria	Exclusion criteria
• Written in the English language	• Studies utilising quantitative data collection/analysis methods
• Focus on staff experiences of working in domestic violence shelters	• Qualitative findings synthesised by researcher/not supplemented with quotations from participants
• Data collection using qualitative methods (e.g., focus groups, interviews, open-ended survey questions)	• Participants included multiple stakeholders (e.g., service users, staff working in domestic violence field other than shelters) and/or did not differentiate between stakeholders
• Qualitative data analysis required (e.g., generating themes)	• Majority of participants were not frontline workers or worked directly with frontline workers (e.g., Executive Directors)
• Majority of participants were frontline staff working in shelters/refuge and/or staff directly supporting frontline staff (e.g., supervisors and/or managers). Where Executives Directors are participants, they are supplementing the aforementioned participant criteria rather than the majority	• Studies focusing on staff experiences of domestic violence services in specialist settings outside of domestic violence shelters (e.g., homelessness shelters, refugee settings)
	• Focus on descriptions of service delivery and/or on participant feedback on specific assessment/intervention/programmes
	• Does not specify staff roles (e.g., domestic violence service providers)
• Mixed methods data was included where the qualitative data was easily distinguishable and extractable and met above criteria	• Focus on service user experience shared through the perspective of shelter staff (little to no discussion of direct staff experience)
	• Where the cultural content/political content prominent in discussions
• Doctoral Thesis incorporating above criteria	• Focus on COVID specific experience
	• Literature reviews

Table 3

Study Characteristics Included in the Review

Study No.	**Title**	**Authors (yr.)** **Journal** **Country**	**Research Aim(s)**	**Participants Characteristics**	**Data Collection & Method of Analysis**	**Main Findings**
1	Challenges and Retention of Domestic Violence Shelter Advocates: a Grounded Theory	Merchant, L. V., & Whiting, J. B. (2015) Journal of Family Violence US.	Develop a model representing the experiences of domestic violence shelter advocates Understand the advocate process/response to challenges faced within their roles	19 former and current shelter workers from Nine domestic violence shelters 17 Female / 2 male Age range 23-61 Ethnicity: Caucasian (7), Hispanic (7), African American (5) Length working in shelter 1-12 years (Ave length 5.4years) Hold professional license such as Clinical Social Worker/Family Therapist (6)	Face-to-face semi-structured interviews Grounded Theory	Three main Categories and 12 sub-challenges 1. Managing shelter shock (coping with the emotional intensity of DV, managing crisis and chaos) 2. Letting go of being the hero (scarcity of resources, not ready for change) 3. Balancing advocate roles (enforcing rules, enabling versus empowering) Remaining sub challenges: Bootstrap, enabling, and balanced shelters

						-Shelter culture and retention -Supportive cultures -Demoralizing cultures -Leaving, promoting, and settling in
2	Experiences and Coping among Female Caseworkers at Women's shelters: A Qualitative Study	Wu, H.N. (2008) Counselling Psychology P.H.D. Dissertation (Department of Communication Disorders and Counselling, School, and Educational Psychology) US.	To better understand the experiences and coping strategies of caseworkers at women's shelters	12 domestic violence shelter caseworkers from five shelters Job titles (director of shelter services, transitional manager, children's advocate, shelter case manager, family advocate, women's advocate, case manager, lead mentor, and children's case manager)	Main source of data collection: Face-to-face semi-structured interviews and telephone interviews Supporting data included the researcher's fieldnotes and reflection journals Intentional analysis for phenomenological approach and constant comparative method	Three major themes and nine sub-themes 1.Work motivation (history of IPV, exposure to IPV, altruism) 2.Shelter work experience (environment, individual, social life) 3.Coping resources (personal coping resources, social, professional)
3	The Day-to-Day Reality of Delivering Shelter	Burnett, C., Ford-Gilboe, M., Berman, H.,	Explore daily reality faced by shelter staff	41 Staff members from four shelters (two urban, two rural)	Individual staff interviews and focus groups	Four emergent themes:

	Services to Women Exposed to Intimate Partner Violence in the Context of System and Policy Demands	Wathen, N., & Ward-Griffin, C. (2016) Journal of Social Service Research Canada	when supporting women that have experienced domestic violence	37 Frontline staff members/ managers/four directors Participants all identified as female	Analysed using principles of interpretive description	1. Trying to manage layers of need 2. Making something out of nothing 3. Access and connecting the dots in a fractured system 4. Holding it together
4	Domestic violence counselors and secondary traumatic stress (STS): A brief qualitative report and strategies for support	Beckerman, N. L., & Wozniak, D. F. (2018) Social Work in Mental Health US.	Examine the nuances and subtleties of the lived experiences of working in a domestic violence shelter To identify the range of experiences of STS and other related psychosocial sequelae	11 Participants from three shelters All Mental Health Counsellors providing services in a domestic violence shelter (with a MSW or mental health counselling degree). Ethnicity: 5 African American, 3 biracial, 3 white Education was predominantly MSW 5 years or less experience within shelters	Focus groups with interview guide Transcripts analysed thematically	Four Themes: 1. Hypervigilance/fear of harm 2. Impact on personal life 3. Shift in worldview 4.Methods of coping
5	Dissertation. A Phenomenological Study of Advocate Experiences and Perceptions of Turnover Rates	Philyaw, L. Y. (2020) Doctorate of Education	Exploration of the lived experiences of shelter advocates and the factors that	12 shelter advocates Age range 21-45yrs Years of experiences range 3-20yrs	Semi-structured interviews (phone) Moustakas-modified and Van	Five main themes and two sub-themes 1.Background experience with domestic violence and advocate's commitment to serve

	within Domestic Violence Shelters	Dissertation (School of Education) US.	contribute to turnover rates		Kaam Method (phenomenology)	victims, while facing challenges in shelter programs (commitment to advocate) 2.The reality of self-care practices reducing stress for advocates providing services to domestic violence victims (self-care) 3.The secondary trauma and informational gaps identified in repeating the victim's domestic violence story 4.The stress associated with hiring new advocates 5. Helpful tools for new advocates
6	Boundaries in carework A case study of domestic violence shelter advocates in the USA	Wies, J.R. (2009) Global Public Health US.	Explore how domestic violence advocates navigate pressures to professionalise their shelter service provision through the use of boundaries	35 Domestic Violence Shelter Advocates from two shelters	Participant observation, semi-structured interviews, and focus groups Ethnographic description and analysis	Main category: Boundaries and domestic violence shelter advocacy Sub-categories: -Physical boundaries -Interpersonal boundaries

7	The influence of low-barrier and voluntary service policies on survivor empowerment in a domestic violence housing organization	Nnawulezi, N., Godsay, S., Sullivan, C. M., Marcus, S., & Hacskaylo, M. (2018) American Journal of Orthopsychiatry US.	Explore how low-barrier and volunteer policies within a DV shelter shaped staff practice and survivor empowerment	12 Shelter staff: 6 Providing direct services 6 Providing direct supervision to advocates	Mixed methods with Semi-structured interviews Inductive thematic analysis	Five themes and eight sub-themes 1.Organizational values guide the enactment of low-barrier and voluntary service polices (providing equal access, inclusivity, and justice, trusting survivors, promoting survivor autonomy and self-determine- nation) 2. Low-barrier and voluntary service policies guide staff practices (engage in empathetic and nonjudgmental listening, prioritize survivors' individual needs, build collaborative relationships, set boundaries, provide intensive support and care) 3. Staff members need tools to engage in low-barrier and voluntary service policies 4. Low-barrier and voluntary service poli-

						cies positively affect survivors. 5.Low-barrier and voluntary service policies have organizational impacts
8	The experiences of domestic violence shelter workers and their perceptions of shelter services - A preliminary study	Brown, C., Serpe, C., & Brammer, S. (2020) Violence and Victims US.	Explore the experiences of shelter workers, their perceptions of shelter services, and their engagement with traumatized residents	98 shelter workers Roles included client/shelter/domestic violence advocates (39.1%) or program managers/directors/coordinators (38.5%) Majority of respondents had either a bachelor's or graduate/professional degree Ethnicity: 69 European American , 6 African American, 3 Hispanic/Latino, 3 Native American, 1 Asian/Pacific Islander, 1 Bicultural, and 15 not reported Age range 21 to 75 Years of advocacy experience 2 months to 28 years	Mixed-methods (survey with open-ended questions) Constant comparison method	28 Themes 1.Lack of progress, revolving door, continued bad choices 2. Greater freedom and empowerment 3. Less participation and access to resources 4. Negligible impact 5. Increase education and life-skills training 6. Provision and awareness of resources 7. Encourage and empower 8. Promote or mandate program services 9. Clear expectations and accountability 10. Lack of funding and necessary resources 11. Lack of structure and enforcement of rules

12. Mental health issues (substance use/lingering trauma)
13. Housing and communal living issues
14. Lack of funding, community awareness, resources
15. Residents’ lack of success
16. Victim blaming
17. Ineffective actions by staff
18. Client improvement
19. No gender discrimination
20. Separate space or shelters are needed
21. Insufficient staff training
22. No gender discrimination
23. Separate space or shelters are needed
24. Insufficient staff training
25. Survivors are not held accountable
26. Belief in the work
27. Still more work to do
28. Increased funding and resources

9	Excusable Deficiency: Staff Perceptions of Mothering at Shelters for Abused Women	Peled, E. & Dekel, R. (2010) Violence Against Women Israel	Examine staff's perceptions of mothering dynamics within a shelter setting and challenges they faced	30 workers across 8 shelters 29 female Roles: 15 social workers, nine matrons, four educators, one psychologist, and one movement therapist Age range 24-69 Years of experience 1-22	Focus groups with interview guide Content analysis	Four main categories 1. The women as mothers 2. Understanding the women's problematic Mothering 3. Who mothers the children at shelters for abused women? 4. Ideology and reality in empowerment intervention with women as mothers

Table 4

CASP Quality Assessment

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Total Score
1	Yes	Yes	3	3	3	2	1	2	3	3	20
2	Yes	Yes	2	3	3	3	2	3	2	2	20
3	Yes	Yes	2	2	3	2	1	3	3	3	19
4	Yes	Yes	3	3	3	1	2	2	2	2	18
5	Yes	Yes	3	2	3	1	2	2	3	2	18
6	Yes	Yes	3	3	2	1	1	1	2	1	14
7	Yes	Yes	2	2	2	1	2	1	1	2	13
8	Yes	Yes	1	2	2	1	2	1	2	2	13
9	Yes	Yes	1	1	2	1	1	2	2	2	12

Figures

Figure 1

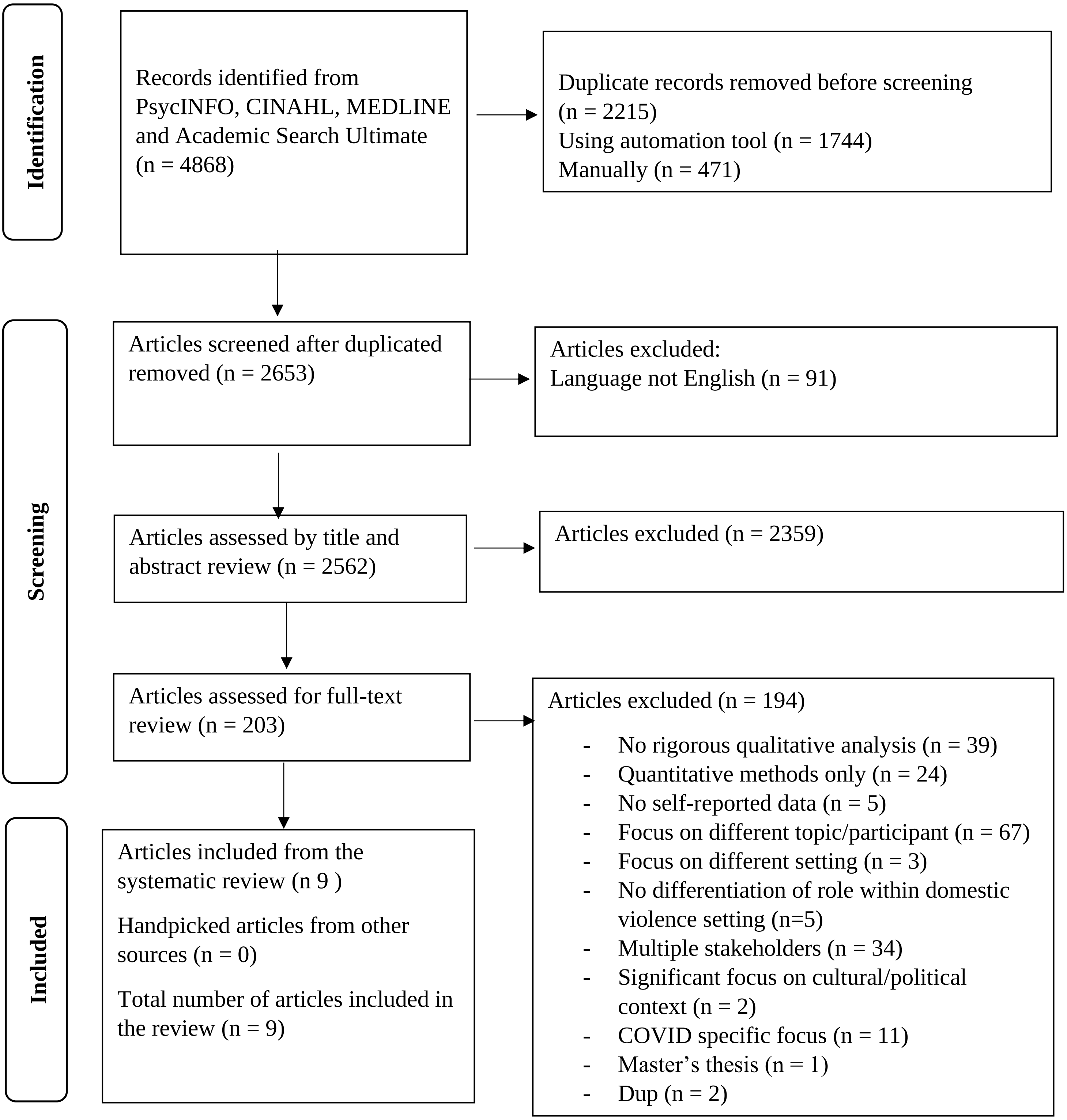
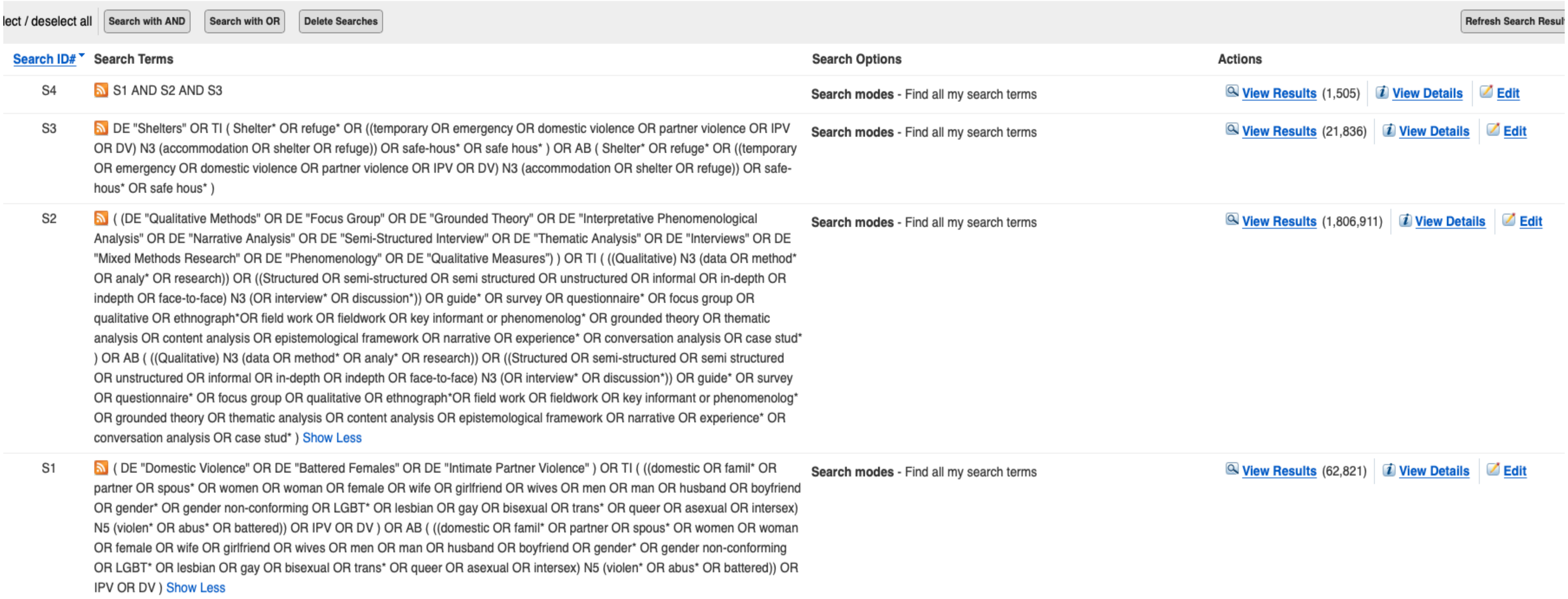


