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Faculty of Environmental Life Sciences

School of Psychology

ATTITUDES TOWARDS HOMELESS PEOPLE, BELIEFS AND BURNOUT AMONG NHS STAFF IN PHYSICAL AND MENTAL HEALTH WORK SETTINGS

Volume 1 of 1

by

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Abstract

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ATTITUDES TOWARDS HOMELESS PEOPLE, BELIEFS AND BURNOUT AMONG NHS STAFF IN PHYSICAL AND MENTAL HEALTH WORK SETTINGS

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Previous research has highlighted a strong association between mental illness and repeat homelessness. Despite this, there is a dearth of literature exploring the processes and mechanisms that underpin this relationship. The first chapter of this research aimed to address this gap by exploring how mental health problems are implicated in the maintenance of repeat homelessness, using realist synthesis. This realist review systematically appraised theoretical and empirical literature across a number of contexts, and iterative searches highlighted 37 relevant and rigorous articles eligible for inclusion. Themes across the literature were abstracted to develop a heuristic model of how mental health problems maintain repeat homelessness via two interacting pathways; social isolation and maladaptive coping (substance-use, gambling, antisocial behaviour). Implications for the findings are discussed and limitations are explored.

Given that staff attitudes are a significant factor impacting accessibility and engagement of marginalised client-groups including homeless clients, the second chapter of this research aimed to explore factors that contribute to stigmatising attitudes in staff working across mental health and physical health settings. Sixty-six health professionals were recruited from a range of NHS settings and were required to complete an online survey exploring demographic factors, psychological factors (attitudes, burnout, evaluative beliefs, effective working with complex clients, stress, support) and professional factors (training and experience). T-tests revealed significant differences between staff with mental health experience compared to physical health staff, such that physical health staff showed more stigmatising attitudes towards homeless clients, lower effective working with complex clients, higher levels of depersonalisation and poorer perceived levels of support. Univariate and multivariate analyses demonstrated significant associations between psychological and professional factors with attitudes, burnout and effective working with complex clients. Clinical implications are discussed and directions for future research are considered.

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Research Thesis: Declaration of Authorship

Print name:	Shalini Raman

Title of thesis:	Attitudes towards Homeless People, Beliefs and Burnout among NHS Staff in Physical and Mental Health Work Settings

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
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6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
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Definitions and Abbreviations

Homeless	Any individuals accessing homeless hostels, living in emergency/temporary accommodation, shelters, or individuals considered sofa surfers, rough sleepers, roofless, or squatters.

Chapter 1: HOW ARE MENTAL HEALTH PROBLEMS IMPLICATED IN THE MAINTENANCE OF REPEAT HOMELESSNESS: A REALIST REVIEW OF THE LITERATURE

1.1 Introduction

Homeless people represent one of the most marginalised and excluded groups in the United Kingdom (UK) resulting in highly problematic outcomes. Exclusion of homeless individuals is multifaceted and is influenced by structural, systemic and individual factors (Chase, 2017). Deconstructing the social exclusion and marginalisation of homeless individuals is complex, given that there are multiple factors at different levels that interact, contributing to repeat homelessness (where individuals experience more than one episode of homelessness in their lifetime). Although there has been substantial research within the recent years exploring the interplay of these factors (Fitzpatrick, Johnsen, & White, 2011), maintenance processes appear to have been neglected altogether and warrant detailed exploration. This will allow the development of appropriate and effective interventions that can break the cycle of perpetuated homelessness and exclusion.

1.1.1 Structural Factors Associated with Homelessness

Traditionally, structural factors have been some of the most considered variables associated with homelessness and explored in the literature. These include economic variables, such as poverty, housing markets, accessibility of education and unemployment, all of which have been detailed as significant risk factors for subsequent homelessness (Fitzpatrick et al., 2011). In a vicious cycle, these factors also play a part in contributing towards further marginalisation and exclusion of individuals, which paradoxically enhances the risk of experiencing homelessness (Bramley & Fitzpatrick, 2018).

The organisation of healthcare. Our health and social systems are governed by a number of structural factors, including economic wealth (Fitzpatrick et al., 2011), and therefore have been

organised on the basis of exclusion and inclusion criteria, in order to achieve an equilibrium between supply and demand (Canavan et al., 2012). Accordingly, homeless clients that present with multifaceted needs are prime candidates for exclusion on the basis of their perceived complexity. In order to address complex needs, integrative interventions are required (Fitzpatrick-Lewis et al., 2011; Rosenheck, Resnik, & Morrissey, 2003). Existing integrative services are in the extreme minority and a move towards this structure nationally, would require significant funding and re-organisation of health and social systems. This would be a challenge in the current climate of the NHS, where demand is significantly outweighing supply and funding (Paudyal & Saunders, 2018). As described by the Inverse Care Law (Hart, 1971), individuals that have the most complex needs are often the least likely to have access to adequate healthcare. This is a phenomenon which directly applies to homeless individuals (Aldridge et al., 2018). It is also acknowledged that in areas where there are the highest levels of morbidity and mortality, there are also higher waiting lists in health and social care services, larger caseloads for staff to manage and fewer resources (Riley, Harding, Underwood, & Carter, 2003). This is strongly related to levels of poverty and deprivation (Marmot, 2005), heightening risks of adverse life events and on-going homelessness (experiences of homelessness that are continuous, without periods of being homed).

1.1.2 Individual Factors Associated with Homelessness

Beneath these structural and systemic factors associated with homelessness, lie individual and interpersonal explanations of homelessness. These include behavioural factors, such as self-harm/suicidality, criminality and substance-use. These behaviours tend to be negatively connoted across society and are often viewed within healthcare as 'problematic', synonymous with poor levels of commitment/motivation, and unwillingness to engage and comply with treatment. This can result in justification for exclusion from services, resulting in needs not being met and an increased likelihood for difficulties to become exacerbated (Canavan et al., 2012).

Psychological factors include personal characteristics (e.g. temperament), mental health problems (as traditionally classified using diagnostic classifications e.g. depression, personality disorder etc. that impair functioning), family breakdown and adverse childhood experiences (ACE's) (Bramley & Fitzpatrick, 2018), and are likely to impact behavioural factors in complex feedback loops. Together these variables can form interdependent relationships, whereby

experiences of trauma yield distress, destabilising the individual's ability to cope. This may result in a greater vulnerability towards developing mental health issues or substance misuse problems (Maguire, Johnson, Vostanis, Keats, & Remington, 2009). Problematically, risks of on-going homelessness increase significantly as a result, because mental health and substance-use problems are likely to interfere with successfully obtaining and maintaining a tenancy (Polcin, 2016). Further to this, experiences of homelessness increase risks of being exposed to additional adversity, making it harder to transition out of homelessness (Fitzpatrick, Bramley, & Johnsen, 2013).

1.1.3 The Interface between Individual Factors and the Environment

There is a complex interplay in the way that individual and interpersonal factors interact with the structures within society which have been shaped through economic, geographical and cultural processes (Bramley et al., 2015). For example, homeless individuals are at a higher risk of having experienced an ACE compared to individuals who are permanently housed, which increases risks of experiencing psychological difficulties, (e.g. attachment difficulties, emotion regulation difficulties and cognitive problems), as well as physical health problems (e.g. heart disease, respiratory problems and HIV), and behavioural difficulties (e.g. aggression, criminality) (Kalmakis & Chandler, 2015). Accordingly, this maladaptive psychological adjustment has an impact on how an individual is able to respond and interact within society. Again, this perpetuates further exclusion and marginalisation as well as an increased vulnerability to on-going homelessness (Maguire et al., 2009).

1.1.4 Mental Health and Homelessness

Within the literature, a number of factors have been shown to be associated with mental illness and repeat homelessness (Fitzpatrick et al., 2013; McQuisition, Gorroochurn, Hsu, & Caton, 2014; Nishio et al., 2017). In order to functionally simplify these dynamic interactions, each factor has been grouped into conceptually similar categories by the researcher and are presented in Figure 1. This hypothesised model incorporates elements of the psychological model proposed by Maguire (2017) of repeat homelessness. The pathways were clustered into problematic observable behaviours, personal factors and structural/relational factors.

Within the psychological-behavioural pathway, psychological processes (the mechanisms that underpin mental health problems, e.g. attentional biases, maladaptive schemas) make individuals vulnerable to engaging in behaviours which are deemed by society as 'problematic', in order to cope with their psychological distress (Kalmakis & Chandler, 2015; Fitzpatrick et al., 2013; McQuisition et al., 2014). Consequently, these 'problematic behaviours', which are incompatible with sustaining a tenancy or obtaining support from services, maintain homelessness. Alongside this, the personal factors pathway outlines how mental health problems can impact individuals' cognitive functioning (organic cognitive capacity; for example, working memory, processing speed) and functional ability (this might relate to the integration of cognitive functioning, physical capacity and socio-emotional capacity, which dictates how able an individual is in their practical functioning within society). This affects the way in which people are able to coordinate with services and structures designed to support them in obtaining and sustaining permanent housing (Nishio et al., 2017). Consequently, this makes people vulnerable to experiencing repeat homelessness. Finally, the structural and relational factors pathway has been one of the more researched areas and highlights how mental health problems can interfere with gaining and sustaining employment, resulting in a greater risk of financial issues and social deprivation. Poverty and unemployment consequently make it problematic for people to sustain their tenancies, resulting in repeat homelessness (Bramley & Fitzpatrick, 2018; Fitzpatrick, 2005). Another key factor is that health and social services remain mostly unintegrated nationally, which means individuals are unlikely to receive holistic care and are likely to be exposed to problematic discharge planning, leading to a greater vulnerability towards experiences of repeat homelessness (Forchuk et al., 2013). It is important to note that there are complex interactions between each of these pathways, which further contribute to the challenges in conceptualising and defining repeat homelessness.

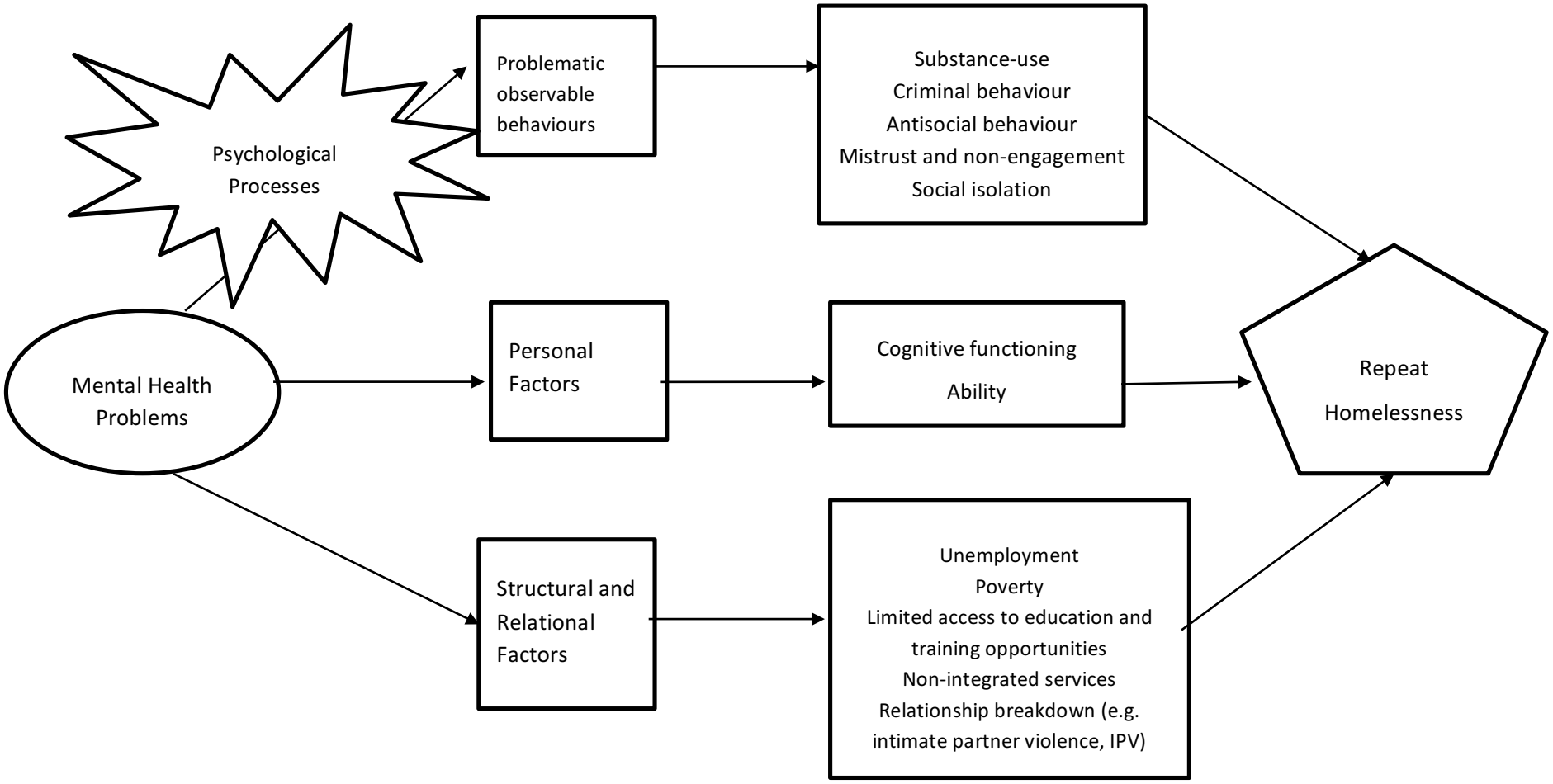

Figure 1. A simplified, hypothesised model demonstrating how mental health problems may be implicated in different pathways contributing to repeat homelessness. N.B. There is a multifaceted interplay between each of the pathways, contributing to the overall complexity of conceptualising repeat homelessness.