Figure 1. PRISMA flow diagram of studies inclusion

Appendices

Appendix 1-A

PsycINFO Database: Search Terms and Subject Term



Search ID#	Search Terms	Search Options	Actions
S4	S1 AND S2 AND S3	**Search modes** - Find all my search terms	View Results (1,505) | View Details | Edit
S3	DE "Shelters" OR TI (Shelter* OR refuge* OR ((temporary OR emergency OR domestic violence OR partner violence OR IPV OR DV) N3 (accommodation OR shelter OR refuge)) OR safe-hous* OR safe hous*) OR AB (Shelter* OR refuge* OR ((temporary OR emergency OR domestic violence OR partner violence OR IPV OR DV) N3 (accommodation OR shelter OR refuge)) OR safe-hous* OR safe hous*)	**Search modes** - Find all my search terms	View Results (21,836) | View Details | Edit
S2	((DE "Qualitative Methods" OR DE "Focus Group" OR DE "Grounded Theory" OR DE "Interpretative Phenomenological Analysis" OR DE "Narrative Analysis" OR DE "Semi-Structured Interview" OR DE "Thematic Analysis" OR DE "Interviews" OR DE "Mixed Methods Research" OR DE "Phenomenology" OR DE "Qualitative Measures")) OR TI (((Qualitative) N3 (data OR method* OR analy* OR research)) OR ((Structured OR semi-structured OR semi structured OR unstructured OR informal OR in-depth OR indepth OR face-to-face) N3 (OR interview* OR discussion*)) OR guide* OR survey OR questionnaire* OR focus group OR qualitative OR ethnograph*OR field work OR fieldwork OR key informant or phenomenolog* OR grounded theory OR thematic analysis OR content analysis OR epistemological framework OR narrative OR experience* OR conversation analysis OR case stud*) OR AB (((Qualitative) N3 (data OR method* OR analy* OR research)) OR ((Structured OR semi-structured OR semi structured OR unstructured OR informal OR in-depth OR indepth OR face-to-face) N3 (OR interview* OR discussion*)) OR guide* OR survey OR questionnaire* OR focus group OR qualitative OR ethnograph*OR field work OR fieldwork OR key informant or phenomenolog* OR grounded theory OR thematic analysis OR content analysis OR epistemological framework OR narrative OR experience* OR conversation analysis OR case stud*) Show Less	**Search modes** - Find all my search terms	View Results (1,806,911) | View Details | Edit
S1	(DE "Domestic Violence" OR DE "Battered Females" OR DE "Intimate Partner Violence") OR TI (((domestic OR famil* OR partner OR spous* OR women OR woman OR female OR wife OR girlfriend OR wives OR men OR man OR husband OR boyfriend OR gender* OR gender non-conforming OR LGBT* OR lesbian OR gay OR bisexual OR trans* OR queer OR asexual OR intersex) N5 (violen* OR abus* OR battered)) OR IPV OR DV) OR AB (((domestic OR famil* OR partner OR spous* OR women OR woman OR female OR wife OR girlfriend OR wives OR men OR man OR husband OR boyfriend OR gender* OR gender non-conforming OR LGBT* OR lesbian OR gay OR bisexual OR trans* OR queer OR asexual OR intersex) N5 (violen* OR abus* OR battered)) OR IPV OR DV) Show Less	**Search modes** - Find all my search terms	View Results (62,821) | View Details | Edit

Appendix 1-B

CASP Checklist

CASP Checklist: 10 questions to help you make sense of a Qualitative research.

The first two questions are screening questions and can be answered quickly. If the answer to both is “yes”, it is worth proceeding with the remaining questions.

Questions:

SECTION A: Are the results of the study valid?

1. Was there a clear statement of the aims of the research?
2. Is a qualitative methodology appropriate?
3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Was the data collected in a way that addressed the research issue?
6. Has the relationship between researcher and participants been adequately considered?

SECTION B: What are the results?

7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings?

SECTION C: Will the results help locally?

10. How valuable is the research?

Appendix 1-C

Analysis: Development of Analytical Themes

Initial Codes	Descriptive Codes	Analytical Themes
• Afraid of being abusers' target • Emotional response after work • Sacrifice personal needs • Hard to separate work from home • Nightmares • Intrusive thoughts • Sleep problems • Exhaustion • Challenge of hearing stories • Physically seeing effects of DV • Impact of personal history • Fear and blame • Emotional attachment to resident	• Affects personal lives • Big mother role • Psychological responses • Shelter shock	**Emotional weight of the work**: captures varying ways in which participants were challenged with more than the physical duties of the role duties. Highlighting the many emotional challenges and responses to the shelter work
• Creating a safe space • Sharing your story • Survivor centred approach • Language barrier • Need for inclusivity • Client challenging behaviour • Difficulties gaining trust • Working with agency staff benefits • Need to work with wider community • Working well with agency staff • Mediating role between resident and system	• Creating a safe space • Relationship building • Need for inclusivity • Working with the wider community	**Connecting with others:** captures the varying ways in which participants experienced connecting with victims of DV, barriers to connecting with others and building connections within the wider community
• Balancing worker and resident wellbeing • Harmony when client, shelter, staff values align • Demand exceeding ability • Lack of funding • Lack of resources • Working with uncertainty • Not feeling valued • Rules • Positive outcomes of boundaries	• Balance own values, shelters and residents • Systemic impact • Rules and boundaries • Power versus empower • Overworked and underappreciated • Lack of funding and resources	**Power versus empower:** captures the power dynamics that inevitably play a part when working to "empower" others within such a DV shelter context

• High turnover • Powerless against system • Pay		
• Coping outside of work • Coping at work • Self-care • Humour • Ease into role • Benefits of supportive culture • Need for supervision • Understanding leadership • Getting promoted • Learn as you go • Need for training • Positive learning from training • Need to be flexible • Need to be creative • Passion as a protective factor	• Importance of teamwork • Staff growth • Training • What you need to work here • Coping	**Making it through:** captures what it is that kept participants working at the shelters despite challenges. It brings together internal and external, professional and personal coping resources utilised by participants

Note. Initial codes include examples from the data and are not representative of all codes generated at this stage.

Appendix 1-D

Journal of Health and Social Care in the Community

Health and Social Care in the Community is an international peer-reviewed journal with a multidisciplinary audience including social workers, health care professionals with a community or public health focus e.g. public health practitioners, GP's, Community Nurses and Social Care researchers and educators.

The Journal promotes critical thinking and informed debate about all aspects of health and social care. Original papers are sought that reflect the broad range of policy, practice and theoretical issues underpinning the provision of care in the community.

Health and Social Care in the Community publishes systematic and narrative reviews, policy analysis and empirical qualitative or quantitative papers including papers that focus on professional or patient education.

Research articles

Research articles should present the results of an original research study. These manuscripts should describe how the research project was conducted and provide a thorough analysis of the results of the project. Systematic reviews may be submitted as research articles.

Reviews

A review article provides an overview of the published literature in a particular subject area.

Formatting

An optional research article manuscript template can be downloaded here. We recommend that all manuscripts include line numbers and follow the structure below:

Title and authorship information

The following information should be included:

- Manuscript title
- Full author names
- Full institutional mailing addresses
- Email addresses

Affiliations. Hindawi Limited remains neutral with regard to jurisdictional claims in institutional affiliations. Responsibility for affiliations ultimately rests with the author, although Hindawi may request changes be made to countries listed in affiliations to ensure consistency across published output (for indexing and discovery reasons).

Abstract

The manuscript should contain an abstract. The abstract should be self-contained, citation-free, and should not exceed 300 words.

Introduction

This section should be succinct, with no subheadings.

Materials and methods

The methods section should provide enough detail for others to be able to replicate the study. If you have more than one method, use subsections with relevant headings, e.g. different models, in vitro and in vivo studies, statistics, materials and reagents, etc.

Hindawi journals have no space restriction on methods. Detailed descriptions of the methods (including protocols or project descriptions) and algorithms may also be uploaded as supplementary information or a previous publication that gives more details may be cited. If the method from a previous article is used then this article must be cited and discussed. If wording is reused from a published article then this must be noted, e.g. This study uses the method of Smith et al. and the methods description partly reproduces their wording [1].

If a method or tool is introduced in the study, including software, questionnaires, and scales, the license this is available under and any requirement for permission for use should be stated. If an existing method or tool is used in the research, the authors are responsible for checking the license and obtaining any necessary permission. If permission was required, a statement confirming permission was granted should be included in the materials and methods section.

Publishing protocols. We encourage authors describing any methodology, in particular laboratory-based experiments in the life sciences but also computational and bioinformatics protocols, to upload details of their methods to protocols.io. This is an open access website that allows researchers to record their methods in a structured way, obtain a DOI to allow easy citation of the protocol, collaborate with selected colleagues, share their protocol privately for journal peer review, and choose to make it publicly available. Once published, the protocol can be updated and cited in other articles.

You can make your protocol public before publication of your article if you choose, which will not harm the peer review process of your article and may allow you to get comments about your methods to adapt or improve them before you submit your article (see also the protocols.io FAQ page).

Results and discussion

This section may be divided into subsections or may be combined.

Main text (review only)

This section may be divided into subsections or may be combined.

Conclusions

This should clearly explain the main conclusions of the article, highlighting its importance and relevance.

Data availability

This statement should describe how readers can access the data supporting the conclusions of the study and clearly outline the reasons why unavailable data cannot be released.

Conflicts of interest

Authors must declare all relevant interests that could be perceived as conflicting. Authors should explain why each interest may represent a conflict. If no conflicts exist, the authors should state this. Submitting authors are responsible for coauthors declaring their interests.

Conflicts of interest (COIs, also known as ‘competing interests’) occur when issues outside research could be reasonably perceived to affect the neutrality or objectivity of the work or its assessment. For more information, see our publication ethics policy. Authors must declare all potential interests – whether or not they actually had an influence – in the conflicts of interest section, which should explain why the interest may be a conflict. If there are none, the authors should state: “The author(s) declare(s) that there is no conflict of interest regarding the publication of this article”. Submitting authors are responsible for coauthors declaring their interests. Declared conflicts of interest will be considered by the editor and reviewers, and included in the published article.

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Section Two: Empirical Paper

Staff Experiences of Racism within the Homelessness Sector: An Exploratory Study

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Doctorate in Clinical Psychology

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Abstract

Background: Racism exists in all aspects of society, with the workplace being no exception. Its devasting impact on individuals from ethnic minority communities includes significant mental health challenges, such as depression, trauma-related difficulties, and suicide. Research has begun to focus on the staff experiences of racism within health and social care settings, highlighting varying forms of racism and barriers to accessing support faced by staff working in direct care roles. No prior research has focused on staff experiences of racism within the homelessness sector. Aim: To explore staff experiences of racism within the homelessness sector, including how staff members make sense of and cope with such experiences. Methods: The study utilised a qualitative approach. Seven female participants working within the homeless sector were recruited. Data was collected using semi-structured interviews and results were analysed using Reflexive Thematic Analysis (RTA). Results: Five themes were generated: (i) experiencing racism in blatant and subtle forms, (ii) powerlessness, (iii) feeling unheard and misunderstood, (iv) psychological impact, (v) perseverance and protection. Conclusions: Findings highlighted the pervasive nature of covert and overt forms of racism, and the interplay of interpersonal, institutional, and structural forms of racism that serve to maintain challenges faced by staff members from ethnic minority communities. Clinical implications and recommendations are discussed.

Keywords: racism, homeless, shelter, staff experiences

Introduction

The Equality Act (2010) stipulates that it is illegal to discriminate against anyone based on "race, including colour, nationality, ethnic, or national origin" in any aspect of society, including the workplace. Whilst such legislation is imperative in promoting change, equal outcomes and treatment cannot be guaranteed (Miller, 2020), and racism remains a key issue permeating society (Wong et al., 2021).

Commonly, racism is defined in relation to aspects such as inferiority attributed to ethnic minority communities or organisational systems that create unequal opportunities through laws and practices (Paradies, 2006). Collectively such definitions highlight racism as multi-layered and complex, however, individually they serve to omit key aspects. For example, definitions that solely focus on racism maintained due to power differentials, fail to acknowledge racism carried out by those who hold limited social power (Berman & Paradies, 2008).

To address such limitations, Berman and Paradies (2008) define racism as "that which maintains or exacerbates inequality of opportunity among ethno-racial groups" (p.217). Racism can manifest through negative beliefs and attitudes, acceptance of stereotypes, or discriminatory acts, including expression of negative beliefs and violence against ethnic minority communities (Berman & Paradies, 2008; Okazaki, 2009). Racism can operate at several levels. On an institutional level, ethnic minority communities are disadvantaged through policies, legalities, and procedures operating within societal institutions (Williams et al., 2019). Structural racism operates at a macro level. This involves systems and institutions that reinforce each other's discriminatory impacts, including housing, education, and healthcare systems (Reskin, 2012; Williams et al., 2019). Internalised racism involves the acceptance of negative attitudes and/or beliefs relating to an individual's ethnic minority community (Jones, 2000), whilst interpersonal racism refers to interactions between individuals (Krieger, 2014).

Interpersonal racism can be experienced overtly, including through verbal abuse, ridicule, and acts of violence (Beagan et al., 2023). Interpersonal covert racism manifests in more subtle forms and incorporates microaggressions, a common form of racism that communicates hostility and leads to a sense of othering. For example, asking someone where they are from might appear innocent, yet it can convey that a person does not belong (Mistry & Latoo, 2009; Sue et al., 2007). Covert forms of racism may prove more challenging to identify and report, given the potential ambiguity around its intentionality (Snyder & Schwartz, 2019). Nevertheless, both overt and covert racism ultimately has a detrimental impact on those on the receiving end (Sue et al., 2007).

Racism has been found to negatively impact an individual’s psychological wellbeing. Goto et al. (2013) carried out a meta-analysis of 34 studies assessing the relationship between interpersonal discrimination and mental health. Findings suggest interpersonal racism is associated with depression and difficulties associated with substance and alcohol use. Similarly, in a meta-analysis of 293 studies, racism was associated with poor mental health outcomes, including depression, anxiety, and psychological stress (Paradies et al., 2015). Further studies suggest low self-esteem as an outcome of perceived everyday racism (Cénat et al., 2022; Tawa et al., 2012).

In addition, a growing body of epidemiological research suggests that racism negatively affects physical health (Paradies, 2006), including increased risk of hypertension (Dolezsar et al., 2014), cardiovascular disease (Lewis et al., 2014), sleep disturbances, and fatigue (Grandner et al., 2011). The interplay between racism, mental health, and physical health outcomes is complex (Lewis et al., 2014). For example, Steffen and Bowden (2006) found that sleep disturbances functioned as a mediating factor between perceived racism and depressive symptoms. However, existing research has identified perceived racism as having a direct detrimental impact on ethnic minority communities. For example, studies emphasise the cumulative effects of perceived racism leading to trauma-related difficulties (Carter, 2007), including re-experiencing racism, avoidance, or hyperactivity, which may present itself as difficulties associated with anxiety and depression.

The existence of racism and its impact has been found in varying contexts, including the workplace. Regmi et al. (2009) highlight that irrespective of equality legislation aiming to protect ethnic minority communities, racism in the workplace is evident. When researching racism experienced by Nepalese immigrants working in varied positions, including roles within the government and the charitable sector, Regmi et al. (2009) found structural and institutional racism to be present. This included limited career progression and training opportunities, resulting in reduced job satisfaction and increased psychological stress. These findings were mirrored in studies investigating microaggressions, including assumptions of inferiority, such as disbelief in qualifications obtained by individuals from ethnic minority communities working within the educational sector (DeCuir-Gunby & Gunby, 2016).

The health and social care sector has a growing research base highlighting racial inequality experienced by service users. For example, barriers to accessing healthcare (Rhee et al., 2019) and reduced quality of care for individuals from ethnic minority communities (Williams & Rucker, 2000). Less attention has been given to the experiences of racism from the staff perspective (Rasmussen & Garran, 2016).

Nevertheless, in a meta-analysis investigating healthcare professionals’ experiences of racism, Snyder & Schwartz (2019) found that both physicians and nurses experienced racism from patients and their relatives. This included racial slurs, refusal to work with staff members from ethnic minority communities and questioning their abilities to work within their role. Racism was also found to be present in interactions with colleagues and management, along with a lack of acknowledgement of the presence of racism from those in senior positions, which led to a sense of powerlessness and fatigue for those experiencing racism. In addition, Snyder & Schwartz (2019) noted several ways healthcare professionals coped with such experiences, including seeking support from colleagues with similar experiences and supporting patients experiencing racism. Coping through attempts to ignore or justify racism was also reflected within the study findings, along with barriers to challenging racism due to potential personal and professional repercussions.

Similar findings emerged from an inquiry conducted by the Equality and Human Rights Commission (2020) assessing experiences of racism among lower-paid workers within the health and social care sector across Britain. These included direct racist attacks from service users and their refusal to be seen with black members of staff working as carers. Additionally, the inquiry highlighted that staff experienced racism from colleagues and management, experienced limited or no support from management (e.g., unwillingness to confront racism), limited training opportunities in comparison to white colleagues, and racism within the workplace resulted in a negative impact on their mental health. In addition, the inquiry found a lack of formal pathways to report racism, along with fears that reporting racism may harm their job security and be met with disbelief and no protection.

Overall, staff members within health and social care settings have been found to experience racism in a variety of forms, including overt (Brockmann et al., 2001) and subtle forms of racism (Mistry & Latoo, 2009), as well as regularly experiencing racism from those they provide care for. This has been shown to be particularly prevalent for individuals working in direct care roles within residential settings (Ejaz et al., 2011) In addition, studies assessing direct care roles and discrimination suggest a high prevalence of individuals from ethnic minority communities work in support worker positions (Ejaz et al., 2011; Hammond & Yen, 2010).

An area of health and social care that relies on support roles is the homelessness sector. As with other health and social care settings, existing homelessness and racism research has focused on the service user perspective, such as barriers to accessing care (e.g., Olivet et al., 2021). There is no existing research on staff experiences of racism within the homelessness sector. Thus, a scarcity of recommendations on how best to support homeless staff experiencing racism. This is particularly important given the findings from several studies suggesting discrimination is associated with mental health difficulties (e.g., Goto et al., 2013; Paradies et al., 2015). Furthermore, it has been suggested existing associations between staff working directly with homeless individuals and work-related stress may lead to reduced empathy for service users (Lemieux-Cumberlege & Taylor, 2019).

The present study explored staff experiences of racism within the homelessness sector. The study aimed to increase understanding of racism within homelessness settings, to understand how staff members make sense of and cope with experiences of racism, and to offer insight to enhance staff support, including offering recommendations to clinical psychologists working within homelessness settings.