1.2 Aims and Objectives

The present review aims to explore the relationship between mental illness and repeat homelessness, specifically, the underlying processes driven by mental health problems that are responsible for maintaining homelessness. Within the scope of this review, the primary focus will be directed towards how mental health problems are implicated in the maintenance of repeat homelessness via the psychological-behavioural pathway shown in Figure 1. This is a priority area, given that developing insight into psychological and behavioural processes may enhance understanding of this client-group and provide information regarding service provision and delivery of interventions that may be effective in breaking the cycle of perpetual homelessness (Bruce, Horgan, Kerr, Cullen, & Russel, 2017; Keats, Maguire, Johnson, & Cockersell, 2012).

1.3 Method

In line with the literature exploring causes of homelessness conducted by Fitzpatrick et al. (2005) the current realist review will use a critical realist epistemological approach. This sits in-between social constructionism, where reality is entirely socially constructed and there are no objective 'truths', just multiple perspectives (Hedges, 2005) and positivism, where there is no acknowledgement of social construction and there is only one objective reality. In other words, a critical realist posits that the world does exist independently of society's perception of it, however, societies co-construct discourses and there may be multiple interpretations of one reality (Bhaskar, 1989; Joseph & Wight, 2010).

1.3.1 Rationale for Realist Synthesis

To date, much of the literature has focussed upon prevalence rates, causation, and risk factors for homelessness. Significantly less of the literature has considered factors associated with repeat or on-going homelessness. Further, to the researcher's knowledge, there is a dearth of research exploring what, how, through what processes and under what context; does repeat homelessness exist and become maintained. Accordingly, a realist review was appraised as being the most helpful

and appropriate way of answering these questions, given that the homeless population is heterogeneous, therefore making generalisable trends and patterns a challenge to define (Wong, Greenhalgh, Westhorp, & Pawson, 2012). Additionally, research concerning homelessness is varied in quality, and the variance in chosen methodology is great, making it difficult to systematically review and draw concrete conclusions from existing literature. Further to this, the level of complexity involved with conceptualising the dynamic interactions between factors associated with homelessness makes conducting empirical research a challenge (Bramley et al., 2015). Data with these characteristics lend themsleves well to exploration through realist synthesis, because generated findings are informed by a combination of existing literature and theory.

The realist review adopts an iterative approach facilitating the development of possible theories, which are refined and shaped by relevant literature generated through repetitive searches (Pawson, Greenhalgh, Harvey, & Walshe, 2005). These backwards and forwards processes result in the development of a middle-range theory. Middle-range theories constitute the process of abstraction from relevant and rigorous research and explain the mechanisms of change responsible for a particular outcome under a specific context (context-mechanism-outcome configurations) (Wong et al., 2012). These middle-range theories developed through realist review are eligible for later empirical testing (Jagosh et al., 2012). Realist reviews do not aim to provide absolute truths, but instead provide opportunities to develop insight into the possible processes and mechanisms that underlie an observed effect (Pawson et al., 2005).

1.3.2 Scoping the Literature

In the initial stages of the review process, scoping of the literature took place using flexible search terms related to 'homelessness', 'repeat homelessness', 'mental health problems', 'substance-use' and 'maintenance'. From these initial searches, it became apparent that there was limited research focusing on mechanisms and processes underlying repeat homelessness and very limited reference to the concept of how individual factors maintain homelessness. This highlighted a gap in the research and shaped the research question for this realist review. This meant that a greater degree of flexibility in selecting papers for review was required to allow the researcher to make inferences. This enabled abstraction of any possibly relevant information from existing research, guided by additional evidence-based psychological theory (Wong, Greenhalgh, Westhorp, & Buckingham, 2013).

1.3.3 Iterative Search Process

From the initial scope, relevant literature was added to a 'known set' of data. The known set consisted of literature already familiar to the researcher and was comprised of empirical research, grey literature and theoretical papers (including book chapters, drawing on theories to provide insight into repeat homelessness and mental illness, but not peer reviewed). Grey literature (e.g. websites, policy documents) was not explicitly searched, but highlighted through the initial scope and through discussions between the researchers. This known set was used as a foundation for informing and shaping subsequent searches as the researcher's understanding in the field grew. Purposive sampling techniques were utilised, aimed at identifying literature able to expose or make conjectures around processes underpinning the relationship between mental illness and repeat homelessness (Pawson et al., 2005; Wong et al., 2013).

Subsequently, a rigorous search of various academic databases took place to enable consideration of the wider evidence-base. MEDLINE, PsychINFO, CINAHL and PsychARTICLES were explored using key search terms; homelessness, repeat homelessness, mental health problems, maintenance, substance-use, and antisocial behaviour. Synonyms of each of these terms were also included in the search to maximise the likelihood of identifying relevant literature. Search terms were used flexibly and broad inclusion criteria were applied, given that the researcher anticipated limited studies being directly relevant to the present research question. Literature was deemed fit for inclusion if it met at least one of the following criteria:

- Articles that explored mental health problems in relation to repeat, recurrent, on-going or chronic homelessness.
- Articles that mentioned theories or psychological processes that may be related to mental health problems and/or homelessness.
- Articles that detailed substance-use and other problematic behaviours in relation to homelessness and mental illness.
- Articles exploring mental health in populations at high risk of repeat homelessness e.g. veterans, sex workers.

Papers were excluded if they did not mention mental health and homelessness or if their aims and objectives were solely focussed on the structural factors related to homelessness. Literature from the known set and the initial search were sifted and assessed according to their relevance and rigor as described by Wong and colleagues (2013) resulting in a combined total of 31 articles contributing to synthesis (Figure 2). An iterative method was utilised throughout the review and a snowball approach took place where relevant references identified in articles led to the identification of others. Articles in the known set were subject to a citation search using Google Scholar, which were sifted giving rise to a further 6 articles for inclusion. This search process resulted in a total of 37 articles contributing to synthesis (Figure 2).

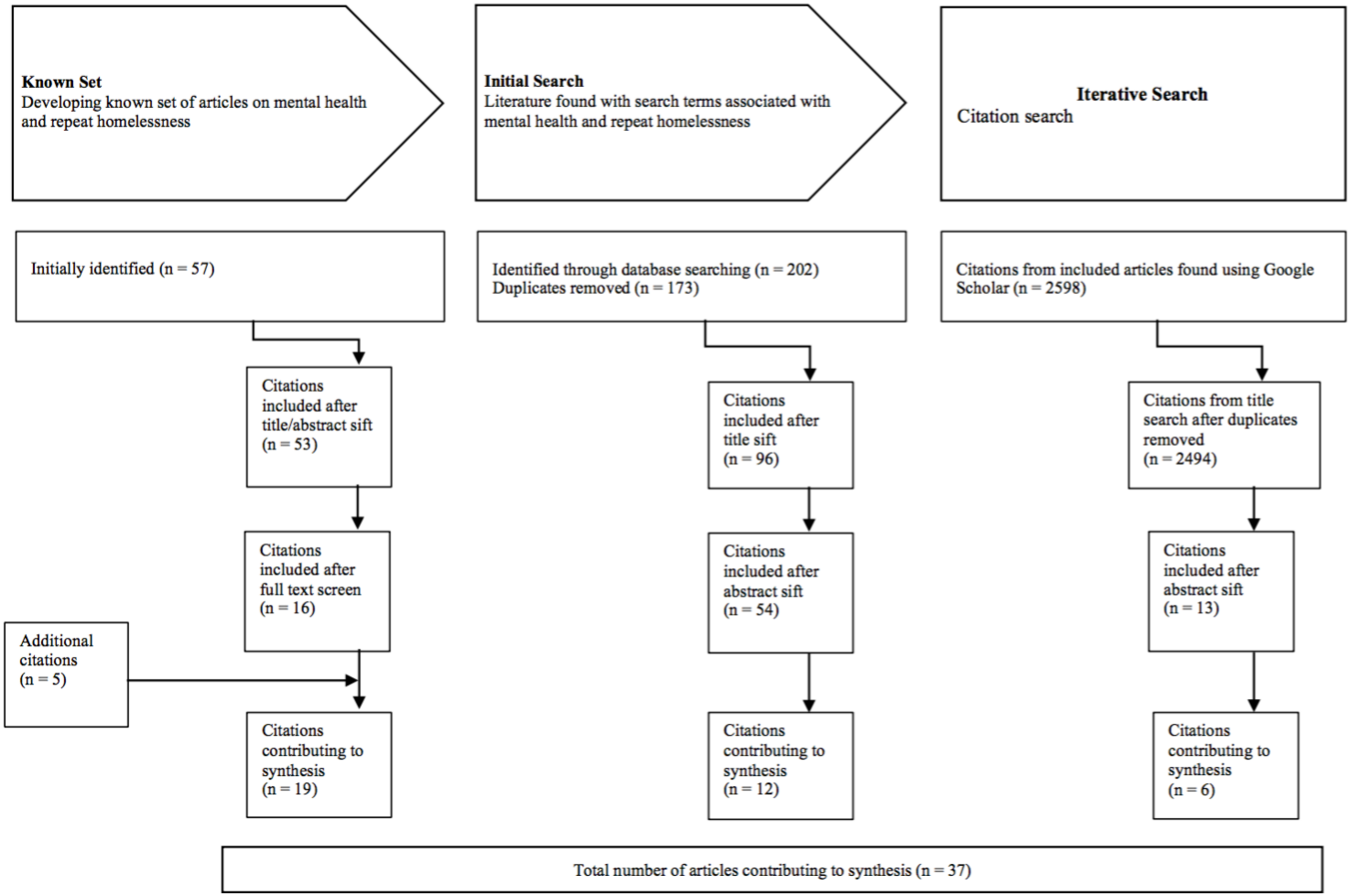

Figure 2. Flow diagram illustrating document selection adapted from Wong et al., 2013.

1.3.4 Quality Assessment

All of the relevant empirical articles were quality assessed to determine their rigour (Wong et al., 2013), although this was not used as a basis for exclusion of studies. The Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018) was employed to assess the robustness of the empirical articles, once they had been sifted for relevance to the research question. The MMAT is a valid and reliable quality assessment tool for reviews, which demonstrates strengths in assessing rigor in research with vastly different methodological designs (Pace et al., 2012). This was important for the present review, given the diversity in methodological designs existing within the homelessness literature. The MMAT provided a comprehensive, time-efficient tool to assess the quality across each of the included empirical studies (Pluye & Hong, 2014).

The Critical Appraisal Skills Programme (CASP; 2017) was employed for quality appraisals of systematic review research. The CASP is a 10-item online checklist, which is routinely used to assess the quality of systematic reviews as well as other methodological designs (Monforte-Royo, Villavicencio-Chávez, Tomás-Sábado, Mahtani-Chugani, & Balaguer, 2012). Fifteen percent of the articles were separately quality assessed by a secondary colleague who was unfamiliar to the research study, to ensure reliability of the quality assessment conducted by the primary researcher. 100% consistency between the two researchers was achieved.

1.3.5 Data Extraction and Synthesis

Following assessments of relevance and rigor, the articles were categorised according to the behavioural construct they predominantly described. Literature detailing different psychological theories related to homelessness was studied to provide a platform to answer the 'how' part of the research question. Aspects of the articles that described the relationship between mental health problems and repeat homelessness were extracted, as well as any processes and mechanisms discussed in relation to why and how homelessness may be maintained. The process of data synthesis took place, whereby demi-regularities (key repeated patterns, which may vary according to contextual factors) were explored and integral processes were considered (Jagosh et al., 2012; Wong et al., 2013).

Preliminary models were developed for each of the constructed behavioural pathways. These pathways were later combined to create an overarching model exploring the implications of mental health problems in repeat homelessness. This review marks the very early stages of

exploring the complex mechanisms underpinning repeat homelessness in relation to mental illness and therefore, the process of discovery made use of assumptions and intuitive judgements (Gilovich, Griffin, & Kahneman, 2002) shaped by evidence-based psychological theories. Accordingly, it must be noted that although heuristics were essential in these initial stages of theory building (where empirical evidence is limited), these processes may have led to bias (Gigerenza, 1991).

1.4 Results

The findings exposed three theory-based psychological processes (attachment theory, cognitive-behavioural theory and social-cognitive theory) and two key behavioural processes (social isolation and maladaptive coping) occurring within the psychological-behavioural pathway into repeat homelessness.

The first section discusses the psychological processes underpinning mental health problems, which result in the behavioural expressions that lead to subsequent repeat homelessness (Figure 1). These were identified through a combination of bottom-up and top-down processes. Psychological theory was highlighted and included in the review as a result of having searched the literature, and additionally, the researcher brought forward ideas about key theories likely to be implicated in homelessness, which guided searches within the evidence-base. As a result of these approaches, three key psychological theories were implicated in the experience of repeat homelessness for individuals suffering from mental health problems; attachment theory, cognitive-behavioural theory and social-cognitive theory. Each of these theories are explored in relation to the development of mental illness and their consequent role in social isolation and maladaptive coping, which contributes to repeat homelessness.

The second section explores the two behavioural processes; social isolation and maladaptive coping. Both of these pathways maintaining repeat homelessness were integrated to provide a comprehensive, model of the psychological-behavioural maintenance pathway of repeat homelessness. Each model will be explored and discussed separately initially (Figures 3 & 4), and then combined to reveal the middle-range theory and integrated final model (Figure 5). This final model has been functionally reduced and simplified in order to conceptualise the maintenance of homelessness in a meaningful way.

1.4.1 Psychological Processes

Attachment theory. Attachment theory provides a comprehensive foundation for understanding human development and the importance of attachment relationships in early childhood (Bretherton, 1992). Attachment is a template that is formed through early childhood experiences with significant caregivers. This template is used to understand, manage and form relationships with others and the world. The attachment relationship is used as a foundation for

responding to distress and ensuring that needs are met effectively throughout the lifespan. This adaptive behavioural system has an evolutionary function of driving proximity/connection-seeking with the caregiver, which promotes survival (Mikulincer, Shaver, & Pereg, 2003). Experiences of a problematic attachment relationship with a significant caregiver, for example, as a result of ACE's (abuse, domestic violence, neglect, parental mental health/substance-use issues), can result in the development of an insecure (avoidant/dismissive or ambivalent/preoccupied) or disorganised attachment rather than a secure attachment (for a more in depth discussion around these processes, please refer to Mikulincer et al., 2003). ACE's are highly prevalent within the homeless population, thereby increasing the risk of developing insecure/disorganised attachment styles (Fitzpatrick et al., 2013; Piat et al., 2015; Taylor-Seehafer, Jacobvitz, Steiker, 2008). This has an adverse impact on the child's ability to regulate, manage and tolerate distress. Prolonged distress overtime can result in the development of mental health problems, such as depression, anxiety and personality disorders (Aldao, Nolen-Hoeksema & Schweizer, 2010), which have been highly implicated in pathways into repeat homelessness (Fitzpatrick et al., 2013; Tsai & Rosenheck, 2013).

Cognitive-behavioural theory. The cognitive model is a pertinent framework for consideration when exploring how mental health problems are implicated in the maintenance of homelessness (Maguire, 2017). The cognitive model recognises the importance of early life experiences, and describes how they shape how the self, others, the world and the future are understood (Dobson, Poole, & Beck., 2018). Difficult early life experiences (e.g. ACE's) may contribute to the development of negative beliefs, which impact emotional and behavioural experiences (Beck, 1979). Negative evaluative beliefs about others and self, have a key role in yielding problematic behaviours and distressing emotions (Chadwick, Trower, & Dagnan, 1999). In particular, self and other evaluations appear to be the most powerful beliefs in eliciting unhelpful emotional and behavioural sequelae, because they involve appraisal and judgement (Jones & Trower, 2004). Appraisals and judgements are particularly emotive because as 'social beings' we have evolved to live in communities, (for the purposes of aiding survival) which predisposes people into highly valuing what other people think about them. This framework provides a helpful way of understanding how perceived judgement from others (other-self) and judgements made about others (self-other) and self (self-self) might contribute to a deterioration in psychological well-being, which maintains repeat homelessness.

Social-cognitive theory: stigma. Stigma is a phenomenon driven by social-cognitive processes, leading to the discrimination, exclusion and marginalisation of specific groups (Corrigan, 2000). Stigma is considered within the homelessness literature (Belcher & DeForge, 2012; Daiski, 2007) and has been highlighted as an important construct in conceptualising barriers towards accessing appropriate healthcare. Within society, stereotypes (knowledge structures) are developed either from direct experiences, or through indirect experiences of culturally derived discourses. These stereotypes shape attitudes and inform whether we consider others to be part of our in-group, or an out-group member (Corrigan, 2004). Unfortunately, individuals with mental health problems that are homeless often engage in maladaptive coping styles, which may mask the psychological difficulties being faced by the individuals. Therefore, at a societal level, the way in which homeless individuals present may be appraised by wider society as 'unacceptable' or 'problematic' and therefore result in their out-group membership. Accordingly, stereotypes become reinforced, reducing the likelihood of the out-group being able to integrate within the community; thereby perpetuating stigma (Crocker & Major, 1989).

These mechanisms were exposed in Daiski's (2007) qualitative study, where homeless individuals described experiencing stigma in relation to their experiences of addiction and mental illness, which limited their access to services. This resulted in their symptoms worsening and subsequently becoming increasingly reliant on substances in order to cope. Alongside this, the literature highlights how experiences of stigmatisation can lead to feelings of hopelessness and helplessness for people, which also drives marginalisation and on-going homelessness (Cleary, Horsfall, & Escott, 2014). There is evidence to suggest that perceived stigma from others can become internalised and reinforce unhelpful person evaluations, contributing to the development and/or exacerbation of mental health problems and distress (Cleary et al., 2014). This may influence how individuals respond and interact with their environment (e.g. rejecting other people), potentially eliciting further societal stigma in a vicious cycle.

Stigma - Mental health diagnosis in the homeless population. The organisation of mental health services by diagnostic classification systems has a role in the perpetuation of stigma for homeless individuals. Specifically, the homeless population is heterogeneous and present with complexity, which makes it a challenge for diagnosis to apply and/or be meaningful (Boyle & Johnstone, 2014; Fazel, Khosla, Doll, & Geddes, 2008; Gergen, Hoffman, & Anderson, 1996). Diagnosis can obscure complexity, giving the illusion that there is a comprehensive understanding, when in fact there is on-going confusion and misunderstanding related to the individual's

presentation. Alongside this, certain diagnostic labels are negatively connoted and perpetuate societal narratives around futility and dangerousness (e.g. schizophrenia, personality disorder). This impacts both the individual's sense of self and how the individual is perceived by others (James & Cowman, 2007), leading to the exclusion or inclusion of these individuals within the community (Markham & Trower, 2010; Veronka et al., 2014). These processes perpetuate stigma and result in worsening psychological symptoms.

In summary, problematic attachments contributing to emotion dysregulation and negative evaluative beliefs underpin a number of mental health problems, which are likely to be prevalent within the homeless population. The interaction between these cognitive and emotional processes with stigma (environmental), is likely to cumulatively contribute to enhanced psychological distress, leading to two key behavioural expressions; social isolation and maladaptive coping.

1.4.2 Social Isolation Pathway

Through the process of synthesising the data that had been abstracted from the 37 articles included in the review; social isolation was a key factor highlighted in relation to mental illness and repeat homelessness (Bramley & Fitzpatrick, 2018; Cleary et al., 2014; Daiski, 2007; Kurtz, Surratt, Kiley, & Inciardi, 2005). The results revealed a number of themes; the processes underpinning the relationship between social isolation and mental illness, implications for relationship breakdown, how social support enhances access to resources and the impact of social isolation on psychological well-being, which are discussed in turn.

Processes underlying the relationship between social isolation and mental illness. As shown in Figure 3, people who suffer from mental health problems may be more likely to avoid others, leading to a greater likelihood of becoming socially isolated. For example, if an individual holds negative evaluative beliefs that 'obtaining support is futile', that 'they are undeserving of help' and that 'others will reject them', corresponding to feelings of shame and failure; then seeking help from services, friends and family become increasingly challenging (Foster, Gable, & Buckley, 2012; Maguire, 2017; Spicer, 2017). This may result in individuals pushing significant others, caregivers and support professionals away (Maguire, 2017). Without a support network, it

may be more difficult to manage finances and individuals may be more vulnerable to experiencing stress and psychological distress (Ozbay, Fitterling, Charney, & Southwick, 2008), increasing their risk of experiencing repeat homelessness. In this way, Martin (2015) argued that mental health difficulties are pivotal in influencing how relationships are developed and maintained. Counterintuitively, the rejection of help may strengthen stigmatising narratives about homeless people and reinforce the problem-saturated story that homeless people cannot be helped (Kurtz et al., 2005; Shinn, 2007). Again, this cycle is perpetuated as psychological distress is enhanced, leading to a greater risk of social isolation and on-going homelessness.

In support of this notion, Spicer's (2017) qualitative study exploring barriers to mental health care among chronically homeless female sex-workers, found that fears of being judged, disrespected and a strong sense of stigmatisation by others were highly prevalent. This resulted in feelings of hopelessness and experiences of isolation, which the women attributed as playing a key role in fostering on-going homelessness. Similarly, Van Voorhees, Resnik, Johnson and O'Toole (2018), found that feelings of disconnectedness in war veterans was higher for those with self-reported post traumatic stress disorder (PTSD) than those without PTSD, and were less able to accept help and engage as well as benefit from the peer mentorship programme. It could be theorised that symptoms of PTSD experienced by these veterans, were characterised by negative evaluative beliefs across all three dimensions. For example; impacting their beliefs as to whether the programme would be beneficial (self-other), their sense of their own self-efficacy in being able to engage with the programme (self-self) and whether the mentors would be respectful or rejecting of them in the programme (other-self). The results from both of these studies highlight the negative effects that mental ill-health can have on developing and sustaining positive social relationships, which thereby perpetuates on-going homelessness.