Method

Design

Staff experiences of racism within homelessness settings is an area yet to be researched, therefore, an in-depth exploratory study was selected to develop an understanding of participants' experiences.

A qualitative approach was employed using Reflexive Thematic Analysis (RTA) to analyse the data. Thematic Analysis (TA) was selected over other qualitative approaches as it offers a flexible approach to identifying themes and patterns across the dataset that is not theoretically bound (Braun & Clarke, 2006). In addition, the reflexive aspect intentionally brings to the forefront the active role of the researcher as an interpretative tool (Braun & Clarke, 2022). This was considered an unavoidable and integral part of the process that supports an in-depth understanding of individuals' experiences of racism, along with how individuals make sense of their experiences through both explicit and implicit data analysis (Braun & Clarke, 2022; Byrne, 2022). Furthermore, this supported managing any potential biases impacting data collection and analysis given the researcher is a member of an ethnic minority community.

Participants

An information-rich sample of individuals was selected using purposeful sampling methods (Patton, 2002). A total of seven participants consented to take part in the study, all of whom identified as women working in the North West of England. Inclusion criteria specified identification as a member of an ethnic minority community, to be working in a direct service-user facing role within the homelessness sector (non-NHS capacity) and have experienced racism within their working environment.

The study initially aimed to recruit six to eight participants fitting with the practical guidelines for TA (Braun & Clarke, 2013). Guided by research supervisors, recruitment stopped at seven participants given the richness of data collected and the challenges faced with data collection during the COVID-19 pandemic.

Procedure

Recruitment

Managers based at different homelessness sites, including temporary accommodation, day centres, and outreach teams working with street homeless individuals were approached via email requesting circulation of the recruitment poster. Where consent was obtained, delivery of a physical copy was provided to place in staff communal spaces. The poster included a summary of the study, what participation would involve, a link to a participant information sheet with further information, and the researcher's contact details.

Following this, opportunities to discuss the study at team meetings were sought from team managers. Contact details were left at the end of the meeting for participants to get in touch, maintaining anonymity. A further recruitment source included speaking with attendees of Psychologically Informed Environment (PIE) online training within a local NHS Foundation Trust. Training is accessed by individuals working across the homelessness sector. With the permission of the lead facilitator, study details and the recruitment poster were shared at the end of the training.

Data Collection

Data was collected using one-to-one semi-structured interviews with the use of an interview topic guide. This allowed for closeness to the research area whilst maintaining flexibility. The use of follow-up questions and deviation from the guide ensured space for further elaboration of participant experiences (Ranney et al., 2015). This contributed to researcher-participant reciprocity, a key aspect of a reflexive approach to research (Galleta & Cross, 2013). Understanding the issue through direct conversation can also act to empower people to share their stories (Creswell & Creswell, 2014).

Participants were given the choice to be interviewed face-to-face or online using Microsoft Teams. One participant opted for a face-to-face interview which was carried out at their place of work, whilst the remaining six were conducted online. Interviews ranged from 53 to 94 minutes and began with a discussion of the participant’s roles and responsibilities. This was followed by questions relating to their experiences of racism at work, including specific examples, and how participants perceived and responded to such experiences. Given the difficult content, participants were given the option to have a break during the interview or to reschedule. Whilst many opted for breaks, no interviews were rescheduled. All interviews were recorded using the Microsoft Teams recording function.

Data Analysis

Data was analysed using NVivo 12 software. All interviews were transcribed verbatim to ensure all information remained true to participant accounts. A six phase RTA was employed to develop themes across the data sets (Braun & Clarke, 2022). Transcripts were read twice to ensure familiarisation with the data. At this stage, all initial insights and analytic points were captured in note form for individual transcripts and the whole dataset. Initial systematic coding captured all segments of meaning including those with minimal differences, leading to a few hundred codes which were later reduced by combining codes and removing duplicates. During coding, transcripts were reviewed twice, in a varied order, to ensure further insight (Braun & Clarke, 2022). Reviewing codes more than once, with support of research supervisors, resulted in both semantic and more latent coding.

Ethical Considerations

Ethical approval was obtained via Lancaster University’s Faculty of Health and Medicine Ethics Committee.

Confidentiality

Written consent to take part was obtained prior to the interview. All aspects pertaining to confidentiality and its limits were included within the participant information sheet and revisited at the start of the interview. At the end of the interview, participants were given the opportunity to ask questions and reflect on the interview experience. Participants were provided with a debrief sheet detailing available sources of support for individuals experiencing racism, along with details on reporting racism. Following data collection, all participants were assigned a pseudonym to maintain anonymity.

Terminology

Ethical consideration was given to the most appropriate terminology to use when addressing individuals from ethnic minority communities. Whilst it is acknowledged preferences will vary, ‘ethnic minority communities’ or individuals from ‘ethnic minority communities’ was deemed the most appropriate terminology as guided by the UK government (2021) and Lancaster University’s Faculty of Health and Medicine Ethics Committee. At times, deviation from agreed terminology occurred when utilising a direct quote or referencing another study.

Reflexivity

As a researcher that identifies as a member of an ethnic minority community, maintaining a reflexive stance remained crucial throughout the research process. Holding a position of ‘insider researcher’ can be beneficial in gaining rich understandings of participant experience. However, consistent awareness of the researcher position, its influence, and any underlying assumptions impacting findings was key (Barrett et al., 2020). To support this, regular supervision was sought, along with the use of a reflexive diary noting considerations, as recommended by Braun and Clarke (2022).

Epistemological Position

The present study has been conducted from a Critical Realist (CR) position (Bhaskar, 2013). CR defies an understanding of reality through observation alone but rather through social contextual factors, such as varying human experiences that give rise to social events, activities, and phenomena (Tikly, 2015). Thus, CR acknowledges that whilst racism may be studied, it cannot be understood without acknowledgement of the interplay of factors influencing those impacted by racism. For example, individuals' interpretations and understandings of racism (Dyson et al., 2014). CR further highlights a "need to discover aspects of reality afresh in each particular context" (Pilgrim, 2014, p.13). Thus, the study of racism within homelessness supports the addition of a new context to racism research.

Results

The analysis generated five themes: experiencing racism in blatant and subtle forms, powerlessness, feeling unheard and misunderstood, psychological impact, and perseverance and protection (see Appendix 2-A for theme development).

At the time of the interviews, all participants worked within temporary accommodation for homeless individuals, with one participant working within the private rented sector for homeless individuals, following 15 years of working within temporary accommodation. The most common job role cited was that of "accommodation support worker" where participants noted the role involved both practical and emotional support given the complex needs of residents. Participants had worked within the homelessness sector between a few years to 21 years. In keeping with participant language, the term 'resident' is used when referring to homeless individuals based at temporary accommodation, and 'service user' as a more generic term for homeless individuals accessing care.

Theme One: Experiencing Racism in Blatant and Subtle Forms

This theme captures the different forms of racism experienced by participants whilst working within the homelessness sector. Most participants discussed experiencing racism in the form of verbal attacks. This was commonly discussed in reference to residents using racial slurs: "She would use the N word literally like you say Saturday, Sunday, Monday, Tuesday […], every time she comes to reception" [Lucy].

Participants shared experiences of residents openly expressing “they don’t want to work with black members of staff” [Lucy] and described verbal attacks that related to the oppression of black people: “There was a woman there who was abusing the black staff […] and said to two members of the black staff, it was better when you lot were still in chains” [Alison]. It appeared participants experienced racism in direct ways, without an attempt to hide racist thoughts and expressions, with one participant commenting, “it just spills off people's tongues” [Clara].

Participants also described experiencing racism in covert forms: “Sometimes some things are quite subtle so there's nothing out and out but you're aware that they just don't want to interact with you […] engage with you on any level” [Lucy]. This highlighted another level of experiencing racism that went beyond blatant to racism that is “felt in their actions” [Charlie]. Another participant raised the concept of “microaggressions” when referring to specific incidents:

> Sometimes it's not even the overt racism, it’s the microaggressions […] there's only three black female members of staff yet residents still can't tell us apart. We just either get called that black lady that was on earlier today or we'll get each other’s names [Sam].

One participant [Opal] noted disbelief by colleagues when sharing their qualifications and another described others “not taking me seriously” [Rachel], going on to elaborate that this is typically the case when others hear her accent:

> I'm white European so they don’t know if I'm British or not […] It always starts when a person is racist, has racist tendency. When I start to speak […] they talk down on me […] they start to talk very slowly like I can’t speak English [Rachel].

Participants noted further experiences of subtle racism, including being asked where you are from: “I feel that I know what people ask me […] because maybe people are interested in other cultures […] but the people when they ask you ‘but where are you from’ [Opal]. Here, the participant was noting this as a more covert form of racism that singled them out in a negative sense.

Although less commonly discussed, one participant spoke of noticing racism from white members of staff: “Because she dealt with black residents differently than white […] she was harsher on the black residents” [Charlie]. Another participant felt opportunities for staff from ethnic minority communities were minimised in favour of their white colleagues, something they felt was reflected in having “never been offered training” [Opal].

When discussing more subtle forms of racism, participants rarely questioned their interpretation of others’ actions to be anything other than racially motivated, but rather shared their experience of racism in both blatant and covert forms.

In summary, participants experienced racism in several ways, including openly in the form of direct attacks, residents refusing to work with participants, microaggressions, and reduced opportunities for learning.

Theme Two: Powerlessness

Powerlessness embodies the limited control and influence participants felt they had when they attempted to change existing circumstances in relation to racism at work. This theme incorporates barriers to change faced by participants.

Participants commonly spoke of reporting incidents of racism to others, including management: “I sent an email for the management to tell them what had happened and didn't get a response back” [Alison]. This was echoed through additional accounts with another participant stating, “I went one step above my manager and still nothing happened. Went in there in tears and said I’m dying I can't do this […] 'leave it with me Clara’ […] he's gone on retirement now” [Clara]. The act of reporting racism, with a continued lack of response, left participants with a sense that “when it comes to putting actual action to it, we’re [organisation] not gonna do a single thing, just keep operating exactly the same way” [Sam]. The sentiment was echoed in other accounts: “If someone is being racist to me, then my feelings are hurt […] I feel powerless. What can I do if my own manager, the organisation aren’t gonna back me up, then what can I do?” [Charlie].

Participants discussed reporting racism to the police which typically resulted in no change:

> They’ll speak with this member of staff; they’ll speak to the service user who sort of denies everything but only give them like a verbal warning […] the unfortunate thing is that it’s not always a successful way that they end up leaving the accommodation which is what we want it to be [Lucy].

One participant reported racism to the police which led to court proceedings: “The judge decided that they needed to do more tests about his capacity […] I think they thought, oh well because he’s unwell there’s not really much you can do” [Alison]. This created an additional challenge of “having to listen to his solicitor or barrister then justify his behaviour and I get that’s his job but […] that’s horrific” [Sam].

Participants spoke of justification of racism being commonplace: “Your colleagues will be saying, it’s their mental health” [Lucy]. Participants discussed understanding the complex mental health difficulties experienced by residents “but when it comes to the racial slurs, that’s just completely different” [Lucy]. Another participant commented, “you can’t just blame his mental health, I said, because he’s not going out on the street and abusing random people” [Alison].

Alongside a lack of action in response to reporting racism and responses that serve to justify racism, participants spoke of challenges faced when the vulnerabilities of service users were prioritised following racist incidents: “Despite everything that’s happened, the manager’s response was ‘well, they’re vulnerable we need to accommodate them’” [Alison]. Another participant commented, “It’s like they’re making me feel like I can’t put myself first, so I have to put the feelings of that person before me” [Charlie]. This reinforced participants’ sense of powerlessness: “It just feels like you've gone back to colonial times where they can abuse you as much as they want and you carry on doing their grunt work” [Sam].

This sense of powerlessness was further reinforced through comments made by union officials, managers, and other colleagues relating to the requirements of the role: “You're the professional, you need to get on with it” [Alison]. One participant commented, “We didn't sign up as a professional to be taking racial abuse,” yet the message “you need to be professional all the time because they're the vulnerable ones and we're not vulnerable” [Charlie] was evident across participant accounts.

Participants also stated when racism was present, it could go on for “months and months […] and they could say it [racial slurs] 50-60 times a day” [Lucy], with another participant stating, “There was someone there for over a year that was abusive” [Charlie]. Participants spoke of residents rarely getting evicted for racism alone. However, when this was the case, one participant commented, “It was such a long process to get him out […] like a year and half so it's a year and a half of that kind of behaviour” [Sam]. A few participants spoke of individuals that had been racist returning to their place of work: “Because of the nature of the client group that we work with, people can come back through the system” [Alison], again adding to the sense of powerlessness experienced by participants.

The barriers discussed above appeared to leave very little room for change to participants' circumstances. Consequently, they spoke of going to the union. One participant described going with others that had experienced racism to generate more power: "I think we should all go together so that's what we did, and I think that's the reason why they stepped up" [Alison]. Whilst others felt that, in the end, "they didn't do anything" [Charlie] and seemed to "subside and die a death" [Lucy].

Overall, participants felt constrained by both their role and the focus placed on service users' vulnerabilities. They felt strongly "if it's not addressed […] it sets a precedent that this is behaviour that is tolerated […] is acceptable" [Clara]. Thus, there was a desire for others to step in as "technically, you are the victim, so you really want somebody to step in and deal with it rather than you having to deal with it yourself" [Lucy]. Despite this, participants found this was usually not the case: "My manager refused to come out and deal with it when he knows the abuse the resident was giving us. It was badly handled" [Charlie]. Others highlighted colleagues "that were really nice to the guy who was abusing" [Alison]. Whilst it was acknowledged such a response may be "a way to calm the situation" [Charlie], it was received by participants as "they're not dealing with it [Charlie].

In summary, a sense of powerlessness was found to be present in participants' experience of support seeking, justification of racism shown, focus on service user needs, and lack of confronting racism by colleagues and management.

Theme Three: Feeling Unheard and Misunderstood

A prominent aspect of powerlessness was feeling unheard and misunderstood. Though there is some overlap with the previous theme, this was particularly striking and developed into a separate theme. This theme represents difficulties participants faced having their experiences of racism acknowledged, understood, and validated.

Participants spoke of times when racism experiences were minimised: “He's just come and started abusing us for no reason whatsoever and we've got colleagues who are kind of excusing that behaviour” [Alison]. One participant commented, “People used to say they hadn’t heard something when they're right there with you […] I think it's because […] it's uncomfortable and they don't always know how to handle things” [Lucy].

Participants felt a lack of feeling validated and heard: “He's abusing us because of the colour of our skin and […] there's no sympathy, and there's no empathy from some people” [Alison]. Additionally, participants felt “there wasn't understanding of why we were getting upset and I'm thinking that you're a manager, you should know. They just either didn’t get it or they refused to” [Charlie].

Conversely, participants acknowledged times when they felt heard through others’ responses:

> I think she [manager] had compassion. Maybe not understanding […] but compassion in how she saw it for what it was […] for me it was comforting to actually see that somebody saw what I saw because I didn't say a word [Clara].

This was echoed in further comments: “You have some people really […] come on board to support you and so they'll sort of step in, and we can take a backseat” [Lucy], and “there was a few of our white colleagues who were openly supportive so when that guy in particular came to the reception, was trying to abuse us, they would step in and tell him ‘you need to leave’” [Alison].

In addition to participants expressing a desire to be understood when racism is witnessed by others, participants hoped for understanding when sharing experiences of racism. However, participants spoke of feeling misunderstood in these circumstances: “I speak to my manager because I’m passionate about it, he’s telling me I’m being aggressive.

Because I'm passionate, you're not hearing, you're not listening, you're not feeling […] they just look at me, I'm being aggressive" [Charlie]. Participants regularly expressed frustration in having "no platform. It always sounds like you're whining" [Clara].

Participants felt they were rarely understood by their white colleagues due to a lack of insight, with one participant stating, "He who feels it, knows it" [Lucy]. Another spoke of managers having "no understanding because it's not happening to them because they're not black, they can't see what we see, and they can't feel what we feel" [Charlie]. Echoing thoughts of others in relation to "the lack of actual diversity in management" [Sam] as reason for feeling unheard and misunderstood.

To increase insight into the difficulties faced, participants voiced a need for "greater diversity" [Clara] in senior positions, in addition to:

> Dialogue and conversations about what people may or may not find offensive […] having dialogues about even terminology, what's acceptable, what's not acceptable across all ranges of individuals, so that's whether it relates to colour, ethnicity, sexuality […] those dialogues need to be had but they're not always comfortable [Lucy].

Participants felt training would be a useful way to increase awareness. Linking closely with comments within the powerlessness theme relating to prioritising the vulnerabilities of service users, one participant commented, training is "focused solely on the resident" [Charlie]. Participants felt there should be "training in racism, there should be something for managers" [Charlie], and training to support colleagues to "know what the right or the wrong thing is to say to you or […] the service user" [Lucy].

In summary, participants regularly felt unheard and misunderstood due to colleagues' and managers' lack of acknowledgement of racism. Participants experienced misunderstandings of character and did not feel a platform existed to voice their experiences of racism. Participants spoke of a lack of insight from those who have no lived experience, offering recommendations of further dialogue and training to generate understandings of how to support colleagues and approach racism.

Theme Four: Psychological Impact

This theme captures the psychological impact of racist abuse on participants. As well as regularly commenting on the emotional impact, participants shared their physiological and behavioural response to racism.

Whilst the negative emotional impact was evident from all participants' dialogue, participants expressed a range of emotions from feeling "very angry" [Opal] and loneliness: "I was on my own because I wasn't getting support" [Alison], to having a sense of despair:

> I could have climbed to the top of the building and jumped off […] you know it sounds drastic […] but because I have enough sense not to do that, but that is to the pits of where it can take you [Clara].