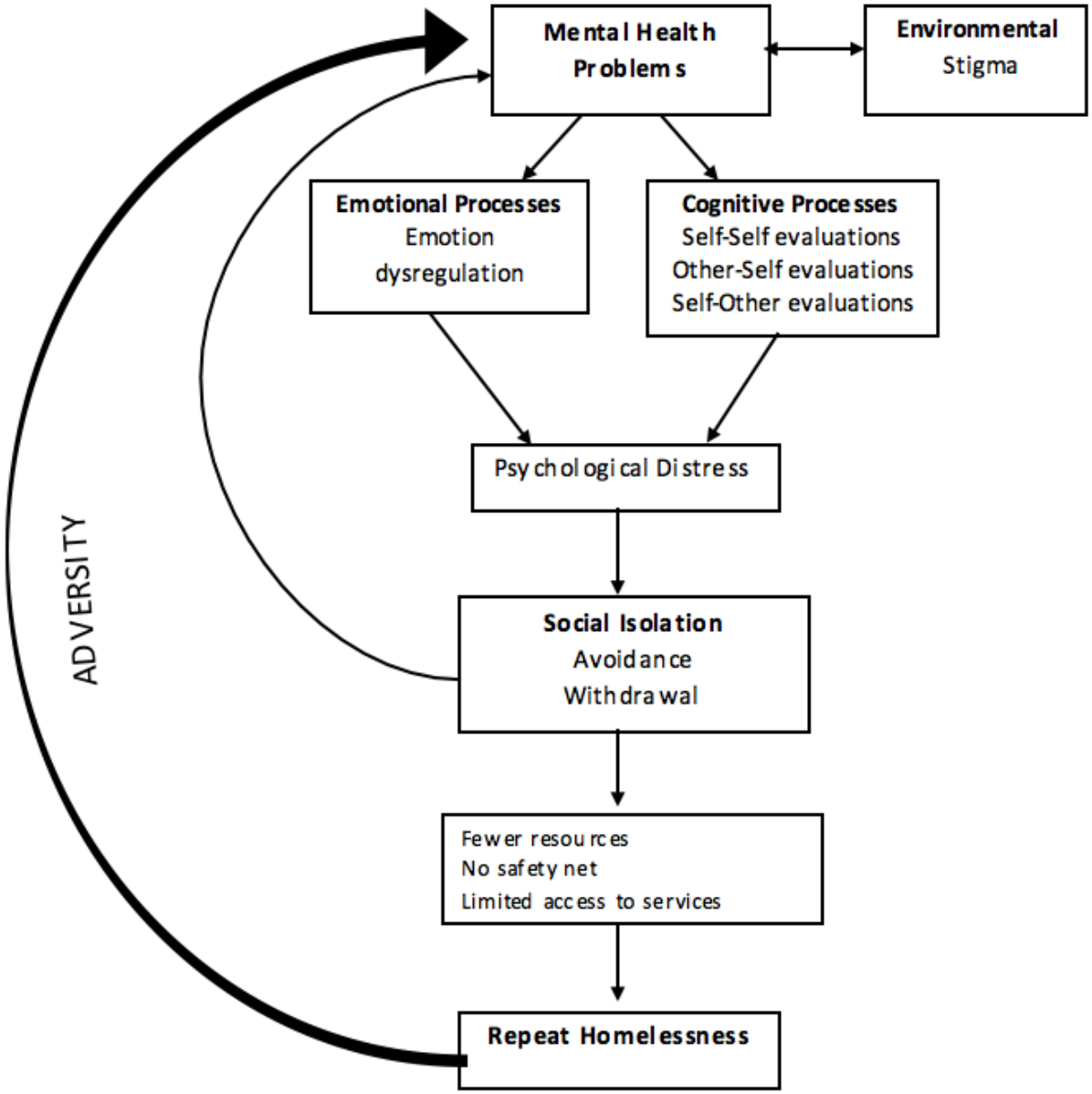

Figure 3. Preliminary model exploring mechanisms of social isolation that underpin the relationship between mental health problems and repeat homelessness.

Implications for relationship breakdown. The cognitive and emotional processes that underpin mental illness can make forming and sustaining interpersonal relationships with institutions, services and even with family members very challenging. This increases the likelihood of relationship breakdown and accordingly limits the likelihood of extensive support networks available to provide people with a safety net against repeat homelessness. Evidence suggests that enabling a child to remain living at home until adulthood can reduce the likelihood of later experiencing homelessness (Bramley & Fitzpatrick, 2018). It is possible that living at home for longer may be reflective of more adaptive familial relationships that contribute to enhanced levels of resilience. Additionally, living at home for longer may enhance financial stability, which protects against experiences of repeat homelessness. Interestingly, for homeless individuals, experiences of having lived at home into adulthood are very rare (Bramley & Fitzpatrick, 2018); supporting the idea that familial conflict/instability (which is likely to be heavily affected by the presence of mental illness) is influential over levels of vulnerability towards experiencing homelessness (McQuisition et al., 2014; Shinn, 2007; Tsai & Rosenheck, 2003).

Alongside this, there is evidence within the literature to suggest that there is a correlation between experiences of domestic violence and repeat homelessness, which may be affected by mental health and social isolation (Bramley & Fitzpatrick, 2018; Shin, 2007). Domestic violence is commonly characterised by manipulation and control, which usually involves the increasing extent of social isolation of the victim from their support networks (Baker, Billhardt, Warren, Rollins, & Glass, 2010). This often means that the victim is more vulnerable and is likely to have fewer resources facilitating them in terminating the relationship. Remaining in an abusive relationship is likely to negatively impact mental health, strengthening unhelpful beliefs around rejection and mistrust of others, making accessing support even more challenging. Further to this, often in order to escape the abusive relationship, the victim is forced into temporary shelters (Bramley & Fitzpatrick, 2018; Shinn, 2007). Once homeless, individuals are vulnerable to experiencing further adversity, contributing to worsening mental health, further marginalisation and social isolation (Bramley & Fitzpatrick, 2018). This makes transitioning out of homelessness even harder.

Social support enhances access to resources. It can be posited that if social relationships exist for an individual, repeat homelessness is less likely to occur, because the individual is likely to be able to draw upon a greater breadth of resources (McQuisition et al., 2014). Across the existing literature, increased social support has been associated with being stably housed, whilst individuals experiencing recurrent and chronic homelessness tend to have lower levels of social support (Klop, Evenblij, Gootjes, de Veer, & Onwuteaka-Philipsen, 2018; McQuisition et al., 2014; Van Straaten et al., 2017). Nishio and colleagues (2017), explored the barriers towards transitioning out of homelessness in Japan. Individuals with mental health difficulties and cognitive disability had a significant tendency to attribute difficulties within their relationships as a barrier impeding their transition from homelessness compared to individuals without mental illness and cognitive disability. Limited/lack of social relationships were regarded as an important resource in contributing stability and security for people. Specifically, lack of social support was shown to be highly implicated in homeless individuals being unable to gain access to stable housing, as individuals reported being unable to secure housing without a guarantor. This highlights the interaction between societal constraints and constructs on interpersonal and individual factors. Similar to this, Tsai and Rosenheck (2013) found an association between individuals experiencing mental health difficulties and poorer social support, which contributed to experiences of poorer quality of life and more episodes of lifetime homelessness.

The impact of social isolation on psychological well-being. Unfortunately, limited social support is closely associated with a deterioration in mental well-being, which reinforces the problematic psychological processes contributing to social isolation in the first place. This may result in repeat homelessness and a greater propensity towards engaging in difficult future relationships (Johnstone, Parsell, Jetten, Dingle, & Walter, 2016; Shinn, 2007; Spicer, 2017; Tsai & Rosenheck, 2013). The experience of unhelpful relationships (abusive, neglectful, exploitative) in themselves are likely to shape evaluative beliefs, resulting in a greater propensity to isolate oneself further. This will reduce opportunities of developing positive relationships and experiences that challenge self-critical, mistrustful, fearful beliefs about themselves and others (including services). In line with this, the study conducted by Powell and Maguire (2018) demonstrated that homeless individuals had significantly higher levels of paranoid thinking including mistrust, and emotion dysregulation, compared with the general population. This may provide an explanation for why homeless individuals might intentionally isolate themselves, which

paradoxically contributes to on-going homelessness. Additionally, as discussed by Warnes, Crane, Whitehead and Fu (2003) paranoia often results in ubiquitous mistrust for services and denial of psychological difficulties, leading to further psychological distress and consequent social isolation. This highlights the circular nature of the relationship between social isolation, psychological difficulties and repeat homelessness.

1.4.3 Maladaptive Coping Pathway

Maladaptive coping was referenced in each of the 37 articles included for synthesis, underscoring its importance in conceptualising the relationship between mental illness and repeat homelessness (Figure 4). The results highlighted the following themes; processes underlying the relationship between maladaptive coping and mental illness, mental health difficulties and substance-use, the importance of context, mental health difficulties and gambling as well as the theoretical underpinnings of impulsive behaviours. Each of these themes are discussed in turn.

Processes underlying the relationship between maladaptive coping and mental illness. In particular, substance-use, gambling and antisocial behaviour, including aggression and violence have often held the spotlight in the homelessness literature with regard to tenancy outcomes (Cleary et al., 2014; Edens, Mares, Tsai, & Rosenheck, 2011; Folsom et al., 2005).Despite this, the mechanisms that connect mental illness to maladaptive coping within the context of repeat homelessness are under-researched. The psychological processes implicated in mental illness that result in social isolation are also likely to have a significant role in the development and maintenance of maladaptive coping. In line with this, Powell and Maguire (2018), explored psychological mechanisms associated with paranoia and maladaptive behaviours in homeless individuals, and found that emotion regulation mediates the relationship between paranoid thinking and maladaptive behaviour. This raises the importance of how cognition can drive problematic behaviour when compounded by emotion dysregulation. Furthermore, an association between reduced emotion regulation abilities and increased engagement in maladaptive behaviours, such as substance-use was established; highlighting that effective regulation of distressing emotions can reduce acting on impulsive urges, which improves behavioural control (Linehan, 1993).

Mental health difficulties and substance-use. Negative beliefs fostering mistrust, reinforcing psychological distress may prevent homeless individuals from accessing support services that may be able to improve their psychological symptoms. Accordingly, individuals may attempt to alleviate their distress, which in some cases may involve unhelpful coping styles (Maguire, 2017). As highlighted by the literature, substance-use is a common strategy that people use to self-medicate in order to dampen or reduce their negative emotional experiences (Benda, 2006; Daiski, 2007; Fitzpatrick et al., 2013; Holdsworth & Tiyce, 2013; Piat et al., 2015; Spicer, 2017). Unfortunately, substance-use leads to a number of adverse long-term consequences, such as addiction, financial problems, unemployment, emotional lability, and impulsivity, which maintain and exacerbate mental illness. This vicious cycle perpetuates on-going substance-use in order to 'cope' and drives a number of secondary problematic outcomes (Fitzpatrick et al., 2013).

There is a plethora of studies that have explored the relationship between substance-use and homelessness and across the literature there is consensus that substance-use increases the likelihood of repeat homelessness (Creech et al., 2015; Edens et al., 2011; McQuisition et al., 2014; O'Connell, Kasprow, & Rosenheck, 2008; Tsemberis & Eisenberg, 2000). Creech et al. (2015) explored the relationship between health and mental health factors between recurrent and chronic homelessness compared to single episode homelessness in war veterans. The authors found that self-reported substance-use and experience of a mental health problem, were significantly associated with chronic and recurrent homelessness compared to those having experienced only a single episode of homelessness. Although the authors do not theorise around the mechanisms contributing to this observed effect, these findings might imply that the experience of mental health problems results in substance-use as a way of managing symptoms (Benda, 2006; Yeater, Austin, Green, & Smith, 2010). Though this provides temporary relief, it is likely to lead to further deterioration in mental health (Edens et al., 2011). The bi-directional relationship between mental illness and substance use, heightens the risk of individuals engaging antisocial behaviour, such as criminality (shop-lifting, sex work, illegal employment) and violent behaviour (Daiski, 2007; Foster et al., 2012; McQuisition et al., 2014; Van Straaten et al., 2017). People may behave in these ways as a means of generating income and resources in order to fund their substance-use (Daiski, 2007; Kurtz et al., 2005), or as a form of self-protection against violence from others (Cleary et al., 2014; Riley et al., 2003). Subsequently, entering into financial difficulty and/or being arrested and obtaining a criminal record is likely to lead to eviction and experiences of repeat homelessness (McQuisition et al., 2014).

There is evidence to suggest that using substances alone can maintain homelessness, because landlords are unlikely to tolerate illicit activity or be willing to let out their property to individuals that have substance-use difficulties (SUD's) that might damage their property (Maguire, 2017). Secondly, the effects of substances can compromise people's daily living skills, including organisation for managing bills and attending necessary appointments, which may be integral to sustaining their tenancy (Martin, 2015). Furthermore, becoming homeless exposes individuals to additional adversity and potential trauma, which is likely to negatively impact mental health and strengthen reliance on substances to cope with traumatic circumstances (Benda, 2006; Cleary et al., 2014; Yeater et al., 2010). Being homeless with a criminal record and substance-use difficulties has a cumulative negative effect on accessing support services, societal stigma and on-going homelessness (Van Straaten et al., 2017).

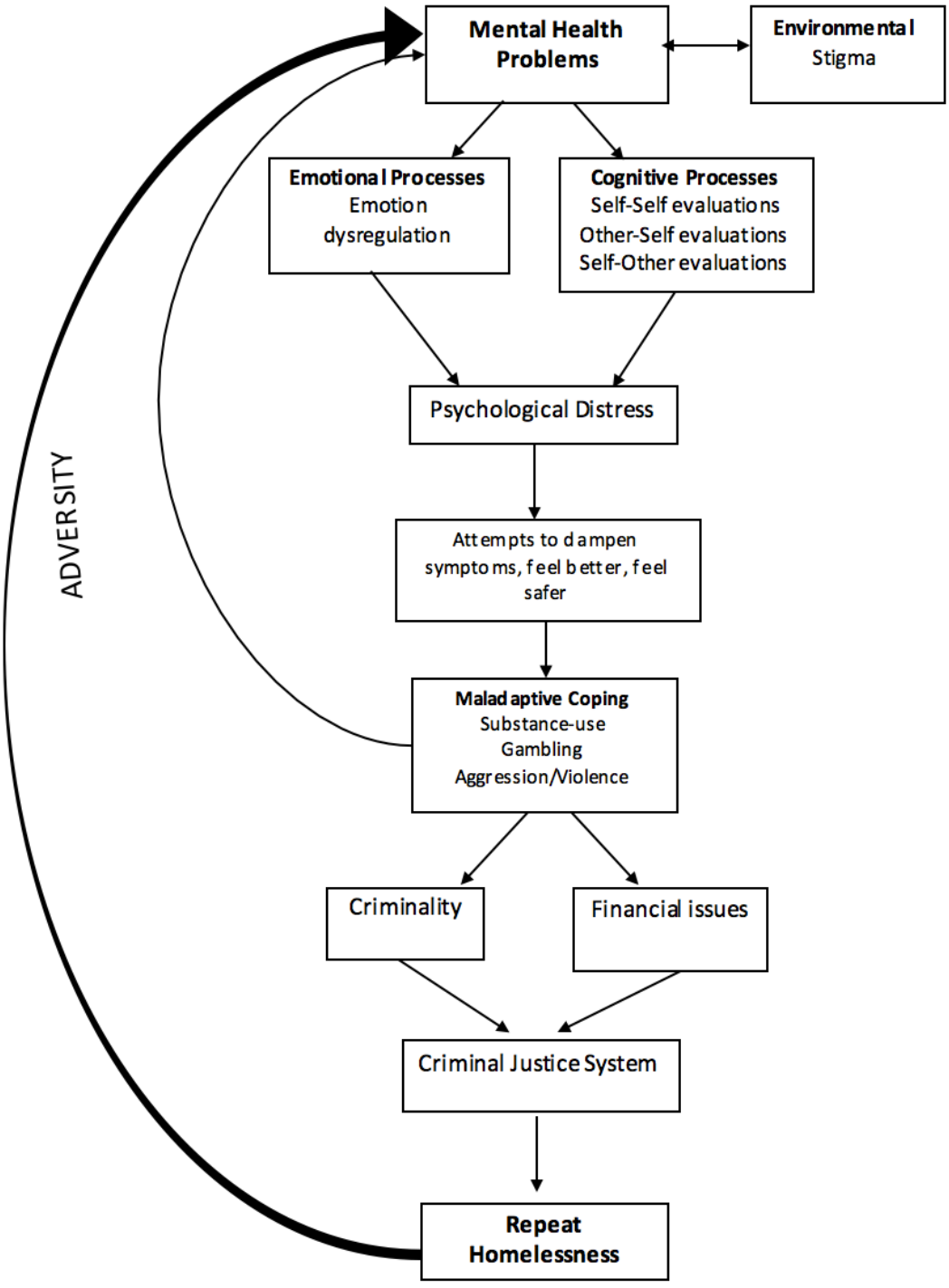

Figure 4. Preliminary model exploring mechanisms of maladaptive coping that underpin the relationship between mental health problems and repeat homelessness.

The importance of context. Despite the overwhelming evidence underscoring the interplay between mental illness and substance use as factors implicated in the maintenance of repeat homelessness, the significance of context remains vital in our conceptualisation of these processes. Interestingly, whilst exploring variables associated with housing retention amongst chronically homeless individuals, Collins (2013) did not find alcohol-use, psychiatric symptom severity and history of homelessness to be predictive of resumed homelessness. These findings highlight the importance of considering the impact of context on the mechanism-outcome relationship (Wong et al., 2012). Here the housing intervention project, employed a low-demand threshold approach, abstinence from substances was not a requirement and supportive services were offered to participants. These factors are likely to account for the fact that individuals with severe mental illness and substance-use difficulties were able to sustain their tenancy over the two-year period.

The reality of local community housing support services may involve limited levels of support, where the relationship between mental health and addiction problems may be accentuated. In a similar way, the study conducted by O'Connell and colleagues (2008), demonstrated that veterans experiencing more mental health problems overall were associated with a lower likelihood of loss of housing. Again, these findings can be understood within the context that participants with more severe mental health symptoms had greater access and engagement in support services, which is likely to have been protective against loss of housing. The results from both these studies underscore the importance of context in understanding the factors maintaining homelessness and demonstrate the complexity involved in conceptualising the interaction between maladaptive coping and effects of the environment, which compound repeat homelessness.

The interaction between substance-use and environmental constructs in maintaining repeat homelessness was described by Canavan et al. (2012). The authors explored barriers to care for homeless people with mental health problems and found that a large majority of health services across Europe classed active substance-use as a reasonable basis for exclusion from their services. This meant that individuals who could have benefitted from mental health intervention, were instead excluded as a result of their substance-use. Inevitably, this is likely to have perpetuated their substance-use as a means of managing their symptoms (Benda, 2006; Canavan et al., 2012). In line with this, a number of research studies have highlighted that individuals with

the greatest difficulties tend to be the most disconnected from support services (Aldridge et al., 2018; Fitzpatrick, 2005; Kertesz et al., 2005).

Mental health difficulties and gambling. Alongside substance-use, problematic gambling (gambling resulting in negative outcomes, such as debt, emotional lability, law enforcement intervention etc.) in recent years, has gained more recognition as a common issue within the homeless population. This is likely to be due to the socio-cultural shift in Western societies in terms of gambling accessibility generally, marketing and popularity (Orford, 2011). Gambling can become very problematic and addictive, resulting in similar experiences and outcomes as substance-use. In this way, gambling is implicated through similar processes to substance-use in the model of repeat homelessness (Figure 4) and itself interacts with substance-use behaviours.

Exploring these relationships, Nower, Eyrich-Garg, Pollio and Garg (2015) found that mental health problems (PTSD, antisocial personality disorder (ASPD), major depression, bipolar disorder etc.) significantly predicted problematic gambling in homeless individuals. Further to this, individuals classified as problematic gamblers were significantly more likely to use illicit substances than non-problematic gamblers and non-gamblers. The authors explain that impulsivity is a common feature of many mental health disorders, including ASPD and bipolar disorder, which is likely to predispose individuals towards engaging in risky behaviours. Additionally, problematic gambling is likely to lead to adverse experiences (debt, confrontations, substance-use) that contribute to homelessness. It is likely that there is a bi-directional relationship between gambling and homelessness; such that problematic gamblers may be vulnerable to experiencing financial difficulty and therefore struggle to afford housing. Alternatively, homeless individuals may have a greater propensity to gamble, in order to escape their distress (Holdsworth & Tiyce, 2013), or as an opportunity to gain monetary income, or to gain shelter in a warm environment (Bramley, Norrie, & Manthorpe, 2018). This enhances the likelihood of experiencing adversity, financial problems, and becoming associated with illicit activity, resulting in subsequent on-going homelessness (Cleary et al., 2014; Daiski, 2007; McQuisition et al., 2014).

Theoretical underpinnings of impulsive behaviour. These findings are consistent with attachment theory and neurobiological theories, where ACE's that disrupt attachment can impact frontal lobe development responsible for executive function, thereby resulting in higher levels of impulsivity and subsequent engagement in risky behaviours. These processes can make individuals vulnerable to gambling and using substances, as individuals are less able to weigh up longer term adverse consequences against short term reward and gains (Del Prete et al., 2017). Engaging in gambling behaviour may expose the individual to traumatising experiences, perpetuating mental illness, further maladaptive coping (Foster et al., 2012; Nower et al., 2015, Powell & Maguire, 2018) and repeat homelessness (Holdsworth & Tiyce, 2013). Furthermore, engaging in both substance-use and problematic gambling, heightens risks of incarceration, which makes the transition out of homelessness post-incarceration even more challenging (Fries, Fedock, & Kubiak, 2014; McQuisition et al., 2014).

1.4.4 The Integrated Final Model

Interaction between Social Isolation and Maladaptive Coping. The final model demonstrating how mental health problems are implicated in maintaining homelessness consisted of an integration between the social isolation pathway and the maladaptive coping pathway (Figure 5). Both models (Figure 3 and 4) shared the same psychological processes and it was evident from the literature that there was a clear interaction between maladaptive coping and social isolation, which has an even greater impact on repeat homelessness. A common theme in the literature detailed how individuals experiencing mental illness that experience social isolation, are more likely to experience adverse life-events, which enhances the likelihood of engaging in maladaptive behaviours in order to cope (Bramley & Fitzpatrick, 2018; Clearly et al., 2014; Daiski, 2007). Cleary et al. (2014) described how marginalised individuals are often socially isolated with limited networks for support, which exposes them to a greater risk of experiencing victimisation and discrimination. These experiences themselves can result in traumatisation and deterioration in mental health. The authors argue that these experiences may contribute to the development of antisocial behaviour in order to protect themselves from the threat that others may pose, which paradoxically may exacerbate the individual's difficulties. Aggressive behaviour, or engagement in substance-use/gambling, is likely to drive further relationship breakdown and social isolation, hence, homelessness is maintained and the cycle is perpetuated (Figure 5). It is also important to consider that presenting aggression can often mask underlying mental health

difficulties, leading to other people withdrawing. This is likely to exacerbate mental illness and increase the likelihood of on-going aggression, as well as subsequent criminal justice involvement and repeat homelessness (Holdsworth &Tiyce, 2013).

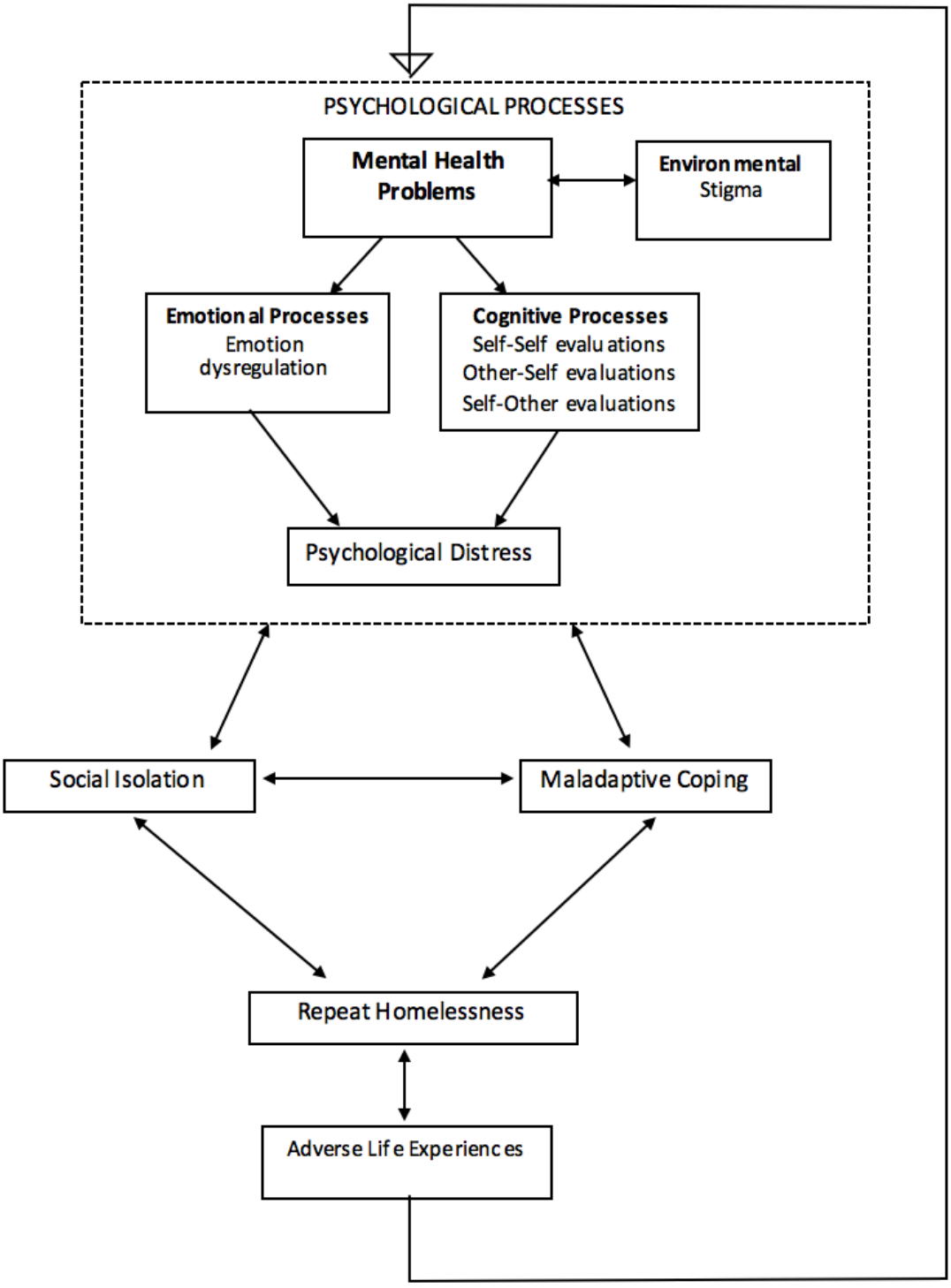

Figure 5. An integrative model of how mental health difficulties perpetuate repeat homelessness.