Participants spoke of feeling "hurt" [Opal], along with a sense of hopelessness: "I've been called a ****** numerous times. A ***** black **** […] I've had time off for the same thing. You know where it took me to a point where I thought […] I can't do this no more" [Clara]. Furthermore, most participants spoke of experiencing racism in front of others. This emphasised a lack of action from others, as discussed in the previous theme, along with an internalised sense of shame as one participant stated, "it's embarrassing" [Sam] when referring to others overhearing racist comments directed towards them.

When sharing experiences of physiological responses to racism, it was clear participants were impacted in several ways. For example, in response to seeing a referral for a past resident that have been racist, one participant stated, "My heart has jumped, my anxiety has risen again" [Clara]. Most participants spoke of feeling worn down and exhausted, this was in response to racist incidents and the numerous times participants attempted to share their experiences: "It’s exhausting having to say the same thing” [Charlie] and “when you are faced with racism in all of its formats, it chips away at you to where sometimes you do feel like, am I nothing?” [Sam]. Participants also spoke of disrupted sleep: “It was causing me sleepless nights. I was really stressed at that time” [Alison].

The emotional and physiological impact was further reinforced by concerns when at home regarding challenges participants will face at work: “When you know tomorrow you probably gonna be facing the exact same thing and that takes a big psychological toll on you […] and there was the time with the sweats” [Sam] and “You’re kind of on tender hooks thinking when you go into work […] is he gonna be there” [Alison]. One participant discussed the impact of racism lasting long after the resident left: "That guy left about 2-3 years ago and I'm still feeling it” [Sam].

Taking time off sick was acknowledged by participants as a response to racism: “I have had periods of being off with mental illness through racist behaviour work related, that’s what my sick notes will say, work related” [Clara] and “I went off work for a few weeks. I'm never off sick” [Alison]. Medication was also mentioned: “Well, quite frankly I’m on and off medication” [Clara], in addition to seeking counselling [Opal].

Overall, experiences of racism took a negative toll with participants experiencing a great sense of hopelessness, anxiety, and, at times, suicidal thoughts. Participants were confronted with these challenges at work, within their personal lives, and left with long lasting effects.

Theme Five: Preservation and Protection

This theme captures the ways in which participants safeguarded themselves from racism and its impact. For some, this involved actively removing themselves from the situation: “Sometimes I kinda take a break […] just to try to move away from those people”, another participant stated they “walk away and go and try and calm down a little bit and don't let them see that it's bothering you because they do it even more” [Alison]. For others, “locking yourself in the bathroom and having a little cry” [Sam] is needed as a coping strategy or having to “switch off the minute it starts […] so you’re hearing words but it's almost like you're not hearing them really” [Lucy].

In contrast to removing themselves from the situation, participants sought to protect themselves by actively challenging racism: “They think it's OK to say it […] it’s never OK […] I'll try my best to be that person to say ‘that's not OK” [Sam], or by humanising themselves in the face of a dehumanising act such as racism. For example, one participant spoke of sharing a little about themselves: “I started two months […] and just tell them a little tiny story about me […] then majority of people just melts down and are normal” [Rachel]. The participant spoke of getting there straight away:

> Defence is offence straight away, so you start to disarm them at the beginning […] in the sense, ‘I'm a foreigner, I'm aware I'm a foreigner and I know I have accent and I'm fine [laughs] and I work for the council, so deal with it’ [Rachel].

For many, refusing to work with service users above and beyond what is required, was one of the ways in which participants could limit interactions with racist individuals and gain some sense of control. Others refused to work with such individuals: “I told my manager, ‘I'm not dealing with him […] I'm not standing there and being abused by him’” [Alison]. In reference to evicted residents, this participant went on to say, “If he comes back, I was fully prepared to walk out and was not looking back” [Alison]. In contrast, when dealing with returning residents who have been racist, one participant commented, “Each time they come through, you just have to see it as a new occasion […] maybe things have changed” [Lucy]. Although varied, both accounts highlighted a need for removal from the experience of racism to cope.

Although contrary to earlier discussions on powerlessness resulting from little change following reporting of racism, reporting to management, police, and unions was discussed as a way to take a stand:

> I tried to put that to the back of my head so I will wait and see how you are with me when you get there […] if they started being abusive […] I wouldn't let that go and have to go to the management and say look, this isn't acceptable [Alison].

This was also discussed in relation to enduring repeated racial abuse in front of others, including colleagues, where reporting it to the police acted as a direct coping response. One participant shared an incident of repeated racial slurs and being blamed for a resident's eviction that led to reporting the incident to the police:

> This is a place where people are sitting all over the place, people walking up and down, my colleagues, walking up and down. 'There's that f****** n*******b******* there's that f****** n*******b******* […] f****** n*******b*******.' I had to walk through the hallway while she's calling it and there's a police station connected to the town hall. I walked out of the building, round the corner into the police station, reported it" [Clara]

In summary, participants' responses, although varied, involved protecting themselves in the face of racism. Participants' responses to remove themselves, challenge racism, or humanise themselves to their attacker, highlighted the onus on participants to tackle racism.

Discussion

The present study provides an insight into staff experiences of racism within homelessness settings. Findings highlight the extensive challenges staff encounter when faced with various forms of racism, the subsequent challenges seeking support and understanding, the detrimental impact on staff wellbeing, and the ways in which staff attempt to manage such difficulties.

Firstly, participants noted ways in which racism was experienced in both overt and covert forms. This aligned with similar studies investigating racism within health and social care settings (e.g., Brockman et al., 2001; Mistry & Latoo, 2009). In relation to covert racism, participants spoke of experiencing microaggressions, including a lack of engagement from service users and receiving questions, such as ‘where are you from?’ It has been suggested that such microaggressions are hard to identify given the uncertainty of intention (Snyder & Schwartz, 2019). However, participants in the present study spoke of an intrinsic awareness of such covert racism. This was commonly attributed to lived experience; leaving individuals from ethnic minority communities primed for such incidents (Bryant-Davis & Ocampo, 2005). Importantly, participants did not appear to debate whether covert racism was intended to cause harm but acknowledged the harm overt and covert forms of racism caused.

In addition, participants discussed barriers when reporting racism including a lack of acknowledgement from management. Ozturk and Berber (2020) noted such responses likely stunt any change to the circumstances of individuals experiencing racism, particularly given managers are typically the first point of contact for reporting abuse. Furthermore, participants discussed no change due to a lack of action from others in authoritative positions, such as the police and unions. Therefore, although structural and institutional racism was not explicitly discussed, these barriers map onto the argument that interpersonal, structural, and institutional racism cannot exist separately; it is the interplay between these that shapes individuals’ experiences of racism (Nazroo et al., 2019).

Beagan et al. (2023) assessed interpersonal, structural, and institutional racism faced by nurses in Canada. Along with the limited support from colleagues and managers, findings suggest a scarcity of individuals from ethnic minority communities in management roles, which the authors attributed to institutional racism. In the present study, participants felt the lack of diversity in senior positions, and therefore a lack of lived experience of racism, contributed to feeling misunderstood and invalidated. Consequently, as highlighted in the present study, the onus for tackling racism fell to individuals from ethnic minority communities. Verissimo (2021) argues this reinforces the need to focus on the structural aspects of sustaining oppression, thus offering a more holistic understanding for those experiencing racist abuse.

This study also highlights the detrimental impact of racism on participants' psychological wellbeing. For example, participants experienced sleep disturbances, exhaustion, and suicidal ideation as found in existing research on racism and mental health (e.g., Goto et al., 2013; Grandner et al., 2011). Furthermore, existing research suggests individuals experience traumatic responses as a result of racism, including anxiety and hypervigilance (Carter, 2007), with workplace racism acting as a key risk factor (Carter & Forsyth, 2010). This links closely to participants' fears concerning further exposure to racism. Importantly, as argued by Bryant-Davis and Ocampo (2005), such fears are well founded given the pervasive nature of both covert and overt forms of racism within society. This is particularly noteworthy for the present study's participants given their prolonged exposure to racism, awareness of racist service users returning to the service, and lack of evictions due to racism.

Finally, as found in research highlighting coping strategies of nurses and physicians who experience racism at work (Snyder & Schwartz, 2019), participants commonly focused on the need for separation from racial abuse both physically, such as taking a break away from racist individuals, and mentally, through attempts to ignore or rationalise racism. Seeking support from other staff members with shared experiences was also found to be crucial. This fits with participants' commonly discussed variations on the statement "he who feels it, knows it." However, such reliance on co-worker support is likely heightened when facing limited engagement from those in senior positions (Snyder & Schwartz, 2019).

Clinical Implications and Recommendations

The findings highlight the pervasive nature of overt and covert forms of racism experienced by participants and the barriers faced when attempting to implement change. These findings are sadly nothing novel for individuals experiencing racism, however, offer recognition of the overlapping impact of racism acting on an interpersonal, institutional, and structural level, crucial for those in positions to implement change.

To understand how to best implement change, it's important to review current interventions supporting staff in homelessness settings. A framework that continues to gain traction is Psychologically Informed Environments (PIE) (Schneider et al., 2021). The principles of PIE include staff support and training, and the utilisation of Reflective Practice (RP) as a tool to develop new learnings on challenges faced by staff (Buckley et al., 2021). In addition, the presence of Clinical Psychologists (CPs) supporting the implementation of PIE has revealed effective outcomes for both service users and staff (Buckley et al., 2021; Cockersell, 2016). For example, through access to CP led support and training, staff can manage and develop positive relationships with service users. However, as noted in the present findings, staff support commonly focuses on service user trauma. Therefore, importance should also be placed on providing interventions specifically for staff experiencing racism.

The present findings highlight a sense of isolation for participants from colleagues and managers who do not have lived experiences of racism. CPs can work to incorporate training to support a greater understanding of the experiences of their colleagues, how best to respond when witnessing racism, and work towards an anti-racist approach. This serves to place the responsibility for change away from those directly experiencing racism where the burden is commonly placed (Foster et al., 2019). Training should draw upon psychological theories of trauma with specific reference to racism, highlighting physiological and psychological responses (Bryant-Davis and Ocampo, 2005; Carter, 2007) including anxiety, hyperarousal, and sleep difficulties, as experienced by participants. Participants also discussed the impact of repeated exposure to racism. Therefore, training should cover the risks of prolonged and cumulative racism resulting in long-lasting psychological trauma (Williams et al., 2021).

In addition. participants within the present study regularly discussed the minimisation of their difficulties in favour of prioritising service users' needs and mental health, resulting in no platform to discuss the impact of racism. Such minimisation acts as a risk factor for racial trauma (Helms et al., 2010). Therefore, CPs should support the implementation of RP that aims to provide a direct source of support for staff experiencing racism. These should differ from traditional forms of RP that involve attendees considering alternative responses to work-based situations (Schön, 1983) as it risks placing the responsibility of change on individuals experiencing racism. It would be more useful to allow for reflective spaces where individuals can share their experiences and feel heard and understood.

Furthermore, consideration must be given to the role of clinical psychology in maintaining oppressive structures. For example, continuing to provide interventions based solely on Euro-centric understandings will serve to minimise effective support for individuals from varying cultures and communities (McInnis, 2015). Greater attention should be placed on psychological interventions that deliver culturally competent support. For example, The Association of Black Psychologists (ABPSI) work to support individuals from ethnic minority communities by providing training on diversity and inclusion, along with raising awareness on institutional racism to organisations (ABPSI, 2022). Therefore, CPs and staff working with individuals experiencing racism can seek consultation and support when delivering training from those with existing expertise.

The present study also highlighted the importance of direct support from those with lived experience. Groups such as the Emotional Emancipation Circle (EEC), created by black psychologists with African centred models who work to support black individuals overcome the detrimental impact of racism (EEC, 2018), can further supplement staff support. For example, through self-help groups for individuals that have experienced racism, the EEC aim for people to feel understood, validated, and offer a space to build individuals self-worth. With this awareness, clinical psychology can work towards replacing the commonly cited challenge of connecting with ‘hard to reach’ communities (Flanagan & Hancock, 2010; Naz et al., 2019) and focus on how psychological interventions can develop and shift to provide more fitting support to individuals from ethnic minority communities.

Strengths, Limitations, and Future Research

Until recently, there has been very little research focusing on the staff experiences of racism within health and social care settings. A strength of the present study lies in it being the first exploration within homelessness settings. As with existing research (Snyder & Schwartz, 2019), the findings demonstrate the devasting and pervasive nature of racism. The significance of these findings brings further focus to the lack of attention paid in research which acts as an additional barrier to implementing change.

In relation to limitations, racism can be a very difficult issue to discuss and whilst every effort was made to put participants and potential participants at ease, recruitment was carried out within the workplace with direct contact made with managers to share recruitment details. This may have acted as a deterrent due to potential fears of negative repercussions. Utilising alternative channels for recruitment, including social media, may have increased the response rate. Furthermore, interviewing participants who are currently working, or have worked predominantly within temporary accommodation, allowed for a greater understanding of staff experiences of racism within a residential setting. However, this also acts as a limitation within the present study as it narrowed the focus to experience within homelessness shelters. In addition, the small number of participants does not allow for generalisation outside of the study settings. Information regarding participants' age and ethnicity was not collected for this study. This supported anonymity given the small number and location of services. However, it also acts as a limitation of the study. Where possible, future research should include these demographics to allow for greater understandings within the findings.

In addition, future research could expand on the current investigation and aim to recruit participants in other areas of homelessness, such as staff working in day centres or street outreach workers. Furthermore, a key finding of the present study centred on limited support and response to racism from those in managerial positions. Therefore, research focusing on managers' perceptions of racism is needed. This could be done through qualitative methods (i.e., interviews) that work to provide insight into potential barriers to implementing an anti-racist approach. Finally, utilising a realist approach, research should seek to collate information from key stakeholders/actors currently working to dismantle racism and provide support to those impacted, such as the ABPSI and EEC, to better inform the creation of anti-racist interventions.

Conclusion

Racism is insidious in nature and embeds itself in all aspects of society. The present study brings focus to racism experienced by homeless staff that acts on an interpersonal, institutional, and structural level, all of which work together to reinforce the oppression faced by those directly impacted. However, research exploring staff experiences of racism within health and social care settings, remains limited. Further attention in research and in practice is needed to work towards an anti-racist approach and reduce the burden placed on individuals from ethnic minority communities to implement change.

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Appendices

Appendix 2-A

Analysis: Development of Analytical Themes

Initial Codes	Final Themes	Example Participant Quotations
• Feeling othered • Not being taken seriously • Microaggressions • Verbal racism • Hard to explain • Intimidation • Consistent use of racial slurs • Where are you from? • Residents not wanting to work with staff from ethnic minority communities • Talked down to • Hidden racism • Overhearing racist language • Looks could kill	**Experiencing Racism in Blatant and Subtle Forms**	“But when he was in our accommodation, he was there with his partner, you could tell that he didn't particularly want to speak to the black staff but because they were black staff on shift, he would, he’d come in and speak to you. He'd prefer to speak to a white person” “It was very aggressive, he looked at me you know when you say if looks could kill.” “Like if you are from another planet you know like yeah that kinda thing. Yeah where you come from?” “They speak to you like you are like my English is not sufficient enough. very patronizing” “Then Sometimes some things are quite subtle so there's nothing out and out but you're aware that they just don’t want to interact with you” There was another occasion where we had a resident that was worse than that. he was abuse every black member staff, there’s four of us and we all got the abuse. He called us all N**** B****
• Face same thing again • Not just me • Re-referral for racist resident • No response from managers	**Powerlessness**	“Because at one point she turned on both of us, now thinking what we are gonna do cause you've got to look at a vulnerable woman” “People do have mental illness, diagnosis of whatever. But when it comes to the racial slurs, that's just completely different. as far as I’m concerned”

- Nobody spoke to resident after racist incident - Unions not doing anything - Racism not acknowledged - Sets precedent racism is ok - Client mental health - Focus on homeless individual - Got to carry on working with racist person - Not seen as vulnerable		"It's like they're making me feel like I can't put myself first, so I have to put the feelings of that person before me" "I've gone from my managers to above my managers and had waffle" "Now I've come to work in a government building that promotes equality, diversity, racial equality, no harassment and I'm standing in the midst of the town hall talking to a more than team leader in front of a plaque of racial equality. Craziness, you know" "I think that we've got rules and regulations and I think it protects residents more than staff"
- Blaming staff member - Accused of not being professional - Seen as aggressive - Racist sympathiser - Accused of not being a team player - Minimising racist behaviour - Lack of diversity in management - Feel it, know it - Training focus on resident - Management need training - Colleagues lacking insight - No dialogue - Not asked if OK	**Feeling Unheard and Misunderstood**	"In terms of not helpful, initially, I think it was when people used to say they hadn't heard something when they're right there with you So I don't know how you didn't hear it but I think it's because it makes. It's uncomfortable and don't always know how to handle things" "He's abusing us because of the colour of our skin and I said there's no. sympathy and there's no empathy from some people" "When I went in and complained about...of this resident that used the N-word and she accused me of not being a team player because to safeguard myself. I said even if he was at the door, I'm not letting him in because I don't want that interaction" "Because of the lack of actual diversity in management and because they don't get it and they are very lax in dealing with it, I think they subscribe to that horrible nursery rhyme, sticks and stones" "What had happened in my childhood that I had to deal with and it wasn't expecting to have to deal with it in the workplace and it's like it was falling on deaf ears"

• Hopelessness • Feeling anxious • Sweats • Drinking • Angry • Feeling fatigued/worn down • On tender hooks • Sleeping difficulties • Isolation • Embarrassment • Re-traumatising	**Psychological Impact**	“It was causing me sleepless nights. I was I was really stressed at that time” “We're worn out and worn down” “It made me very angry and I felt like I was on my own” “I get a knock on the racism angle you know; I tend to drink or take to the medication” “I could have walk up the top of the climbed to the top of the building and jumped off and thought you know what” “I used to go home. Honestly sometimes crying there Before I get home just crying then just go home just horrible”
• Walk away • Not giving a reaction • Shutting off • Killing with kindness • Go to police/court • Take a stand • Refusal to deal with racist resident • Support from others with lived experience • Get colleague to work with racist resident • New start	**Preservation and Protection**	“It got to a point where we refused to deal with this resident” “Locking yourself in the bathroom and having a little cry” “So I had to speak to one of my other black colleagues and say 'cause she was getting really upset about that and I said you know that this person was doing it to get a reaction out of you so I know it's upsetting because it's upsetting me but I said walk away and go and try and calm down a little bit and but don't let them see that it's bothering you because they do it even more” “So, and then this is where always had to put my lanyard out. And this is where they start to take me seriously, because they realized I'm there as a professional” “If they are unpleasant or a nasty person, I would kill them with kindness”

		“Each time they come through, you just have to see it as a new occasion to you know, maybe things have changed. Maybe a different working with them, stuff like that because. Well, you can't hold it against them. What happened maybe six months ago”

Note. Initial codes and quotations include examples from the data and are not representative of all codes generated at this stage.

Appendix 2-B

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Section Three: Critical Appraisal

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Critical Appraisal

The following critical appraisal aims to provide an overview of key findings of the meta-synthesis and empirical study carried out as part of the present thesis. This will include a summary of the findings presented in previous sections, any insights gained from reviewing findings across both studies and personal reflections on the process.

Summary and Overview of Findings: The Experiences of Staff Working with Vulnerable Populations: Racism, Power, and Psychological Impact

A systematic literature review of research exploring staff experiences of working within Domestic Violence (DV) shelters yielded nine studies for review. With the use of a thematic synthesis approach (Thomas & Harden, 2008), four analytical themes were generated: emotional weight of the work, connecting with others, power versus empower, and making it through. The empirical study used a qualitative approach to explore staff experiences of racism within the homeless sector. Seven participants agreed to take part in the study and individual semi-structured interviews were used to explore their experiences. A phenomenological approach to thematic analysis was adopted to support an in-depth understanding of staff experiences (Smith et al., 2022). This resulted in five themes: experiencing racism in blatant and subtle forms, powerlessness, feeling unheard and misunderstood, psychological impact, and perseverance and protection.

Several key observations were considered necessary to highlight when reviewing the findings across the literature review and empirical study. Firstly, both studies explored the experiences of staff working with vulnerable populations that have experienced trauma. The literature review included staff working with individuals who have experienced DV. The empirical study participants worked with a population who have likely experienced trauma in their lifetime (Buhrich et al., 2000) and are experiencing the trauma of homelessness (Tsai et al., 2020). This presented unique challenges for participants across the studies. For participants working in DV shelters, this typically involved discussions on the difficulties of being exposed to the psychological and physical effects of DV. Whilst the emotional challenges of working closely with homeless individuals experiencing trauma have been found in existing research (e.g., Peters et al., 2021), the present empirical study highlighted the explicit prioritisation of service user vulnerabilities by those in senior positions. For example, by expressing the need to be ‘professional’ and justifying racism due to service users' mental health. Therefore, a key finding across the studies relates to the challenges participants faced when managing their wellbeing in a context where service user vulnerabilities take precedence.

Importantly, the present studies bring the vulnerabilities of the participants to the forefront, for example, by highlighting the psychological trauma experienced. However, it is essential to note the distinction between experiencing the insidious nature of racism as a direct trauma (Williams et al., 2021) as discussed in the empirical study, and the secondary traumatic stress (Figley, 1995) and vicarious trauma responses (McCann & Pearlman, 1990) found in the literature review. Nevertheless, the detrimental psychological impact was evident across both studies with participants’ citing difficulties including disturbed sleep, increased anxiety, and fears of personal safety.

Furthermore, whilst it has been argued that individuals working in structures capable of maintaining injustices are responsible for addressing existing inequalities (Young, 2006), particularly those in positions of power (Ozturk & Berber, 2020), participants across both studies faced barriers when accessing support on an organisational and systemic level. Staff experiencing racism were often met with a lack of action after reporting a racist incident and an overall lack of insight into their experiences from those in authoritative positions, including the police, unions, and management. Participants working in DV shelters felt there was a lack of insight, on a systemic level, into residents' needs and experiences, leading to inadequate funding and resources for an already stretched service. Subsequently, participants across the studies discussed a sense of powerlessness in changing their circumstances.

The sense of powerlessness in the face of organisational and structural barriers was coupled with the onus placed on the participants to manage their challenges. For participants in the literature review, this typically related to providing practical and emotional support to residents, despite the limited resources to offset the emotional weight placed on shelter staff. In the empirical study, participants were also challenged to continue working in an environment with limited support in the face of racism. Lloyd et al. (2009) argued that the responsibility of managing work-related stresses, and the consequences, has been placed on workers in health and social care settings for too long, and as found in the present studies, led to participants feeling emotionally exhausted.

Another observation when reviewing both studies was the commonality of participants' working environments. The participants of the literature review all worked or have previously worked in DV shelters. Although unintentional, six participants in the empirical paper worked in shelters for homeless individuals, whilst the remaining participant worked in a homeless shelter for 15 years prior to their role at the time of the research interview. This brought about some key considerations. Firstly, DV and homeless shelters provide a safe refuge for vulnerable populations with a high prevalence of complex needs, including mental health and drug and alcohol-related challenges (Burnett et al., 2016; Moore et al., 2010). As noted in the present studies, staff working in both shelters provide practical and emotional support to residents (Adisa et al., 2020; Sullivan & Virden, 2017). The literature review also highlighted the challenges faced when enforcing rules and boundaries that residents must adhere to (e.g., Merchant & Whiting, 2015), which Peters et al. (2021) document as a challenge experienced by staff working in homeless shelters.

The challenges of staff in the present studies were further emphasised by working in residents living spaces, as one participant noted in the literature review, “You almost live with them” (Peled & Dekel, 2010, p.1229). For participants in the empirical study, experiences of racism were compounded by multiple verbal attacks throughout the day and racist residents who could stay in the shelter for over a year. Thus, risking long-lasting psychological trauma as a result of the prolonged and cumulative racism endured (Williams et al., 2021). In the literature review, participants spoke of repeated exposure to residents' traumatic material. The cumulative exposure to such trauma risks higher levels of secondary traumatic stress (Lu et al., 2023). Therefore, the findings across the studies highlight that the all-encompassing nature of shelter work likely heightens the challenges participants face.

A key finding connecting both studies is the experience of racism. In DV and homelessness literature, racism is rarely considered from the staff perspective. However, participants across the studies experienced negative responses from service users, including refusal to work with staff members from ethnic minority communities. The findings support existing literature in other areas of health and social care settings that have begun to shed light on staff experiences of racism and its detrimental impact on staff wellbeing (e.g., Goto et al., 2013; Snyder & Schwartz, 2019).

In addition, the need for support from managers and colleagues, and an overall supportive culture was evident in both studies. Newell and MacNeil (2010) note this to be particularly important when working with vulnerable populations. In the literature review, support from colleagues and management worked to reduce stress and when this support was lacking, increased burnout fitting with existing research assessing burnout levels in nurses (Velando-Soriano et al., 2019). The empirical study emphasised the need for others to take a stand against racism, with barriers to change including a lack of diversity and insight from those in senior positions. Participants across both studies echoed a need to be heard and understood by those they worked with. This was considered particularly crucial given the significant emotional toll experienced by participants.

Overall, the present thesis offers key considerations into the experiences of staff working with vulnerable populations. Whilst differences were apparent in discussions of challenges faced, the findings across both studies highlight the difficulties of working in a context where service user vulnerabilities are prioritised, staff experience powerlessness, and the broader organisational and systemic factors contribute to an overall detrimental psychological impact. Insight into the importance of a culture that promotes feeling supported and understood was also presented.

Personal Reflections on the Research Process

Selection of research topics.

As a first-generation British Indian woman, the experience of feeling othered has been common since I was young. This was not something I fully understood growing up and, at times, came from places of good intention and curiosity. An example is when a teacher asked me at school to let all the white children ask me, and the other black and brown children, questions to show we were ‘all the same.’ It was not until later that the true irony of the experience dawned on me, and the realisation of the power differential that served to silence my discomfort felt at the time.

The experiences of racism in my professional life have also been somewhat misguided. For example, one clinical psychology placement supervisor continuously asked me to work with any brown client that came into the service. Whilst the benefits of working with psychologists from the same ethnic minority community are documented (Cabral & Smith, 2011), it was the lack of discussion and a sense of being singled out for being brown that did not sit comfortably. Whilst the nuances of racism were certainly ever-present in many parts of my life, it was not until I worked as a support worker on a hospital ward, that my frustrations greatly increased. On the ward, I witnessed racism in the form of racial slurs, physical attacks, and refusal to work with staff from ethnic minority communities. During discussions with management, the common response was to take five minutes or ‘this is part of the job’. I later worked in a homeless service as a trainee clinical psychologist. Through conversations with staff working in direct care roles, I found that the experiences of the ward were mirrored in interactions with staff and clients within the service. The commonality of both services appeared to be the dismissal of racism based on the embedded ethos of prioritising the vulnerabilities of service users, whilst crucial, I strongly felt this should not result in the silencing of racism and its devastating effects. It was therefore a personal passion to bring to light staff experiences of racism when working with vulnerable populations in an area that has not been explored, the homelessness sector.

Regarding the literature review, I hoped to expand understanding of the experiences of staff working in homeless services. However, these findings were presented in an existing meta-synthesis (i.e., Peters et al., 2021). Whilst the review did not discuss experiences of racism, it offered extensive insight into staff's emotional experiences and challenges. Additionally, I hoped to review staff experiences of racism in other areas where staff work with vulnerable populations, such as the DV field. Some literature commented on DV staff experiences of racism. However, this was minimal and following discussions with my research supervisors, did not meet the criteria for a systematic literature review.

My personal determination to continue searching for a topic that focused on staff perspectives was important. However, this resulted in a long process that ultimately left me feeling deflated and saddened by the scarcity of such research in health and social care settings. Despite the challenges faced, I was extremely pleased with the final literature review topic. I felt this complimented the empirical study well in a way that heightened the awareness of difficulties faced when working in challenging environments. The particular focus on shelters allowed for a more nuanced look at staff experiences of working closely and continuously with vulnerable individuals.

Empirical study data collection and analysis reflections.

As a researcher who is Indian, has experienced racism in personal and professional life, and has worked in homeless services, researcher reflexivity remained critical throughout the process. I maintained my reflective stance by keeping a reflective journal (Wall et al., 2004) noting down any preconceptions I may have due to my personal experiences, the positions I hold in society, and any emotional responses I experienced throughout the process (Braun & Clarke, 2022). Whilst I understood I would have some influence as a researcher and human being (Chan et al., 2013), regular supervision allowed me to bracket any subjectivity to best minimise influence at all stages of the process, allowing for a more accurate representation of participants' experiences (Jootun et al, 2009).

It was particularly important to extend reflections beyond the benefits of being an ‘insider,’ which can include deeper awareness of the challenges faced and bringing a sense of comfort to participants (Chavez, 2008), to the more likely scenario of being a combination of both an ‘insider’ and ‘outsider’ (Braun & Clarke, 2022). This is particularly likely given the nuances of researcher/participant identities (Braun & Clarke, 2022). The subsequent complexities of which were not lost on me. For example, although I have experience working in homelessness settings, it was important to recognise my role within the psychology department greatly differed from the roles of participants in support worker roles. Furthermore, my experiences of racism may vary from experiences of racism for participants.

Nevertheless, when carrying out research interviews, I regularly noted times I felt I could relate to the experiences of participants. These invoked feelings of sadness, anger, frustration, and a desire to break away from the researcher role and share my experiences. However, I maintained a ‘not-knowing’ stance to ensure an in-depth insight into the roles and experiences of participants. I regularly reminded myself of the importance of adherence to the researcher-participant dynamic, utilising supervision to share and understand my emotional responses. There were also times during the interview when I felt a great desire to offer a more therapeutic approach. This was reinforced by my role within the service as a trainee psychologist. Whilst I ensured my desire to offer a therapeutic stance did not take precedence, I maintained a compassionate approach to interviewing. This included offering space for participants to express any emotions they felt, ensuring a non-judgemental stance, and allowing time for breaks if needed.

Following the interviews, some participants spoke about the surprise they felt at their responses during the interview, including crying. For many participants, this was their first time speaking about their experiences of workplace racism. I found myself feeling both saddened by this and extremely appreciative of the willingness to share such difficult experiences. Furthermore, one participant discussed fears the research would be a ‘tick box exercise’ towards anti-racism at work. This was particularly challenging for me as it invoked concerns my research would somehow take away from the focus of sourcing anti-racist incentives into the service. However, with the use of supervision, I reconciled that this was a deeper-rooted issue and one that enhanced the need for the present research.

Furthermore, in response to sending emails to managers of services for recruitment purposes, which was then circulated across many teams and departments within homelessness services, I received emails from managers/heads of departments looking to share the findings with their teams. This felt extremely positive, and I felt hopeful the research can support generating future conversations on racism within homeless services. However, I also received a couple of emails from a manager and a head of the department voicing concerns the research would reflect badly on the department/organisation. Wanting to appease the situation, my supervisor responded to the concerns reassuring them this would not be the case. Whist, I also felt the pressure to reassure, this felt dismissive of the issue at hand and the overall aim of shedding light on experiences of racism. Looking back on this experience, I felt in some way this reflected the experiences of the participants working in an organisation that's fears of being seen as racist risk muting conversations needed for change.

Reflections on terminology/inclusivity

The terminology used in both papers was very important to me. I felt strongly I did not want to exclude anyone, this included attempting to use language that did not resonate with those who had experiences of the issues discussed. For example, I appreciate the varying preferences in the use of the term's 'victim' and/or 'survivor', when referring to individuals who have experienced DV. For example, the use of 'survivor' can be a source of empowerment, however for others may elicit dismissive feelings. Therefore, I avoided these terms where possible. I also found myself feeling frustrated when searching for definitions of DV that commonly dismiss DV experiences outside of cisgender women. Whilst highlighting the extreme prevalence of violence against women is a matter close to my heart, it remains critical to ensure DV is understood in its most inclusive sense. Therefore, when introducing the literature in the review, I ensured a more inclusive overview of DV.

The term 'ethnic minority communities' was used as guided by the Lancaster University ethics board and the UK government. In one way I felt relieved the guidelines did not suggest the use of Black, Asian and Minority Ethic (BAME) terminology. Whist BAME is something I adamantly avoid due to personal feelings of misrepresentation and awareness of similar responses (Aspinall, 2021), I do not find myself feeling overly comfortable referring to myself as a member of an ethnic minority community, perhaps giving its grouping together of many nationalities and cultures that seem to remove differences to be celebrated. Personally, I am more comfortable with referring to myself as a brown woman. However, for the purpose of the present research ‘ethnic minority communities’ felt the most fitting terminology given the guidelines, its concise nature, and hopes for the removal of terminology that others may find offensive, such as BAME.

Clinical Implications

Across both DV and homeless settings, it is important to consider the role of clinical psychology. Within homelessness settings, Psychologically Informed Environments (PIE) work to offer support and understanding to service users and staff, with the use of trauma-informed care principles (Schneider et al., 2022). Within the PIE model, Clinical Psychologists (CPs) support the implementation of practices, including reflective practice and staff training. However, the presence of CPs interventions within DV settings is scarce (Chapman & Monk, 2015). Increasing the presence of specialist support through CPs could work to implement PIE models in DV settings. Furthermore, given the evidence on racial trauma (Carter, 2007), CPs could work to incorporate trauma-informed care for staff experiencing racism.

In addition, it is also important to note the need for traditional Euro-centric clinical psychology to broaden its scope of support, allowing for more culturally competent interventions. Whilst clinical psychology training has begun to incorporate such interventions (Benuto et al., 2019), a greater focus on supporting individuals experiencing racism would work to ensure that trainees qualify with more expertise in this area. This could include training on the impact of racism on healthcare professionals which they may offer interventions incorporating reflective practice to in the future.

Strengths and Limitations

The majority of research focusing on staff working in DV shelters and in homelessness settings has focused on the service user perspective (e.g., Robinson, 2020; Rhee et al., 2019). The resident perspective offers important insight, such as the barriers faced when accessing care (e.g., Rhee et al., 2019) with the aim to improve services. The research also offers an understanding of the challenges of working with individuals who have experienced trauma, with a particular focus on therapeutic settings (McCann & Pearlman, 1990) and the high turnover rates, staff burnout, and the existence of racism when working within a direct care role with vulnerable populations. However, in the case of staff experiencing racism within the homeless sector, there has been no research, and very limited research offering an in-depth understanding of staff experiences of working in DV shelters. Therefore, a significant strength of the present thesis is the literature review, and the empirical paper, are the first of their kind and illuminate the challenges staff face and the significant impact on their wellbeing.

In terms of limitations, both studies explored extremely difficult topics that likely evoked challenges for participants. For example, for participants in the literature review, discussing work-related challenges may have been diluted due to any data collection methods that included managers and directors. As part of the recruitment process for the empirical study, participants managers were asked to share the study information with their staff. Whilst attention was given to ensure anonymity, it is possible this caused a barrier for participants to take part in the study due to concerns of negative repercussions. Furthermore, the small number of studies within the literature review and the small sample of participants within the empirical studies does not allow for the generalisation of findings outside of the study settings.

Future Research

The present thesis demonstrates a clear need for future research. Firstly, given the limitations in generalisation, it is important to develop further understanding by building upon the present findings. For example, by carrying out research in new geographical areas, both nationally and internationally. Further research on racism in homelessness could focus on areas outside of the shelter setting, such as outreach workers who work with street homeless individuals or staff working in day centres. This will serve to strengthen existing findings through any similarities found, along with offering new insight that may have been missed due to small sample sizes and the specific shelter setting common within the present thesis.

The thesis also offers insight into the unique nature of working closely with service users in their living space. Thus, extending research to staff working in shelter accommodation providing emotional and practical support to vulnerable populations, may serve to develop a more in-depth understanding of the complexities involved in working in such intensive complex environments. However, it remains critical to maintain a specific focus on staff experiences of racism. Therefore, future research could also focus on staff experiences of racism within DV shelters, as found in the present research.