In line these findings, Piat et al. (2015) found a similar theme, whilst conducting a qualitative study of pathways into homelessness. The authors found that individuals reported that their experiences of mental health difficulties often strained and pressured relationships, ultimately resulting in breakdown and becoming isolated. Experiences of social isolation appeared to exacerbate mental health symptoms and contributed to their use of substances in order to cope. Participants' depleted finances were as a result of their substance-use, which ultimately led to their loss of housing and their isolation as well as sustained homelessness. Other qualitative studies exploring the experiences of homeless individuals, highlighted feelings of rejection and loneliness in relation to loss of social support, which resulted in increased drug-use, emotional distress and illicit activity (Daiski, 2007; Kurtz et al., 2005). This appeared to perpetuate further isolation and engagement in risky behaviour, such as sex work, leading to on-going adversity and homelessness (Kurtz et al., 2005). These studies highlight the cumulative effect of each of these constructs and how their interactions perpetuate homelessness and consequent adversity in a chronic cycle.

1.5 Discussion

This realist review aimed to explore how mental health problems are implicated in the maintenance of repeat homelessness. In order to do so, searches of the literature took place using an iterative approach; such that as models were being developed and understanding of the topic grew, further searches were conducted simultaneously to provide additional weight for the developing model. This resulted in 37 articles being identified for inclusion in the synthesis process, which focussed upon mental health problems, homelessness, individuals at high-risk for homelessness, substance-use and antisocial behaviour, under varying contexts. There was a dearth of literature focussing specifically on the processes and mechanisms underpinning the relationship between mental illness and repeat homelessness and therefore abstraction was required and inferences were made from the available evidence-base. Accordingly, the model developed is heuristic at these initial stages, and will require further empirical testing. The model explores psychological processes underpinning mental health problems, explained using attachment theory, the cognitive model and social-cognitive theories of stigma. These psychological processes drive two interacting pathways through social isolation and maladaptive coping, which result in repeat homelessness and chronic feedback loops which exacerbate mental illness and perpetuate the cycle of repeat homelessness.

1.5.1 Psychological Processes

Key processes underlying mental health problems were identified through exploration of the literature and through abstraction using relevant psychological theory; primarily, attachment, cognitive and social-cognitive models (Maguire, 2017). Emotion regulation difficulties, impulsivity and negative evaluative beliefs were highlighted as helpful constructs in conceptualising mental health problems and contributed to the overall model (Figure 5; Daiski, 2007; Shinn, 2007).

ACE's are prevalent in the histories of homeless individuals and have been explored in connection with the development of mental health problems, which contribute to homelessness (Fitzpatrick et al., 2013; Herman, Susser, Struening, & Link, 1997; Maguire, 2017; Roos et al., 2013). Problematic attachments as a result of ACE's were found to be significant in negatively impacting emotion regulation abilities and templates for understanding self, others and the world (Aldao et al., 2010; Mikulincer et al., 2003). These processes contribute to experiences of prolonged distress and overtime can result in the development of mental health problems.

Alongside this, cognitive theory describes how negative evaluative beliefs are powerful in eliciting both emotional distress and unhelpful behavioural patterns that consequently strengthen problematic beliefs, perpetuating global mental health difficulties (Beck, 1979). Furthermore, the literature highlighted that this pattern of distress and reinforced unhelpful evaluative beliefs contributed to maladaptive coping and social isolation, exacerbating difficulties further (Klop et al., 2018; Powell & Maguire, 2018; Shinn 2007). Stigma was a construct that appeared closely associated with both mental illness and homelessness (Cleary et al., 2014). Evidence in the literature implicated stigma in the development and perpetuation of negative person evaluations and psychological distress, which appeared to influence consequent behaviours implicated in repeat homelessness (Daiski, 2007; Foster et al., 2012; Spicer, 2017; Van Vorhees et al., 2018). Stigma appeared to have on-going negative effects, such that once an individual had experienced homelessness, they became victims of further stigmatisation and marginalisation, influenced by societal discourses and narratives (Major & Crocker, 1989).

1.5.2 Social Isolation

Individuals experiencing negative evaluative beliefs about themselves and others (influenced by stigma) are likely to experience interpersonal difficulties, which makes forming and maintaining relationships with others challenging. A strong theme within the literature highlighted mental illness as a significant strain on relationships, which often resulted in their breakdown, even amongst families (Piat et al., 2015; Spicer, 2017; Van Vorhees et al., 2018). This resulted in individuals becoming isolated, marginalised and vulnerable to experiencing increased adversity. With a loss of social support, it was evidenced by the literature that individuals were more likely to experience recurrent and chronic homelessness (Klop et al., 2018; Van Straaten et al., 2017). This effect may occur because social isolation negatively impacts psychological well-being, exacerbating mental illness and thereby resulting in greater levels of psychological distress and on-going interpersonal difficulties in a complex feedback loop (Shinn, 2007; Spicer, 2017; Tsai & Rosenheck, 2003).

A key theme highlighted in the literature was the experiences of mistrust of others, leading to withdrawal and consequent isolation (Canavan et al., 2012; Klop et al., 2018; Powell & Maguire, 2018; Shinn, 2007). Additionally, it appeared that at times people in the support network struggled to tolerate/accept the maladaptive behaviours being demonstrated, leading to

relationship breakdown (Daiski, 2007; Kurtz et al., 2005). The literature also underscored the importance of negative self-self evaluative beliefs, including high levels of self-criticism and consequent shame and embarrassment related to their difficulties and associated behaviour. This appeared to be a significant barrier towards individuals seeking help or engaging with social networks (Bramley & Fitzpatrick, 2018; Shinn, 2007). Depleted social relationships driven by mental health difficulties in a bi-directional relationship, led to reduced access to resources and support services (McQuisition et al., 2014). This makes transitioning out of homelessness increasingly difficult, contributing to on-going homelessness, or alternatively, makes individuals vulnerable to losing their tenancy. Unfortunately, becoming homeless reduces social support and integration within the community even further. This may expose individuals to additional adversity and reduces the likelihood of gaining secure housing in the future, perpetuating the cycle of repeat homelessness (Bramley & Fitzpatrick, 2018).

1.5.3 Maladaptive Coping

It was evident from the literature that maladaptive coping, including substance-use, aggression, violence and gambling, were highly prevalent within the homeless population. There was a considerable amount of evidence suggesting that engaging in these behaviours occurred as a consequence of attempts to manage and cope with mental health difficulties and associated psychological distress (Benda, 2006; Daiski, 2007; Fitzpatrick et al., 2013; Holdsworth & Tiyce, 2013; Maguire, 2007; Spicer, 2017). Maladaptive coping was associated with subsequent criminality and adversity, which led to exacerbated mental health difficulties and reinforced further maladaptive coping, particularly substance-use and aggression (Daiski, 2007; Cleary et al., 2014; Edens et al., 2011; McQuisition et al., 2014). These problematic observable behaviours for society are likely to perpetuate stigma and discourses that homeless individuals and individuals with mental illness are 'dangerous criminals' (Corrigan, 2000), strengthening negative person evaluations and emotional distress for homeless individuals.

The literature highlighted that individuals who use substances or gamble are likely to enter financial difficulties, making them vulnerable to engaging in diverse ways of gaining income, such as selling drugs, sex work, shop lifting and further gambling (Daiski, 2007; Kurtz et al., 2005; Nower et al., 2015). These attempts to gain income appeared to heighten risks of getting arrested, exposing individuals to further adversity and traumatisation (Edens et al., 2011). Consequently, this appeared to result in individuals having a greater propensity for violent behaviour (McQuisition et al., 2014). Due to the nature of the criminal justice system and the limited support

and resources provided to individuals leaving the penitentiary system, the evidence-base identified that individuals with mental health problems alongside SUD's were significantly more likely to experience subsequent homelessness (Fries et al., 2014; Van Straaten et al., 2017). Accordingly, individuals tend to become increasingly marginalised and opportunities to re-integrate within the community become more limited, thereby increasing the likelihood of on-going criminality and homelessness.

1.5.4 The Integrated Final Model

The overall model conceptualised the interaction between social isolation and maladaptive coping, given that the literature underscored a strong bi-directional relationship between these two constructs (Cleary et al., 2014; Holdsworth & Tiyce, 2013; Piat et al., 2014). Research indicated that the loss of social support enhanced psychological distress, resulting in an increased risk of using substances in order to cope with feelings of loneliness and isolation (Daiski, 2007; Piat et al., 2014). It was also highlighted, that individuals with limited access to social networks, are more vulnerable towards experiencing adverse life experiences. This contributed to worsening mental health and a greater reliance on substances or gambling to dampen and escape difficult emotional experiences (Cleary et al., 2014, Powell & Maguire, 2018).

In the counter direction, the literature raised how engaging in maladaptive behaviours, such as substance-use, gambling and aggression can result in relationship breakdown and the loss of social support. Considering the subsequent effects of these maladaptive behaviours, such as increased psychological symptoms, emotional lability, financial problems and conflict with others etc., isolation often followed in a vicious cycle (Holdsworth & Tiyce, 2013; Riley et al., 2003). The cumulative effect of both social isolation and maladaptive coping appeared to substantially increase vulnerability and likelihood of experiencing on-going homelessness, exposing individuals to additional adversity, thereby perpetuating the cycle (Bramley & Fitzpatrick, 2018; Kurtz et al., 2005; Piat et al., 2014).

1.5.5 Contrary Findings

Although there was a strong trend identified in the literature between mental illness and repeat homelessness, a few articles included in the review had contrasting findings to the general set where mental illness was not found to be a significant predictor of recurrent or chronic homelessness (Collins et al., 2013; McQuisition et al., 2014; Schinka, Schinka, Casey, Kasprow, & Bossarte et al., 2012). It is possible that in these studies, the validity of assessments of mental illness may have been ambiguous. For example; McQuisition and colleagues (2014) did not detail which Axis I disorders were screened and how they were identified, making it difficult to draw conclusions around the validity and robustness of their assessments. Moreover, only ASPD was assessed from Axis II, when it has been evidenced in the literature elsewhere that other personality disorders, such as Emotionally Unstable Personality Disorder, are also highly prevalent in the homeless population (Ball, Cobb-Richardson, Connolly, Bujosa, & O'Neall, 2005; Fazel et al., 2008). This may have masked the association between mental health and homelessness (Benda, 2006). Finally, it is important to acknowledge that context plays a major role in the relationship between mental health difficulties and homelessness. Therefore, it is possible that in these studies the type of housing intervention being implemented (incorporating high levels of resource and support for participants) changed the context-mechanism-outcome configuration, thereby obscuring the relationship between mental illness and repeat homelessness.

1.5.6 Strengths and Limitations

As with all realist reviews, a key limitation in the present study, is the degree of interpretation and abstraction required to explore and address the research aims, given that authors seldom described processes that might have explained obtained outcomes (Wong et al., 2013). To the researcher's knowledge, this is the first review attempting to explain and explore the processes and mechanisms underlying how mental health problems are implicated in the maintenance of homelessness. Therefore, a greater degree of interpretation was required, potentially leading to bias. Given the complexity in conceptualising factors implicated in repeat homelessness, it was not possible within this review to explore the potential additional feedback loops and interactions occurring between each of the variables.

Most of the articles included for synthesis used a quantitative non-randomised methodology, where the major limitation was non-randomisation. Despite this, quality appraisal scores indicated by the MMAT ranged between moderate and high, with none of the articles

scoring below 50%. Further, given that the homeless population is heterogeneous, the context under which studies were conducted was heavily influential over the effects detected, possibly masking relationships between variables. The variability within the literature can be perceived as a limitation in being able to draw firm conclusions, but a strength of this review is that trends were identified despite the highly variable literature.

A further limitation is the fact that the review was conducted by a single researcher. Although ideas and literature were discussed amongst supervisors during the search and synthesis process, providing additional perspectives, the review was heavily influenced by the interpretations and insights of a single researcher, which is likely to account for bias. Finally, given the time-frame and resources available, this realist review only considered the psychological-behavioural processes that are implicated in repeat homelessness. It is acknowledged that mental illness is associated with a number of additional variables which perpetuate homelessness through different pathways, which warrant exploration in their own right (Figure 1).

A strength of this review is the foundation that the generated model can provide in starting to build a comprehensive understanding of how repeat homelessness is maintained. Further empirical testing of the model to ensure its validity, could inform how services are designed and delivered with greater efficacy and efficiency allowing homelessness to be addressed. An additional strength is the breadth of studies included in the review, allowing cross-cultural/cross-contextual processes to be identified and synthesised into an integrative model. This appears to be particularly important in this client-group, because of the inconsistencies in defining and conceptualising homelessness across the literature.

This realist review is strengthened by its systematic approach and iterative methodology, in relation to an evidence-base lacking clarity and systemisation. This approach has allowed exploration of the research aims, which otherwise would not have been possible and has resulted in insights being generated, that prompt future research for further support. This study has also raised the importance of addressing the gap in the literature in relation to processes and mechanisms maintaining homelessness. It is hoped that this will encourage further exploration of the themes and constructs highlighted in this review, in subsequent research. More specifically, future research aiming to explore the inferences made in this review should consider:

1. Person evaluative beliefs held by homeless individuals compared to the general population and their impact on behaviour and social relationships.

2. Societal stigma and problem-saturated narratives relating to homelessness and mental illness. What processes are occurring and how they may be associated with community integration and maladaptive coping (e.g. substance-use).

3. If emotion regulation abilities correlate with attachment style and if this mediates the relationship between negative evaluative beliefs and maladaptive coping in homeless individuals.

4. If there are certain maladaptive coping strategies that influence certain types of loss of social support (e.g. romantic relationship breakdown; family instability; conflict within friendships; relationships with professional services etc.) and vice versa.

5. Which maladaptive coping behaviours are the strongest predictors of repeat homelessness e.g. violent behaviour, stealing, alcohol-use, drug-use, gambling.

1.5.7 Conclusions

This realist review sought to provide insights into the processes underpinning the relationship between mental illness and repeat homelessness. This study identified 37 articles using iterative approaches and realist synthesis to expose patterns and trends occurring across a variety of different contexts. There is evidence across the broad range of literature that mental health problems are heavily implicated in the maintenance of repeat homelessness. This relationship was explored using a visual formulation and can be conceptualised using both cognitive and attachment theory. These psychological processes perpetuate pathways associated with social isolation and maladaptive coping, which reinforce one another to cumulatively exacerbate mental illness and maintain repeat homelessness.

Although the developed model requires testing to explore the assertions made in this review and to determine its validity/reliability, it signifies the initial stages in the journey to conceptualising a psychosocial model of repeat homelessness. Insight into the complex interplay of factors associated with repeat homelessness is essential in order to inform service planning and delivery and holds the key to breaking the cycle of on-going homelessness.

Chapter 2 EMPIRICAL PAPER: ATTITUDES TOWARDS HOMELESS PEOPLE, BELIEFS AND BURNOUT AMONG NHS STAFF IN PHYSICAL AND MENTAL HEALTH WORK SETTINGS

2.1 Summary

This study aimed to explore staff attitudes towards homeless clients and to investigate the relationships and interactions between attitudes and burnout with a number of other psychological and processional factors in physical health and mental health settings. The paper will begin by introducing the complexity of defining homelessness and the processes that underpin it, and how this contributes to on-going marginalisation and exclusion from health services. With this in mind the powerful influence of societal stereotypes and stigma will be considered in relation to homeless individuals and more generally complex client-groups. Consequently, the complex relationship between stigma, staff attitudes and burnout will be considered, as well as the impact of training and supervision for staff. Finally, potential differences in attitudes towards homeless clients in mental health and physical health staff are discussed and theoretical explanations for these potential differences are reflected upon, leading to the rationale for the present study.

2.2 Introduction

Homelessness is defined as any experience of having no permanent residence, including rough sleeping, sofa surfing, accessing crisis accommodation or being housed by friends and family. Homelessness is a complex social issue that is multifaceted in its development and maintenance within society. There is a wealth of research acknowledging and documenting the marginalisation and social exclusion of homeless individuals from health services, resulting in significantly higher rates of morbidity, mortality and impoverished quality of life (Rae & Rees, 2015; Thomas, 2012). As highlighted by the literature, a key variable impacting exclusion of homeless individuals in health services, is staff attitudes. Staff attitudes have been demonstrated

to be highly influential over client engagement and retention, as well as over progress in clients' recovery and quality of life outcomes (Bodner, Cohen-Fridel, & Iancu, 2011; Ross & Goldner, 2009). Given the potential value in engineering positive staff attitudes towards homeless individuals, it is important that staff attitudes and associated contributory factors are researched. This could inform interventions for staff that enhance their efficacy and efficiency, thereby reducing marginalisation and exclusion of homeless individuals within health services.

2.2.1 The Role of Stigma

Stigma is integral to the conceptualisation of how attitudes develop and are shaped over time. Public stigma is a construct that refers to how people buy into a shared societal stereotype e.g. 'homeless people are lazy, unmotivated and are to blame for their difficulties' (Corrigan, 2004). These negative discourses are shared within the cultural/social context, which perpetuate negative stereotypes of homeless clients, resulting in the development of stigmatising attitudes. Structural stigma refers to how stereotypes are incorporated into policies, laws and institutions e.g. a person suffering from a severe mental illness may not be eligible for employment at certain institutions (Corrigan, Druss, & Perlick, 2014). Through these processes, health services may facilitate exclusion of certain clients, which strengthen stigmatising attitudes of staff and subsequent marginalisation. For example, health policies may state that treatment should not be administered to individuals who are intoxicated, influencing staff judgements, such that staff may become prone to refusing treatment where it may be warranted/effective in certain cases. Additionally, this may result in staff presenting as discriminatory or critical towards clients who are intoxicated. Inevitably, this results in the perpetuation of stigma and problematic staff attitudes.

2.2.2 Stigma and Help-seeking

Understandably, stigma is a considerable barrier against service-use for homeless individuals, which increases the risk of symptom deterioration. This can lead to individuals becoming more reliant on maladaptive coping strategies (e.g. substance-use, criminality), which strengthen unhelpful stereotypes and perpetuate stigma (Shier, Jones, & Graham, 2010). Paradoxically, this heightens the risk of repeat homelessness (Tsemberis, 2015). There have been

a number of studies demonstrating this effect, whereby clients have experienced incongruence between their preferred self-identity and stereotypes around mental illness (Clement et al., 2015) as well as frequent discriminatory and dehumanising experiences in health services (Wen, Hudak, & Hwang, 2007). Consequently, there is the tendency for homeless clients to avoid accessing services, leading to symptom exacerbation, which often results in an over-reliance on emergency health services. Staff working in such settings typically experience high levels of demand, pressure and stress (Dasan, Gohil, Cornelius, & Taylor, 2015; Johnston et al., 2016), making them more vulnerable to relying on existing stereotyped beliefs about certain client-groups. Via these social-cognitive processes, stigmatising attitudes may develop and affect the treatment provided to clients (Figure 6).

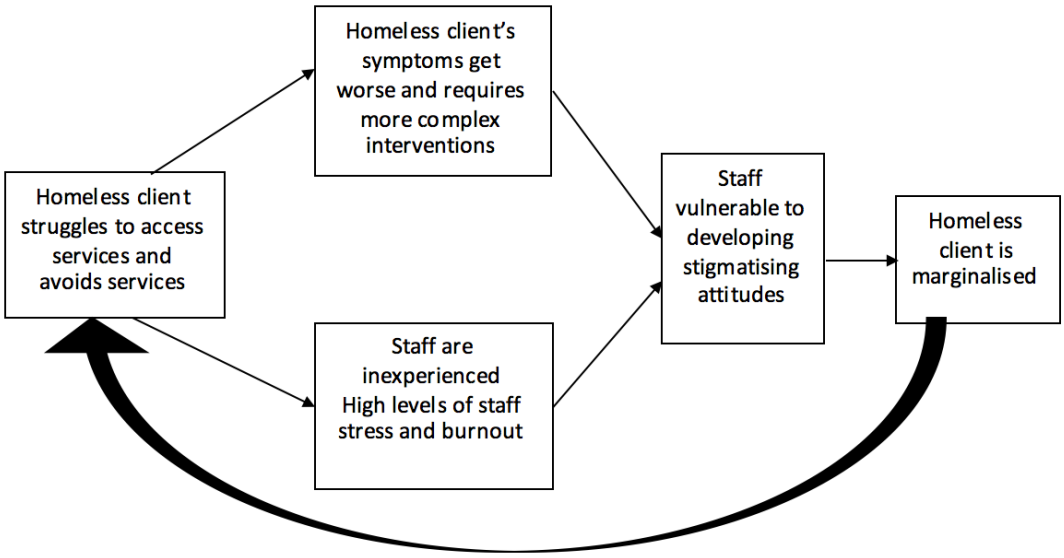

Figure 6. A vicious cycle demonstrating the hypothesised mechanisms impacting engagement of homeless clients in health services.

2.2.3 Beliefs, Attitudes and Burnout

The importance of evaluative beliefs. Evaluative beliefs are conceptualised within cognitive theory as integral cognitive processes that mediate psychological distress (Dagnan & Waring, 2004). This cognitive construct reflects evaluations people make about themselves (self-self) evaluations that people make about others (self-other) and evaluations that people perceive others making about themselves (other-self) (Chadwick, Trower, & Dagnan, 1999). It is widely accepted within cognitive theory that these person-evaluations are highly influential in

engendering emotional and behavioural difficulties and distress (Bridges & Harnish, 2010; Chadwick et al., 1999; Dagnan & Waring, 2004). People experiencing distress are at an increased risk of experiencing stress more generally, which contributes to a greater likelihood of subsequent burnout (Morse, Salyers, Rollins, Munroe-DeVita, & Pfahler, 2012). Burnout is a phenomenon where individuals experience a state of emotional, physical and psychological exhaustion in response to exposure to chronic stressors. Burnout is typically characterised by exhaustion, cynicism and less effective working (Pines & Maslash, 1978). Importantly, burnout in staff has been linked to stigmatising attitudes (Green, Albanese, Shapiro, & Aarons, 2014; Morse et al., 2012), which is highly problematic in perpetuating the exclusion of homeless individuals from health services.

Review of the literature. Despite the limitations of the evidence-base, increasingly there has been greater focus dedicated to exploring how stigma presents and exists within healthcare staff teams and the associated consequences for homeless individuals. Nicol, Dowling, Crawford, Chow and Dong (2016) explored the attitudes of staff working in emergency departments, towards homeless clients and/or individuals using substances. The authors found evidence of stigmatising attitudes in staff, such that 28% (out of 117 physicians) reported resenting the time required to attend to homeless clients, 57% felt overwhelmed by the complexity that they present with and 32% held beliefs that treating homeless clients was not sustainable financially. Interestingly, staff that were more experienced and that had undergone further specialist training, for example, in addiction work or homelessness care, had less negative attitudes. However, overtime the authors found that negative attitudes worsened, which could be attributed to limited access to training/supervision, high work stress and staff burnout. These findings are consistent with Maguire, Grellier and Clayton (2012), who found a reduction in levels of staff burnout and negative beliefs about homeless people, as well as improved perceptions of effective working with homeless clients, following cognitive behavioural therapy (CBT) training and supervision that was provided to hostel staff.

Alongside these two studies, Zrinyi and Balogh (2004) experienced a similar effect when exploring student nurse attitudes towards homeless clients, whereby paramedics held more negative attitudes, compared to student nurses. Their findings support claims by Nicol and colleagues (2016) that paramedics have less access to training and clinical supervision than student nurses, thereby contributing limited insight into the complexity of the problems facing

homeless clients (Bodner et al., 2011; Maguire et al., 2012). This results in lower empathy, lower confidence in working effectively with this client-group and a higher likelihood of attributing self-harm/substance-use behaviours as controllable, resulting in client-blaming (Markham & Trower, 2010). These studies raise the importance of some of the complex interactions that exist between attitudes, beliefs, effective working with complexity, staff support and burnout. They also highlight the powerful negating effect that training and supervision can have on stigmatising attitudes, thereby promoting more effective working with homeless individuals.