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Section Four: Ethics Documentation

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Doctorate in Clinical Psychology

September 2023

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Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Application for Ethical Approval for Research

Title of Project: Staff experiences of racism within the homelessness sector: An exploratory study.

Name of applicant/researcher: Sharon Sandhu

ACP ID number (if applicable)*: **Funding source (if applicable):**

Grant code (if applicable):

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [link].**

Type of study

Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, *two* and four of this form**

✓ Includes *direct* involvement by human subjects. **Complete sections one, *three* and four of this form**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM: Trainee Clinical Psychologist, Doctorate in Clinical Psychology.

2. Contact information for applicant:

E-mail: s.sandhu@lancaster.ac.uk **Telephone**: [redacted]

Address: [redacted]

3. Names and appointments of all members of the research team (including degree where applicable)

Dr S Hodge, PHD, Lecturer, DHR

Dr A Duxbury, DClinPsy, DHR

3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the FHMREC website

PG Diploma Masters by research PhD Thesis PhD Pall. Care

PhD Pub. Health PhD Org. Health & Well Being PhD Mental Health MD

DClinPsy SRP [if SRP Service Evaluation, please also indicate here:] DClinPsy Thesis ✓

4. Project supervisor(s), if different from applicant:

Research supervisors:

Dr Suzanne Hodge, Lecturer in Health Research, Doctorate in Clinical Psychology, Lancaster University.

Dr Anna Duxbury, Clinical Tutor in Health Research, Doctorate in Clinical Psychology, Lancaster University.

Field supervisor:

Dr Colm Gallagher, Clinical Psychologist, Greater Manchester Mental Health NHS Foundation Trust (Mental Health and Homeless Team)

5. Appointment held by supervisor(s) and institution(s) where based (if applicable):

Dr S Hodge, PHD, Lecturer,DHR

Dr A Duxbury, DClinPsy, DHR

SECTION TWO

Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants

1. Anticipated project dates (month and year)
Start date: End date:

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

Data Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line 'chat-rooms'
no

4c. If yes, where relevant has permission / agreement been secured from the website moderator? no

4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users? no

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

6a. Is the secondary data you will be using in the public domain? no

6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder

7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

8. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes

b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

SECTION THREE

Complete this section if your project includes *direct* involvement by human subjects

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

Individuals that have experienced racism in the workplace are likely to be at greater risk of mental health difficulties including depression, anxiety, and reduced self-identity. Addressing racism within health care settings has typically focused on the impact of individual and structural racism from the perspective of the service user. Whilst this is critical, research into experiences of staff is limited. Nevertheless, existing studies highlight repeated staff exposure to racism in settings where staff are working within proximity of service users regularly.

This study aims to build on research on racism within the care sector by exploring staff experiences within homelessness services. This is yet to be investigated and deemed important given the close working relationships required for effective care. Semi-structured interviews will be used to generate meaningful understandings of how participants perceive and cope with such experiences.

2. Anticipated project dates (month and year only)

Start date: June 2021   End date: Dec 2021

Data Collection and Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

The study will initially aim to recruit 6-8 participants fitting with the practical guidelines for thematic analysis (Braun and Clarke, 2013). At this point, data analysis will be carried out to assess for the level of saturation/sufficiency. If this has not been achieved, up to 6 more participants will be recruited. This was deemed appropriate given existing thematic analysis studies suggest saturation may require closer to 8-12 (Guest et al, 2006, Rhosho, 2011).

Participants will be purposefully selected to ensure information-rich cases related to the topic of interest (Palinkas et al, 2013). All participants will have experienced racism within the workplace. Participants will be recruited from varying contexts within the homelessness sector as to provide insights into shared themes and patterns.

<u>Inclusion criteria:</u>

- Staff working in a direct role with homeless people, including staff working in homelessness residential settings, housing accommodation workers, support workers, staff working in shelters, staff working in day centres, staff working in homelessness outreach teams).
- Must work in proximity of homeless people on a daily basis as part of their role.
- Staff members from ethnic minority communities.
- Have experienced/currently experiencing racism at the workplace.
- English speaker.
- Aged 18+.

<u>Exclusion criteria:</u>

- Do not work directly with homeless people.
- No experience of racism within the workplace.

Participants will be recruited using a first come first served criterion. To reduce the potential for distress if anyone needs to be turned away, a statement will be included in the recruitment materials (participant information sheet, research information webpage) informing the reader that it may not be possible to include everyone that expresses an interest in participating.

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (e.g. adverts, flyers, posters).

Recruitment materials will consist of the following:

- Recruitment poster (Appendix 1): A short summary of what participation in the research will involve, participant inclusion criteria, state all participation will remain anonymous, along with ways of contacting the researcher. The poster will also include a link to a research information webpage.

- Participant information sheet (Appendix 2): this document will include a summary of all the information related to the research. It will be made available for participants who are willing to take part in the research. Information on racism support groups will also be provided.

- Research information webpage: This will include the information in the participant information sheet. This webpage will be on the Lancaster University DClinPsy programme website.

To ensure the appropriate number of participants are recruited (6-12), I plan to recruit in stages.

Stage 1:

- Request permission to share recruitment poster with non-NHS staff members accessing Psychologically Informed Environment (PIE) Training within the trust I am currently based at (Greater Manchester Mental Health NHS Foundation Trust: Mental Health and Homeless Team). Training is accessed by individuals working across the homelessness sector in Greater Manchester. With the permission of the lead facilitator, I will share the recruitment poster at training. This will be shared via the training platform, Microsoft Teams. I will ask people to get in touch if they are interested in receiving the participant information sheet. Attendees will also be asked to share the poster if they are aware of anyone that would be interested in taking part in the research. I will ensure it is made clear that participation in the research is voluntary.

- Team/site managers will be approached directly requesting sharing of the recruitment poster with their team

via email. They will also be asked to share a physical copy in staff rooms. Where possible the recruitment poster will be dropped off to the site or posted to locations that consent to putting up a physical copy. The managers targeted will be those based in varying non-NHS settings nationwide that require face to face working with homeless individuals (e.g. temporary accommodation sites, day centres, outreach teams working to support rough sleepers). Staff managers will be contacted using contact details provided on the service websites.

• When approaching team/site managers, I will also enquire into opportunities to discuss the content of the recruitment poster and participant information sheet at team meetings both face-to-face if this meets with site safety protocol, and within one hours travelling distance, along with any online meetings. This will only take place with agreement of the manager and the individual chairing/facilitating the meeting.

Stage 2 (if appropriate number of participants has not been reached in stage 1):

• Recruitment poster shared with The Frontline Network – network supporting workers from the public, statutory and voluntary sectors working on the frontline with people experiencing homelessness across the UK. Will request sharing of the recruitment poster via online channels/request posting on community forum via the website - https://www.frontlinenetwork.org.uk/

• Recruitment poster shared via Riverside Foundation: not for profit housing association organisation supporting ‘single homeless’ with over 160 housing sites for across the country: I will use contact information via the website https://www.riverside.org.uk/, along with the number listed on the Riverside Facebook Group requesting the recruitment poster be shared with Riverside employees, on the website, and on Riverside social media platforms:

Facebook: https://www.facebook.com/RiversideHousing/

Twitter: https://twitter.com/riversideuk?lang=en

Stage 3 (if appropriate number of participants has not been reached in stage 1 and 2):

• Charities working within the homeless sector will be contacted using the contact forms/emails listed on their websites requesting the sharing of the recruitment poster on their forums, websites, social media accounts, and shared with staff via email communications. I have identified the following charities:

- Shelter (https://england.shelter.org.uk)

- Homeless Link (www.homeless.org.uk)

- Centrepoint (https://centrepoint.org.uk)

- Crisis UK (https://campaigns.crisis.org.uk)

Stage 4(if appropriate number of participants has not been reached in stage 1, 2 and 3):

• Social Media: Professional accounts, utilising my personal name with professional contact details, will be setup for the purposes of recruitment.

- Twitter: Recruitment poster on Lancaster DClinPsy Account, Mental Health and Homelessness Twitter account for staff, along with other professional accounts.

- Twitter, Facebook, and Instagram: Asking colleagues to share the recruitment poster on their social media platforms, including colleagues within the clinical doctorate and from my current workplace (Mental Health and Homeless Service). The aim is to widen the reach of the recruitment poster through networking and snowballing.

- Recruitment poster shared on UK based racism support groups. I will get in touch with the admin to ask if they can share the recruitment poster. I have identified the following group:

UK Against Racism Facebook Group: https://www.facebook.com/UKAgainstHate

• Recruitment poster on racism support, campaign led organisations. I will contact the organisations using the contact details via their websites (contact form, telephone, email). If there is a telephone option available, I will use this in the first instance to request sharing of the recruitment poster. I will ask them to share the poster on their website and social media accounts. I have identified the following organisation:

- “People of Colour led campaign group tackling racism within the charitable sector” (https://charitysowhite.org).

Potential participants will be able to contact me using the contact details provided on the recruitment poster. The details will include a non-personal research mobile number and my professional Lancaster University email. To check for suitability (i.e. meet all inclusion criteria), I will request a telephone conversation. If all criteria are met, I will ensure time Is given to answer any questions the potential participant may have.

A three-month timeframe, from when approval to recruit is received, will be given to recruit participants. If the minimum number has been reached, and it is deemed sufficient for data saturation, recruitment will cease. If this is not the case, a discussion with my research team will be sought. This will include options to continue will existing numbers or widen recruitment methods to include contacting additional sites that have yet to be approached where staff work daily with homeless individuals.

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

Data Collection

Data will be collected using semi-structured interviews allowing for both pre-determined questioning and exploration into participant generated content. It is anticipated the interviews will last between 45-90 minutes. The participant will be given the choice to be interviewed face-to-face at their workplace (if within an hour travelling distance for the researcher), via video call using Microsoft Teams or telephone (audio only). This will allow for greater inclusivity for individuals that are unable to access a computer, have limited or no internet access, prefer to meet face-to-face or prefer to interview outside of the workplace. Prior to arranging face-to-face interviews at an individual's place of work, it will be confirmed there will be suitable location where the interview can take place without any disturbances. Only if this is possible, and the participant is comfortable carrying out the interview at work, will this be offered as option.

Data analysis

Transcripts of the interviews will be transcribed verbatim. A phenomenological approach to thematic analysis will be used to analyse the data. Thematic analysis is considered most suitable to the research question at hand due to its usefulness in addressing existing gaps in the literature and generating scope for further investigation. It is also a useful method for drawing out themes and patterns collected from the perspectives of different participants, highlighting similarities and differences, along with generating unanticipated results (Braun & Clarke, 2006). Whilst a phenomenological approach allows for a depth of meaning by exploring how individuals make sense of their experiences (Smith et al, 2009). I will regularly seek supervision with my research team to ensure I am maintaining an appropriate standard when collecting, analysing, and reporting research findings.

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

I will use my personal laptop to record video, audio, and face-to face interviews using Microsoft Teams given this is a Lancaster University approved method of recording. The recordings will be immediately saved on the university's secure OneDrive within my encrypted folder. The camera function will not be used during face-to-face interviews maintaining anonymity. The recordings will be saved on the Lancaster University secure hard drive accessible remotely via VPN. This will be password protected and saved to Lancaster University Microsoft OneDrive as soon as possible. If for any reason data need to be securely saved for a short time prior to saving to OneDrive, it will be stored on an encrypted, password protected memory stick. This will be stored in a secure location.

When using Microsoft Teams, the interviews will be recorded on my personal laptop using the Teams recording function. These will then be uploaded straightaway to Lancaster University's secure cloud storage (OneDrive). If using telephone call, I will record the interviews using my laptop's recording software. The recordings then will be saved on the secure Lancaster personal hard drive (through VPN), password protected and straightaway uploaded to OneDrive (secure storage cloud). If I encounter any difficulties with these options at the time of saving the recording (e.g. no Internet connection), I will save it on an encrypted and password protected memory stick and upload it to OneDrive as soon as possible (this device will be securely stored in the meantime). No data will be stored on any personal devices.

I will have access to the raw data (recordings and transcriptions), along with both my research supervisors to allow for effective support with data analysis and any potential ethical issues that may arise from the data collected. No other person(s) including my field supervisor will have access to this data.

Teams recordings of interviews will be deleted upon completion of the research project. Transcriptions of the recordings, along with consent forms will be retained in case these are required for any reason until the research has been completed. Following the completion of the research, I will electronically send the data to the research co-ordinator at Lancaster University who will be responsible for the data from that point onwards. The data will be stored electronically at a secure space following Lancaster University protocol. It will be deleted after a period of ten years.

7. Will audio or video recording take place? no ✓ audio ✓ video

7a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

Yes, portable devices will be encrypted.

7b. What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Teams recordings and transcriptions of the recordings will be retained in case these are required for any reason until the research has been examined. Following this, all recordings of the interviews will be deleted. I will electronically send the transcriptions of the interviews, along with consent forms to the research co-ordinator at Lancaster University who will store the data from that point onwards with Dr Hodge acting as data custodian. The data will be stored electronically at a secure space following Lancaster University protocol. It will be deleted after a period of ten years. All data will be immediately deleted from my Lancaster University folders (e.g. OneDrive) following confirmation the data has been transferred to the university.

8. Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

The data underpinning the research will be securely stored electronically at Lancaster University for 10 years. To preserve anonymity, data will not be made publicly available.

8b. Are there any restrictions on sharing your data?

I will ensure all steps are taken to preserve anonymity of participants throughout the research. However, given the small number of participants, there is a risk participant may be identified. Therefore, the data will not be made available.

9. Consent

9a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law? Yes

9b. Detail the procedure you will use for obtaining consent?

Appropriateness for participation in the study will be assessed via a telephone call. Once suitability (i.e. all inclusion criteria are met), has been confirmed, participants have been given time to ask any questions, and have verbally agreed to take part, the consent form will be sent to sign. Participants will be asked to return the consent form signed. They will be able to do this by scanning the document or taking a picture of the signed document and sending it to my Lancaster University email account. Participants will also receive a participant information sheet. Once this step is complete, a suitable time will be agreed to carry out the interviews. Participants will be given 48 hours from receiving the participant information sheet and signing the consent form to reflect and make a final decision about participation.

If a participant is unable to provide written consent, I will obtain verbal consent which will include reading all information from the consent form. This will be recorded and stored separately from the interview data on the Lancaster secure storage cloud for 10 years.

10. What discomfort (including psychological e.g. distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

Given the sensitive nature of the research and exploration into personal experiences of participants, there is potential for emotional responses to the topic. Therefore, participants will receive an outline of the interview topic guide prior to the interview. This will support participants become aware of what will be involved whilst allowed for a more informed decision to take part in the research.

At the start of the interview, information pertaining to the right to withdraw will be revisited. Participants are welcome to withdraw at any point prior, during up to two weeks following the interview. Two weeks considered appropriate given data will be collected and analysed simultaneously. Once data have been analysed, they would not be able to extract/remove the data from the results.

Participants will be given the option to have a break during the interview. If the participant feels the interview is too distressing and it is not possible to continue, an alternative time to meet will be discussed at that time. Alternatively, a follow up call to arrange an alternative time will be arranged. At this point, the participant will be reminded they can withdraw from the process. Space will also be offered following the interview to reflect on the process.

Given the sensitive nature of the research, interviews will only take place at workplace sites if it is the participant's preferred option, the participant and the researcher are comfortable that there is no risk of the setting having a detrimental impact on the researcher or the participant, along with both parties feeling comfortable that the setting will not influence the participant's responses.

will only be selected if both the researcher and participant are comfortable with the interview taking place.

any face-to-face interviews at an individual's place of work, it will be confirmed there will be suitable location where the interview can take place without any disturbances. Only if this is possible, and the participant is comfortable carrying out the interview at work, will this be offered as option.

participants will be asked if they would like the interview to be carried out via telephone (audio), video call, or face-to-face at the workplace.

I will signpost participants to support groups available (Wellbeing and Mental Health Helpline, Stop the Hate UK, 999). A debrief sheet will be provided including and my contact details (non-personal contact number and email) to discuss any concerns that may arise following the interview.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling

considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

All communications with participants will be carried out using professional contact information only. This includes a research only mobile, Lancaster University emails, and professional only social media accounts set up for the purpose of this study.

Given the varying locations for face-to-face interviews, these will only be carried out in locations deemed safe by team managers. Prior to any onsite interviews, I will speak with the managers to ensure a safety procedure is in place (i.e. safety buzzer within the room).

Throughout the research, I will seek support from my research supervisors including during the recruitment, data collection and analysis phases. I will ensure one of my research supervisors is available to contact during interviews in case any issues may arise and advice is required. If I am unable to communicate with my research supervisors for unforeseen reasons, I will contact my clinical tutor.

It is also important to note, my ethnic minority background and my identification of the topic of racism on a personal level. Although, I do not fit the personal criteria for the research or have any concerns this will interfere with the research, it may evoke emotional responses during the research process. To be continuously self-aware in relation to this, I will keep thoughts, responses, and understandings around how my values and experiences my impact the research with the use of a reflexive diary. If I have any concerns in relation to this, I will immediately seek the support of my research supervisors.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

There will be no direct benefits to participating in this study. However, it is possible participants may value a space to discuss their experiences of racism.

The study aims to encourage conversations around racism experienced within the workplace and the potential of such racism from those you care for as part of your job role. The research aims to start a conversation around such matters within a sector where sustainability of its service and staff is critical.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

There will be no incentives taking part in the research.

14. Confidentiality and Anonymity

14a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes

14b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

I will be recording all interviews (video, telephone, and face-to-face) using Microsoft Teams. Therefore, the transcription options on the software will be utilised for all interviews. To optimise anonymity during data collection and analysis, all interview and transcription files will be anonymised. Participants be allocated a pseudonym which will be allocated when saving recordings of the interview, for the purposes of transcription, and data analysis.

Participants will be made aware of confidentiality and its limits (i.e. all information shared within the interview will be kept confidential, the only time this will change is if there is an immediate risk to the participant or another individual discussed in the interview). Confidentiality information will be included in the participant information sheet, on the consent form, and will be discussed at the start of the interview (including use of direct quotes when presenting findings). If a risk issue was to arise, this will initially be discussed with the participant if possible and a discussion with my research supervisor(s) will be sought.

In relation to carrying out face-to-face interviews, it will be made clear to participants this may impact confidentiality. Therefore, participants will be provided with the option to interview via video call and telephone.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

Due to limitations, I have not been able to review the perspectives of a target participant group.

As part of my current role at the Mental Health and Homeless Team, I carried out evaluation interviews at two homelessness hostels around psychologically informed environments. The interviewees of the evaluations included target participants of this research. Interviewees discussed regular experiences of racism whilst at work. They discussed the difficulty working effectively when regularly receiving racism from individuals they provide care for (e.g. residents of the hostels), along with the distressing impact of such racism. Interviewees discussed a need for acknowledgment of such experiences and a desire for effective workplace strategies that minimise the impact of such experiences. Therefore, it was deemed critical to better understand individuals' perspective of those racism when working in the homelessness sector, along gaining an understanding of whether such experiences exist across the homelessness sector.

Participants will be offered space to feedback on the content throughout their involvement in the research. Participants will also be provided with a copy of the interview topic guide prior to the interview. They will be encouraged to contact me via my research-specific mobile or Lancaster University email to discuss any issues that may arise. In the short term, participants will be reminded they are under no obligation to take part in the research, with the aim to take on any feedback moving forward. To do this, a review meeting will the arranged with the research team to discuss implementing any necessary changes.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

- Research findings will be included in my DClinPsy thesis.

- Publication in relevant peer reviewed journals will be pursued.

- Presentation of findings at relevant conferences/training events (e.g. Psychologically Informed Environment training sessions delivered via the Mental Health and Homeless Team)

- Poster with summary of findings to be offered to individuals involved in the research, recruitment process and support groups and organisations for individuals that have experienced racism.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

- Service user safety: If it is disclosed a service user has been mistreated, this will be discussed with my research supervisor and an appropriate course of action will be sought. Transparency in relation to this process will be assured through sharing of the process via the participant information sheet and consent form.

- Whilst the research is specifically interested in the experiences of staff members from ethnic minority communities, it is important that individuals do not feel unfairly targeted based on their ethnicity alone. Therefore, any individual, organisation or support group will be asked to share during the recruitment phase as discussed above and not directly to individually they identify as relevant. For example, team managers will be asked to send the recruitment poster to all individuals within the team.

- Interviewer known to the participant. It is possible, given my role within the homelessness service, participants may have interacted with me on a professional level. Time will be given to discuss any concerns in relation to this. I will assure participants of all confidentiality protocols.

• Impact on service users: Although service users will not be recruited to take part in the study, it is important to note if racism is found to be prevalent, this is likely to impact service users. Therefore, discussions with management to signpost to support groups for anyone impacted by racism will be carried out.

SECTION FOUR: signature

Applicant electronic signature: Sharon Sandhu Date 15 /05/2021

Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review ☐

Project Supervisor name (if applicable): Dr Suzanne Hodge Date application discussed 19/05/2021

Submission Guidance

1. **Submit your FHMREC application <u>by email</u> to Becky Case (**fhmresearchsupport@lancaster.ac.uk) as two separate documents:
    i. **FHMREC application form.**
    Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line.*
    ii. **Supporting materials.**
    Collate the **following materials for your study, if relevant, into a single word document:**
        a. **Your full research proposal (background, literature review, methodology/methods, ethical considerations).**
        b. Advertising materials (posters, e-mails)
        c. Letters/emails of invitation to participate
        d. Participant information sheets
        e. Consent forms
        f. Questionnaires, surveys, demographic sheets
        g. Interview schedules, interview question guides, focus group scripts
        h. Debriefing sheets, resource lists

Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submission deadlines:
   i. Projects including direct involvement of human subjects **[section 3 of the form was completed]**. The *electronic* version of your application should be submitted to Becky Case **by the committee deadline date.** Committee meeting dates and application submission dates are listed on the FHMREC website. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.
   ii. The following projects will normally be dealt with via chair's action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required].** Those involving:
      a. existing documents/data only;
      b. the evaluation of an existing project with no direct contact with human participants;
      c. service evaluations.

3. **You must submit this application from your Lancaster University email address, and copy your supervisor into the email in which you submit this application**

Appendices

Appendix 4-A

RESEARCH PROTOCOL AND RESEARCH MATERIALS

May 2021

Title:	Staff experiences of racism within the homelessness sector: An exploratory study.
Applicant:	Sharon Sandhu
Research Supervisors:	Dr Suzanne Hodge, Lecturer in Health Research, Doctorate in Clinical Psychology Programme, Lancaster University. Dr Anna Duxbury, Clinical Tutor in Health Research, Doctorate in Clinical Psychology Programme, Lancaster University.
Field Supervisor:	Dr Colm Gallagher, Clinical Psychologist, Greater Manchester Mental Health and Homeless Team.

Introduction

The Equality Act (2010) stipulates all individuals are legally protected from any form of discrimination in all aspects of society including the workplace. Nevertheless, experiences of racism have been repeatedly exposed within these settings (e.g. Matsuzaka & Knapp, 2019; Sahraoui, 2019; Ulusoy & Schablon, 2020).

Addressing racism within health care settings has been neglected due to the belief racism does not exist within health care, along with a fear of what may be considered a controversial and challenging issue to address (Johnstone and Kanitsaki, 2008). Nevertheless, existing research highlights racial inequalities in relation to service users. For example, racial inequalities in service users accessing health care (Rhee et al, 2019), along with the quality of care received (Williams & Rucker, 2000).

Despite the growing research base, limited attention has been given to the experiences of racism from the perspective of staff (Rasmussen & Garran, 2016). However, staff members working in health care settings regularly experience racism from those they provide care for. This was found to be particularly prevalent for individuals working within direct care roles within residential settings (Ejaz et al, 2011). Similarly, in a study exploring racism experienced by migrant care workers within an in-patient setting, the majority of individuals interviewed had experienced or witnessed discrimination (Ulusoy & Schablon, 2020). Staff members were found to experience racism in a variety of forms including, verbal abuse, open rejection, covert rejection, and racial violence (Brockmann et al, 2001), along with experiences of 'subtle racism' involving seemingly unharmful racial assumptions including questions around where an individual is from (Mistry & Latoo, 2009).

Studies assessing direct care roles and discrimination suggest individuals from ethnic minority communities are more likely to work in non-qualified roles, such as support positions (Ejaz et al, 2011, Hammond & Yen, 2010). An area of health care that relies on such roles and is currently omitted from the research base is the homelessness sector. Furthermore, coupled with a lack of research in this area, there is a scarcity in recommendations in how best to support staff members experiencing racism. This is particularly important given the findings from several studies suggesting discrimination is associated with mental health difficulties. For example, Hammond et al (2010) found a positive relationship between workplace discrimination and depressive symptoms. Additionally, a meta-analysis investigating the impact of racism on health, found racism to be linked to anxiety, along with negatively impacting an individual's identity, self-esteem, and physical health (Paradies et al, 2015).

It has also been suggested existing associations between staff working directly with homeless individuals and work-related stress may lead to reduced empathy for service users (Lemieux-Cumberlege & Taylor 2019). Therefore, developing an awareness around the experiences of racism will serve to highlight whether further support is required. Subsequently, such research may serve to benefit staff members, service users, and homelessness services looking to provide a more sustainable workplace environment.

The present study aims at exploring staff experiences of racism within the homelessness sector. The investigations will explore what the experiences of racism are, and how people make sense and cope with such experiences.

Method

Design

The present study will utilise a qualitative approach. To address the existing gap in the literature investigating staff experiences of racism within the homeless sector, thematic analysis was deemed the most appropriate approach to analyse the data. Unlike other approaches, thematic analysis is not theoretically bounded and focuses on identifying themes and patterns within the dataset (Braun & Clarke, 2006). Thus, generating scope for further research. To gain a depth of understanding into how people make sense of their experiences, a phenomenological approach to thematic analysis will be adopted.

Data will be collected with one-to-one interviews (semi-structured) and transcribed verbatim. The interviews will be guided by relevant topics to the question at hand, whilst allowing space for participants to share what feels relevant to them.

Participants

The study will initially aim to recruit 6-8 participants fitting with the practical guidelines for thematic analysis (Braun and Clarke, 2013). At this point, data analysis will be carried out to assess for the level of saturation. If this has not been achieved, up to 6 more participants will be recruited. This was deemed appropriate given existing thematic analysis studies suggest saturation may require closer to 8-12 (Guest et al, 2006, Rhosho, 2011).

Participants will be purposefully selected to ensure information-rich cases related to the topic of interest (Palinkas et al, 2013). All participants will have experienced racism within the workplace. Participants will be recruited from varying contexts within the homelessness sector as to provide insights into shared themes and patterns.

Inclusion criteria:

- Staff working in a direct role with homeless people (including staff working in homelessness. residential settings, housing accommodation workers, support workers, staff working in shelters, staff working in day centres, staff working in homelessness outreach teams).
- Must work in proximity to homeless people on a daily basis as part of their role.
- Staff members from ethnic minority communities.
- Have experienced/currently experiencing racism at the workplace.

Exclusion criteria:

- Do not work directly with homeless people.
- No experience of racism within the workplace.

Materials

- Recruitment poster (appendix 1): A short summary of what participation in the research will involve, participant inclusion criteria, state all participation will remain anonymous, along with ways of contacting the researcher. The poster will also include a link to a research information webpage.
- Participant information sheet (appendix 2): this document will include a summary of all the information related to the research. It will be made available for participants who are willing to take part in the research. Information on racism support groups will also be provided.
- Research information webpage: This will include the information in the participant information sheet. This webpage will be on the Lancaster University DClinPsy programme website.
- Consent form (appendix 3): this document will be available for participants that meet the criteria and are willing to take part in the research.

- Debrief sheet (appendix 4): This will include written thanks for participant involvement in the study, an offer to discuss how it felt to be involved in the study, and professional contact details of researcher.

Recruitment

To ensure the appropriate number of participants are recruited (6-12), I plan to recruit in stages. To maximise potential for the appropriate number of participants, recruitment will utilise the following approaches:

Stage 1:

- Request permission to share recruitment poster with non-NHS staff members accessing Psychologically Informed Environment (PIE) Training within the trust I am currently based at (Greater Manchester Mental Health NHS Foundation Trust: Mental Health and Homeless Team). Training is accessed by individuals working across the homelessness sector in Greater Manchester. With the permission of the lead facilitator, I will share the recruitment poster at training. This will be shared via the training platform, Microsoft Teams. I will ask people to get in touch if they are interested in receiving the participant information sheet. Attendees will also be asked to share the poster if they are aware of anyone that would be interested in taking part in the research. I will ensure it is made clear that participation in the research is voluntary.
- Team/site managers will be approached directly requesting sharing of the recruitment poster with their team via email. They will also be asked to share a physical copy in staff rooms. Where possible the recruitment poster will be dropped off to the site or posted to locations that consent to putting up a physical copy. The managers targeted will be those based in varying non-NHS settings nationwide that require face-to-face working with homeless individuals (e.g. temporary accommodation sites, day centres, outreach teams working to support rough sleepers). Staff managers will be contacted using contact details provided on the service websites.
- When approaching team/site managers, I will also enquire into opportunities to discuss the content of the recruitment poster and participant information sheet at team meetings both face-to-face if this meets with site safety protocol, and within one hours travelling distance, along with any online meetings. This will only take place with agreement of the manager and the individual chairing/facilitating the meeting.

Stage 2:

- Recruitment poster shared with The Frontline Network – network supporting workers from the public, statutory and voluntary sectors working on the frontline with people experiencing homelessness across the UK. Will request sharing of the recruitment poster via online channels/request posting on community forum via the website - https://www.frontlinenetwork.org.uk/

- Recruitment poster shared via Riverside Foundation: not for profit housing association organisation supporting 'single homeless' with over 160 housing sites for across the country: I will use contact information via the website https://www.riverside.org.uk/, along with the number listed on the Riverside Facebook Group requesting the recruitment poster be shared with Riverside employees, on the website, and on Riverside social media platforms:
  Facebook: https://www.facebook.com/RiversideHousing/

  Twitter: https://twitter.com/riversideuk?lang=en

Stage 3:

- Contact Charities working within the homeless sector will be contacted using the contact forms/emails listed on their websites requesting the sharing of the recruitment poster on their forums, websites, social media accounts, and shared with staff via email communications. I have identified the following charities:
  - Shelter (https://england.shelter.org.uk)
  - Homeless Link (www.homeless.org.uk)
  - Centrepoint (https://centrepoint.org.uk)
  - Crisis UK (https://campaigns.crisis.org.uk)

Stage 4:

- Social Media: Professional accounts, utilising my personal name with professional contact details, will be setup for the purposes of recruitment.
  - **Twitter**: Recruitment poster on Lancaster DClinPsy Account, Mental Health and Homelessness Twitter account for staff, along with other professional accounts.
  - **Twitter, Facebook, and Instagram:** Asking colleagues to share the recruitment poster on their social media platforms, including colleagues within the clinical doctorate and from my current workplace (Mental Health and Homeless Service). The aim is to widen the reach of the recruitment poster through networking and snowballing.
  - Recruitment poster shared on UK based racism support groups. I will get in touch with the admin to ask if they can share the recruitment poster. I have identified the following group:
    UK Against Racism Facebook
    Group:https://www.facebook.com/UKAgainstHate
- Recruitment poster on racism support, campaign led organisations. I will contact the organisations using the contact details via their websites (contact form, telephone, email). If there is a telephone option available, I will use this in the first instance to request sharing of the recruitment poster. I will ask them to share the poster on their website and social media accounts. I have identified the following organisation:
  - "People of Colour led campaign group tackling racism within the charitable sector" (https://charitysowhite.org).

Potential participants will be able to contact me using the contact details provided on the recruitment poster. The details will include a non-personal research mobile number and my professional Lancaster University email. To check for suitability (i.e. all inclusion criteria is met), I will request a telephone conversation. If all criteria are met, I will ensure time Is given to answer any questions the potential participant may have.

Following this, if the potential participant is happy to go ahead, I will send the participant information sheet and consent form to sign via my Lancaster University email. Participants will be asked to return the consent form signed. They will be able to do this by scanning the document or taking a picture of the signed document and sending it to my Lancaster University email account. Participants will be given 48 hours from receiving the participant information sheet and signing the consent form to reflect and make a final decision about participation. Once this step is complete, a suitable time will be agreed to carry out the interviews.

A three-month timeframe, from when approval to recruit is received, will be given to recruit participants. If the minimum number has been reached, and it is deemed sufficient for data saturation, recruitment will cease. If this is not the case, a discussion with my research team will be sought. This will include options to continue with existing numbers or widen recruitment methods to include contacting additional sites that have yet to be approached where staff work daily with homeless individuals.

All those that showed interest will be thanked for their time.

Data Collection

Data will be collected using semi-structured interviews. It is anticipated the interviews will last between 45-90 minutes. The participant will be given the choice to be interviewed face-to-face at their workplace (if within an hour travelling distance for the researcher), via video call using Microsoft Teams or telephone (audio only). This will allow for greater inclusivity for individuals that are unable to access a computer, have limited or no internet access, prefer to meet face-to-face or prefer to interview outside of the workplace. Prior to arranging face-to-face interviews at an individual’s place of work, it will be confirmed there will be suitable location where the interview can take place without any disturbances. Only if this is possible, and the participant is comfortable carrying out the interview at work, will this be offered as option.

At the start of the interview, time will be dedicated to checking in with the participant (5-15 minutes). This will include ensuring they remain happy to go ahead, making it clear they are able to withdraw at any point during the interview and up to two weeks following the interview. Information pertaining to job role and hours working directly with homeless individuals will be collected at this this time to determine any relevant subthemes based on this information. Anonymity will be revisited, ensuring participants are aware they will not be named. It is predicted these discussions will allow participants to settle into the interview prior to the research question related content. Throughout the interview, consideration will be given to the emotional responses of the participant to the content discussed. Participants will be given the option to have a break during the interview.

If the participant feels the interview is too distressing and it is not possible to continue, an alternative time to meet will be discussed at that time. Alternatively, a follow up call to arrange an alternative time will be arranged. At this point, the participant will be reminded they can withdraw from the process.

The semi-structured interview will utilise an interview topic guide (Appendix 5). Participants will be asked open-ended questions around their motivation to participate in the study, what motivated them to work in their role, what are their general experiences of their role (likes and dislikes). This reflects the structure of similar studies suggesting such questions will allow the researcher to get a general feel about how participants felt about their work (Ryosho, 2011). It will include open questions relating to their experiences of racism at work. Participants will be asked to share specific examples of their experiences. To understand how participants perceive and cope with such experiences, follow up questions will be included (i.e. how did such an experience/s make you feel? How did you cope when you experienced racism?).

At the end of the interview, participants will be given the opportunity to ask any questions and to and reflect on the interview experience. They will also be reminded of available sources of support (Stop the Hate UK for support and reporting, 999). They be provided with a debrief sheet thanking them for their participation. This will also include an invite to contact me post interview if they wish to reflect on the process after the interview. The debrief sheet will be emailed to participants within 24 hours of the interview. At this stage, participants will also be asked if they would be happy to receive the details of another researcher, who they can get in contact with if they wish to be involved in further research on racism in homeless services (as an advisor not a participant). I will ensure participants are aware they are under no obligation to receive the details and/or make contact with the researcher.

The interview topic guide was developed with advice from my research supervisors. Guidance was taken from similar studies (e.g. Ryosho, 2011), and guidance outlined by McGrath et al (2018).

Data analysis

Transcripts of the interviews will be transcribed verbatim. A phenomenological approach to thematic analysis will be used to analyse the data. Thematic analysis is considered most suitable to the research question at hand due to its usefulness in addressing existing gaps in the literature and generating scope for further investigation. It is also a useful method for drawing out themes and patterns collected from the perspectives of different participants, highlighting similarities and differences, along with generating unanticipated results (Braun & Clarke, 2006). Whilst a phenomenological approach allows for a depth of meaning by exploring how individuals make sense of their experiences (Smith et al, 2009)

To enhance methodological and ethical rigour, I will keep a reflexive diary. This will be updated throughout the research process. This will include information on the decisions that have been made with rationale, along with maintaining a sense of self-awareness in relation to how my values, experience and beliefs may interact with the data (Thomas et al, 2011). In addition, I will regularly seek supervision with my research team to ensure I am maintaining an appropriate standard when collecting, analysing, and reporting research findings.

Data Management

The data collected will consist of personal data relating to participant demographics and job role, and interviews (recorded and transcribed). All data will be stored in Lancaster University's approved secure cloud storage. No recordings will be saved on any personal devices.

All video interviews will be carried out via Microsoft Teams and will therefore be recorded using the Teams record function. I will utilise my laptop (personal) to do this. The recording will be immediately saved on the university's secure OneDrive within my encrypted folder. Face-to-face and telephone interviews will also be recorded using the recording function on Microsoft Teams given this is a Lancaster University approved method of recording interviews. The camera function will not be used during face-to-face interviews maintaining anonymity. The recordings will be saved on the Lancaster University secure server accessible remotely via VPN. This will be password protected and saved to Lancaster University Microsoft OneDrive as soon as possible. If for any reason data needs to be securely saved for a short time prior to saving to OneDrive, it will be stored on an encrypted, password protected memory stick. This will be stored in a secure location.

I will have access to the raw data (recordings and transcriptions), along with both my research supervisors to allow for effective support with data analysis and any potential ethical issues that may arise from the data collected. No other person(s) including my field supervisor will have access to these data.

Teams recordings and transcriptions of the recordings will be retained in case these are required for any reason until the research has been examined. Following this, all recordings of the interviews will be deleted. I will electronically send the transcriptions of the interviews, along with consent forms to the research co-ordinator at Lancaster University who will store the data from that point onwards. The data will be stored electronically at a secure space following Lancaster University protocol. It will be deleted after a period of ten years. All data will be immediately deleted from my Lancaster University folders (e.g. OneDrive) following confirmation the data has been transferred to the university.

Ethical considerations

- Participation should only take place on a voluntary basis and through no persuasion from the researcher or organisation sharing research details. Initial conversations will assess for individual interest and voluntary participation.

- Anonymity of participants must be ensured. Participants will be allocated a pseudonym which will be used when saving recordings of the interview, for the purposes of transcription, and data analysis.
- Confidentiality: Participants will be made aware of confidentiality and its limits (i.e. all information shared within the interview will be kept confidential, the only time this will change is if there is an immediate risk to the participant or another individual discussed in the interview). Confidentiality information will be included in the participant information sheet, on the consent form, and will be discussed at the start of the interview. If a risk issue was to arise, this will initially be discussed with the participant where possible, and a discussion with my research supervisor(s) will be sought.
- Service user safety: If it is disclosed a service user has been mistreated, this will be discussed with my research supervisor and an appropriate course of action will be sought. Transparency in relation to this process will be assured through sharing of the process via the participant information sheet and consent form.
- Potential for emotional responses to the topic discussed: Participants will receive a copy of the interview topic guide prior to the interview. This will support participants become aware of what will be involved whilst allowing for a more informed decision to take part in the research. Space will also be offered following the interview to reflect on the process. I will signpost participants to support groups available. A debrief sheet will be provided including and my contact details (non-personal contact number and email) to discuss any concerns and/or reflections that may arise following the interview. Additionally, participants will be assured of their right to withdraw from the research prior to, during and two weeks following the interview.
- Recruitment of participants: I anticipate the recruitment of participants may prove difficult due to potential concerns discussing work related difficulties, along with meeting face-to -face in working environments. I will ensure all options regarding interviews (e.g. telephone, video) are offered. Furthermore, I will ensure participants are fully aware of all confidentiality protocols during the recruitment process.
- Whilst the research is specifically interested in the experiences staff members from ethnic minority communities, it is important that individuals do not feel unfairly targeted based on their ethnicity alone. Therefore, during the recruitment phase, team managers will be asked to send the recruitment poster to all individuals within the team.
- Interviewer known to the participant. It is possible, given my role within the homelessness service, participants may have interacted with me on a professional level. Time will be given to discuss any concerns in relation to this. I will assure participants of all confidentiality protocols.
- Impact on service users: Although service users will not be recruited to take part in the study, it is important to note if racism is found to be prevalent, this is likely to impact service users. Therefore, discussions with management to signpost to support groups for anyone impacted by racism will be carried out.

Timescales

- Submit application to university ethics: May 2021
- Recruitment Process: June/July 2021
- Data collection: June/July 2021
- Data analysis: July/August 2021
- Research paper writing up: August /Sept 2021
- Submission of draft report: Oct 2021
- Deadline for submission of final report: Nov 2020
- Dissemination to the service: Jan-April 2022
- Submit for Publication: Jan- April 2022

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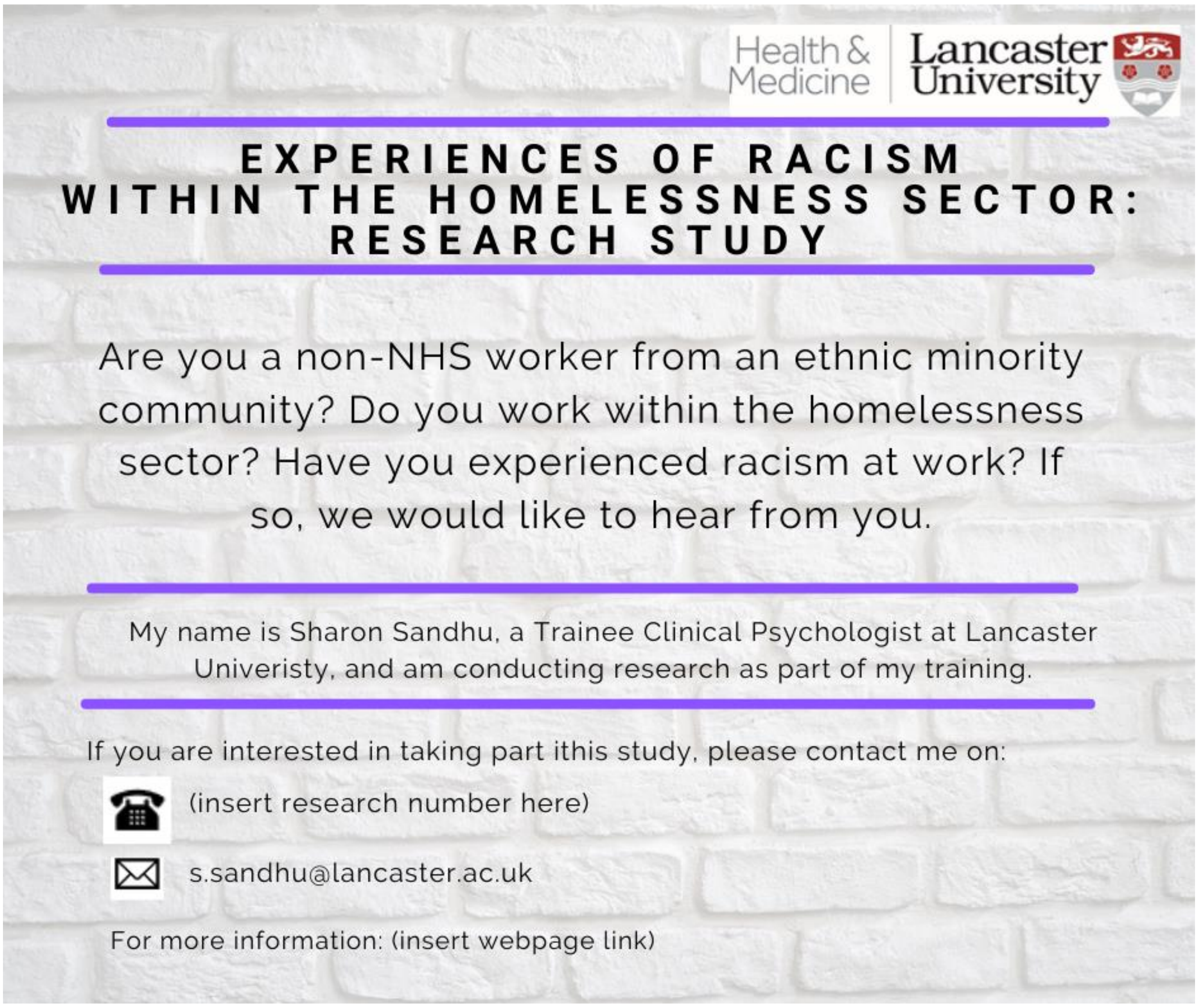
Appendix 1

Recruitment Poster



Health & Medicine | Lancaster University

EXPERIENCES OF RACISM WITHIN THE HOMELESSNESS SECTOR: RESEARCH STUDY

Are you a non-NHS worker from an ethnic minority community? Do you work within the homelessness sector? Have you experienced racism at work? If so, we would like to hear from you.

My name is Sharon Sandhu, a Trainee Clinical Psychologist at Lancaster Univeristy, and am conducting research as part of my training.

If you are interested in taking part ithis study, please contact me on:

☎ (insert research number here)

✉ s.sandhu@lancaster.ac.uk

For more information: (insert webpage link)

Appendix 2

Participant Information Sheet

Staff experiences of racism within the homelessness sector: An exploratory study

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage:

www.lancaster.ac.uk/research/data-protection

My name is Sharon Sandhu, Trainee Clinical Psychologist. I am conducting this research from Lancaster University, Lancaster.

What is the study about?
The purpose of this study is to explore staff experiences of racism within the homeless sector. I am interested in hearing about experiences of people in non-NHS employed roles that work directly with homeless individuals on a daily basis. The aim of the study is to start a conversation around such experiences and develop understandings of how best to support staff members experiencing racism.

Do I have to take part?
No. It's completely up to you to decide whether or not you take part in the study.

What will I be asked to do if I take part?
If you decide you would like to take part, you would be asked to take part in an interview. It is predicted the interview will last up to 45-90 minutes. During the interview I will ask you a few questions to guide the conversation whilst encouraging you to discuss what feels relevant to you. The interview can take place face-to-face at your workplace. I understand this may not be suitable, therefore we can arrange a telephone or video call. Microsoft Teams will be used for the video call. If you have any difficulties setting this up, I am happy to help. The interview will be recorded for the purposes of the research only.

If you change your change your mind and no longer wish to take part in the study, you can withdraw any time until two weeks after the interview has taken place without giving any reason.

Will my data be Identifiable?

The data collected for this study will be stored securely on Lancaster University's approved cloud storage OneDrive. Only the researcher conducting the study (me) and the research supervisors will have access to this data. The files on the computer will be encrypted and the computer itself password protected.

All recordings will be deleted once the project has examined. Any other files (e.g. transcriptions, consent forms) will be securely stored for 10 years. At the end of this period, they will be destroyed.

All your personal data (name, age, job role) will be confidential and will be kept separately from your interview responses. The typed version of your interview will be made anonymous by removing any identifying information including your name (I will use pseudonyms). Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them. All reasonable steps will be taken to protect the anonymity.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to a member of staff about this. If possible, I will tell you if I have to do this.

What will happen to the results?

The findings will be summarised and reported in my doctoral thesis and may be submitted for publication in an academic or professional journal. The hope is to encourage conversations around racism experienced whilst providing care, encourage further research, and inspire implementation of support strategies specifically designed for staff experiencing racism within the homelessness sector.

Are there any risks?

It may be difficult to discuss experiences of racism. This will be considered at every stage of your involvement in the study and after. If you have any questions or concerns prior to or following the interview, please get in touch and I would welcome any discussions on this. If during the interview you felt it was proving difficult to continue, we can take a break, arrange an alternative time to meet or you can decide you no longer wish to take part in the study. If you experience any distress following participation you are encouraged to contact the resources provided at the end of this sheet.

Are there any benefits to taking part?

There are no direct benefits for taking part in the study. However, some may find it helpful talking about their experiences of racism openly.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, you can contact me by email:

s.sandhu@lancaster.ac.uk, or by phone: [redacted]

You can also contact my research supervisors:

Dr Suzanne Hodge: s.hodge@lancaster.ac.uk.
Dr Anna Duxbury: a.duxbury@lancaster.ac.uk.

Complaints
If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Dr Ian Smith, Programme Research Director.
i.smith@lancaster.ac.uk
+44 (0)1524 592282
Health Research
Lancaster University
Lancaster
LA1 4YG

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Dr Laura Machin Tel: +44 (0)1524 594973
Chair of FHM REC Email: l.machin@lancaster.ac.uk
Faculty of Health and Medicine
(Lancaster Medical School)
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet.

Resources in the event of distress
Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance. .....

- Wellbeing & Mental Health Helpline: 0800 915 4640 (freephone) – Lines open Monday to Friday 7-11pm; Saturday and Sunday 12noon-12 midnight.

- Stop the Hate UK (provides independent, confidential, and accessible reporting and support for victims, witnesses and third parties/Helpline: 0800 138 1625)

- 999 (if you feel you or anyone else is at immediate risk of harm)

Please be aware, that participants will be recruited on a ‘first come first served’ basis, so it may not be possible to include everyone who expresses an interest in participating.

Health & Medicine | Lancaster University

Appendix 3

Consent Form

Staff experiences of racism within the homelessness sector: An exploratory study

We are asking if you would like to take part in a research project exploring the staff experiences of racism within the homeless sector. The aim of the study is to start a conversation around such experiences and develop understandings of how best to support staff members experiencing racism. Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Sharon Sandhu.

Please initial each statement

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study. ☐
2. I confirm that I have had the opportunity to ask any questions and to have them answered. ☐
3. I understand that my interview will be audio/video recorded and then made into an anonymised written transcript. ☐
4. I understand that video/audio recordings will be kept until the research project has been examined. ☐
5. I understand that my participation is voluntary and that I am free to withdraw any time until two weeks after the interview has taken place without giving any reason. ☐
6. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication. ☐
7. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published; all reasonable steps will be taken to protect the anonymity of the participants involved in this project. ☐
8. I consent to information and quotations from my interview being used in reports, conferences and training events. ☐
9. I understand that the researcher will discuss data with their supervisors as needed. ☐

10. I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator will need to share this information with their research supervisors. ☐

11. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished. ☐

I consent to take part in the above study. ☐

Name of Participant___________________ **Signature**_____________________ **Date** ___________

Name of Researcher ___________________**Signature** _____________________**Date**

Appendix 4

Debrief Sheet

Title of the study: Staff experiences of racism within the homelessness sector: An exploratory study

Researcher: Sharon Sandhu

Thank you for your involvement in this study, it is greatly appreciated.

The purpose of this study was to explore the experiences of racism of staff working on a regular basis with individuals they provide support/care for. A particular interest was given to the homelessness sector as this was found to be an area with little research looking into racism from staff members’ perspectives. As this is a new area of research, it was considered vital to talk directly with individuals that have experienced racism within the homelessness sector to gain a better understanding of how staff members perceive and cope with such experiences.

The study aims to encourage conversations around racism experienced within the workplace and the potential of such racism from those you care for as part of your job role. The research aims to start a conversation around such matters within the homelessness sector, a sector where sustainability of its service and staff is critical, along with supporting staff with all aspects of their wellbeing.

The findings of this study will be used to inform my Doctorate in Clinical Psychology Thesis. I will also aim to publish findings in professional journals.

If you would like to get in touch to discuss any of the following:

- How did you find the recruitment process?
- How did you find the interview?
- How did you feel during the interview?
- How do you feel following the interview?

Or would like to share any additional comments related to your participation in the research, please do not hesitate to get in touch with me using the contact details below:

Email: s.sandhu@lancaster.ac.uk

Mobile: (insert research mobile number)

Appendix 5

Interview Topic Guide

Introduction to include:

- Introduction to the researcher's role
- Confidentiality and its limits
- Consent/withdrawal from study (including use of quotes)
- Breaks/option to rearrange of required.

Break/rearrangement options if required Opening Questions (select a few):

- Can you tell me a little bit about yourself?
- Please can you tell me what you do in your role.
- How long have you worked in your role/homeless sector?
- Can you tell me what motivated you to go for this role?
- How do you feel about the role generally (likes/dislikes)?
- What made you decide to take part in this research?
- You've told me that you have experienced racism whilst at work. Would it be ok if I ask you some questions about that?

Experience of racism within homelessness sector:

- Can you tell me a little more about your experiences of racism?
- If you don't mind, can you give me an example(s) of when you experienced racism at work?
- How often do you experience racism at work?

Responses and coping when experiencing racism:

- How do you cope with such experiences?
    - How do you respond emotionally to these experiences of racism?
    - What do you do in response to these?
    - Is there anything that helps/doesn't help with racism at work?

Organisational and environmental factors/responses from others:

- Why do you think racism exists within your workplace?

- What do you think other people think about these experiences of racism (e.g. colleagues/team responses/service users)?
- How do others at your workplace respond to experiences of racism at work (e.g. colleagues/team responses)
- Is there anything that would be helpful /unhelpful in relation to supporting you when experiencing racism at work?

Prompt questions:

- Can you tell me a bit more about that?
- Could you explain that a bit more?
- How do you feel about that?
- Why do you think that is?

Probe Questions:

- Can you tell me what you mean by X?
- Why do you think this might be the case?

Appendix 4-B

Ethics Approval Letter

Lancaster University

Applicant: Sharon Sandhu
Supervisor: Professor Bill Sellwood, Dr Anna Duxbury,
Department: DHR
FHMREC Reference: FHMREC20147

21 June 2021

Re: FHMREC20147
Staff experiences of racism within the homelessness sector: An exploratory study

Dear Sharon,

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Email: fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

[redacted]

Tom Morley,
Research Ethics Officer, Secretary to FHMREC.