2.2.4 The Processes Impacted by Training and Supervision

Staff burnout and stress are heavily influenced by beliefs about likelihood for change and positive outcomes, as well as perceived self-confidence to effect this change (Ross & Golder, 2009). These cognitive processes are likely to be shaped by experiences of training and supervision and therefore present key opportunities to address staff experiences of stress and burnout (Bambling, King, Raue, Schweitzer, & Lambert, 2006; Hoffman, Osborn, & West, 2013; Maguire et al., 2012). Supervision is a process whereby staff have the opportunity to discuss/reflect upon their practice/workload, alongside consolidating learning, which can occur in the form of one-to-one meetings or group contexts. There is evidence to suggest that training and supervision provided to staff may contribute towards increased resilience and reduced work stress/burnout, resulting in more compassionate attitudes (James & Cowman, 2007) that foster inclusion of clients even when they might present with complexity. Further to this, the therapeutic relationship has been shown to be integral to treatment outcomes and life satisfaction for homeless clients (Chinman, Rosenheck, & Lam, 2000). Difficulty developing a therapeutic relationship with clients can be a source of frustration and stress for staff, leading to burnout (Bland & Rossen, 2005) and is common when working with homeless individuals. Bland and Rossen (2005) posit that providing on-going clinical supervision for nurses working with clients with complex needs can assist staff in building strong therapeutic alliances, thereby improving outcomes for clients and staff. This echoes much of the literature reviewed, which places considerable value on supervision and training for staff in improving outcomes and the quality of care provided to homeless clients (Bruce, Horgan, Kerr, Cullen, & Russel, 2017; Ewers, Bradshaw, McGovern, & Ewers, 2002; Maguire et al., 2012; Olivet, McGraw, Grandin, & Bassuk, 2010; Salyers et al., 2015; Shulman, Hudson, Kennedy, Brophy, & Stone, 2018; Young, 2018).

2.2.5 Mental Health Versus Physical Health Staff

To the author's knowledge, to date there is no previous research comparing staff attitudes towards homeless clients across mental health versus physical health settings. In light of the considered literature, it could be theorised that physical health professionals are at a higher risk of developing stigmatising attitudes than mental health professionals because they may have limited access to regular training and supervision opportunities, making insight and understanding harder when clients present with behaviours that are challenging or complex. Consequently, they may be more likely to rely on stereotyped beliefs held more widely on a societal level, which are likely to be negative given that the client's presentation is deemed as 'problematic' (Corrigan et al., 2014). Conversely, mental health professionals may be more familiar with working with clients with complex needs and multifaceted difficulties. This may occur as a result of their training, leading to the development of technical knowledge relating to complexity, as well as due to greater experience of working with individuals with complex needs on a day-to-day basis. Therefore, it may be assumed that mental health staff are likely to hold more empathic and compassionate attitudes. This might increase the likelihood of attuning to positive experiences of this client-group, further reinforcing compassionate attitudes (Ross & Goldner, 2009; Rüsch et al., 2009). Further research into this area could provide invaluable information as to how health services may be modified to support staff adequately in working effectively with homeless clients, thereby improving client-outcomes and addressing issues related to staff burnout.

2.2.6 Research Aims

The purpose of the current empirical research paper was to build upon previous research by developing a greater depth of insight into the nature of staff attitudes towards homeless clients working in the NHS and the processes that underpin their development. This research firstly aimed to compare and contrast professional factors (experience and training) and psychological factors (attitudes, burnout, effective working with complex clients, stress and lack of support) across mental health and physical health work settings to identify if differences existed. The second aim was to explore relationships between these professional and psychological factors with staff attitudes and burnout. This can provide further insight into the development of interventions that promote staff confidence and reduce burnout, thereby modifying attitudes that contribute to strong working alliances with homeless clients.

2.2.7 Hypotheses

1. There will be differences between physical health and mental health staff on professional factors (experience and training) and psychological factors (attitudes, burnout, confidence working effectively with complex clients, stress and lack of support) in relation to working with homeless clients.

2. There will be bivariate and multivariate relationships between professional (experience and training) and psychological factors (burnout, evaluative beliefs, confidence working effectively with complex clients, stress and lack of support) with stigmatising attitudes.

2.3 Method

2.3.1 Design

This was a cross sectional, questionnaire-based study, utilising quantitative methodology, exploring predictors of stigmatising attitudes, effective working with complex clients and burnout in mental health and physical health staff. The questionnaire was completed via an online survey software system provided by the University of Southampton. An online forum for participation was selected in order to improve accessibility and ease of completing the questionnaires for participants. Ethical approval was granted by the University of Southampton Ethics Committee and Research Governance Office (ID: 31667). The study was submitted through the Integrated Research Application System (IRAS) and gained approval by proportionate review (ID: 245184) on the 5th November 2018 (Appendices B & C).

2.3.2 Participants

Members of staff across local NHS mental health and physical health work settings were approached to participate in the research. Mental health settings included community mental health teams (CMHT's), inpatient units and acute mental health wards. Physical health settings included specialist NHS homelessness health services, both within clinic and outreach teams, as well as from general physical health hospitals, for example; accident and emergency (A&E), respiratory, renal units etc. It was not essential that staff had previously worked with homeless clients, only that in their current job role there was the potential to work with homeless clients, should they access the service. Administrative staff were not eligible to participate in the study. Additionally, given that the research aimed to study staff working with adults that are homeless, any staff working solely with children and young people were excluded from the study.

2.3.4 Measures

Participants were required to complete the following questionnaires (Appendix D):

Psychological Factors.

Attitudes to Homeless Individuals Questionnaire (AHIQ). With permissions from the authors, the AHIQ was developed by adapting items on the Attitudes to Personality Disorder Questionnaire (APDQ) to reflect homeless clients rather than clients with personality disorders (Bowers & Allen, 2006). The wording of each of the questions remained exactly the same, whilst the term 'personality disorder' was replaced with 'homeless client'. This scale is made up of five subscales measuring constructs associated with stigmatising attitudes; enjoyment/loathing, security/vulnerability, acceptance/rejection, purpose/futility, enthusiasm/exhaustion. This measure was developed with the specific intention of capturing staff attitudes towards clients working in health services and has demonstrated high internal consistency and validity in staff samples (Bowers & Allen, 2006; Clarke, Taylor, Bolderston, Lancaster, & Remington, 2015; Commons Treloar & Lewis, 2008). It was felt that given that the APDQ was designed to measure attitudes to personality disorders, it would be a very relevant scale to use in the present research, considering the high prevalence of personality disorders in the homeless population (Fazel at al., 2008). This 35-item measure employs a six-point likert scale (scored from 1-6) ranging from 'never' to 'always'. After reverse coding relevant items, higher scores indicate a more positive attitude to homeless individuals. In this study, the AHIQ demonstrated excellent internal reliability for the total scale and subscale enjoyment/loathing ($\alpha = .96$). Subscales security/vulnerability, purpose/futility and enthusiasm/exhaustion demonstrated good internal consistency, Cronbach's $\alpha = .80$. Finally, the Cronbach's alpha for the subscale acceptance/rejection indicated that the internal reliability of the scale was satisfactory ($\alpha = .70$).

Maslach Burnout Inventory – Human Services Survey (MBI-HSS). The MBI-HSS is a widely used 22-item scale demonstrating high reliability and validity in detecting burnout in staff from helping professional backgrounds (Maslach, Jackson, & Leiter, 1986). The questionnaire explores three constructs of burnout; emotional exhaustion, personal accomplishment and depersonalisation, and utilises a seven-point likert scale ranging from 'never' to 'everyday', scored

0-6. In this study, Cronbach's alpha for emotional exhaustion, personal accomplishment and depersonalisation scales were .89, .78 and 0.77 respectively, indicating satisfactory and good internal reliability. Higher scores indicate higher levels of emotional exhaustion, personal accomplishment and depersonalisation.

Evaluative Beliefs Scale (EBS). The EBS is a valid and reliable 18-item measure exploring self-self, other-self and self-other, evaluative beliefs in relation to six key areas; sense of worthlessness, unlovability, weakness, badness, failure and inferiority (Chadwick et al., 1999). It was felt that this questionnaire would provide a unique opportunity to explore core beliefs experienced by staff and how they may interact with stigmatising attitudes and level of burnout. This measure employs a five-point likert scale with descriptors ranging from 'agree strongly' to 'disagree strongly' and is scored 0, 0, 1, 2, 3. In this study, Cronbach's alpha for the self-self, other-self and total scale were .87, .90 and .91 respectively, demonstrating good-excellent internal reliability. Item-total statistics indicated that for the self-other subscale, if item 1 ('other people are worthless') was removed, then internal reliability would increase from α = .55 to α = .71, therefore this item was removed from the subscale resulting in satisfactory internal consistency. Higher scores on the scale indicate more negative evaluative beliefs.

Effective Working with Complex Clients (EWCC). This 13-item questionnaire was developed by Maguire (2005) to explore staff confidence in working with complex client-groups. As highlighted by the literature, staff's perceived efficacy and confidence in working with and delivering focused interventions to clients with multifaceted needs has an impact on attitudes towards clients. This impacts the effectiveness of the interventions being provided and the potential for positive outcomes for clients (Maguire et al., 2012). This questionnaire is believed to be similar, but conceptually distinct from the 'personal accomplishment' subscale of the MBI-HSS, which explores more general concepts, such as job satisfaction and fulfilment. This scale utilises a five-point likert scale ranging from 'none' to a 'great deal' and is scored from 1-5, where higher scores indicate more effective working. The Cronbach's alpha for the EWCC indicated that the internal reliability for the scale was satisfactory *(α = .77).*

Perceived Stress Scale (PSS). The PSS is a 10-item, global measure of perceived stress (Cohen, Kamarck, & Mermelstein, 1983). The scale has been used to measure stress in a variety of populations, including in students, staff and clients (DiClemente et al., 1991; Scott et al., 2015). This scale demonstrates adequate validity and reliability and it correlates highly with depression symptomology (Cohen at el., 1983), which is also linked to burnout. The measure utilises a five-point likert scale, with descriptors ranging from 'never' to 'very often', which are scored 0-4 and is

a short, easy-to-administer questionnaire, reducing burden for participants. In this study, Cronbach's alpha for the scale was .31, indicating inadequate internal reliability and poor validity within the current sample. Accordingly, this scale was removed from the analysis.

Nursing Stress Scale (NSS). This valid and reliable measure was developed to explore nurses' experiences of stress (Gray-Toft & Anderson, 1981). In order to avoid repetitions of constructs already being measured by the PSS and to avoid participants having to complete unnecessary questionnaires, one of the seven subscales from the NSS, 'lack of support' was selected independently and used in the present research. Lack of support was a theme that was deemed important to include as part of the study and hypothesised to be related to stress, burnout and attitudes towards clients, with consideration of the literature (Maguire et al., 2012). The subscale has three items, utilising a four-point likert scale ranging from 'never' to 'very frequently' and is scored from 0-3, with higher scores indicating poorer support. In this study, internal reliability of the scale was good *(α = .88).*

Demographic Information.

Participants were asked to provide their age in years. They were required to select their gender (male, female, other) and their ethnicity (White, Black or Black British, Asian or Asian British, Mixed or Other).

Professional Factors.

Work setting - participants were asked to select what type of work setting they were currently working in (mental health, physical health, both).

Experience of working with homeless clients – participants were asked to indicate how much experience they had of working with homeless clients on a four-point likert scale, with descriptors ranging from 'no previous contact with homeless clients' to 'very experienced working with homeless clients'.

Number of years core professional training – participants were required to fill in a free text box to indicate the number of years their core professional training had been. Participants were

instructed to answer this question in relation to whatever they perceived to be their 'core training'.

Number of years working post-core qualification – participants were asked to complete a free text box relating to the number of years they had been working post-training, in order to give the researchers an idea of levels of experience in their job role.

Number of days specialist training in an area relevant to homelessness – participants were required to complete a free text box to indicate the number of days they had attended training in their careers that would be relevant to the homeless population. Examples such as, workshops or training on substance misuse, addiction, trauma or attachment were provided.

Professional discipline – participants were required to select their professional discipline from a list (physical health nurse, mental health nurse, psychologist, psychiatrist, occupational therapist, doctor, social worker, physiotherapist, other). If the participants selected 'other', there was a free text box made available for them to provide further details.

2.3.4 Procedure

The researcher coordinated with link lead professionals across mental health and physical health settings (including; CMHT's, an acute inpatient ward, community outreach homeless healthcare service, A&E and nephrology services) and the rationale for the study was explored. Staff teams were provided with posters and information sheets detailing the research and how to access the online questionnaire. Following initial contact, the researcher continued to send periodic emails to each of the link lead professionals to remind and to encourage staff to complete the questionnaire. On initiation of the online questionnaire, participants were presented with the same participant information sheet that had initially been provided to the teams (Appendix E). In order to continue and complete the survey, participants were required to check a box, indicating their consent to participate in the research. Completion of the questionnaire lasted approximately 15-20 minutes, given that the researcher was keen to reduce burden on participants, especially as staff may be exposed to a number of demands already in their work. Following completion of the survey, participants were shown the debriefing summary (Appendix F), which explained the rationale for the study and provided the contact details of the researchers should any participants have queries following their participation.

To compensate staff for their time and to express gratitude for their participation, they were given the option provide their email addresses in order to be entered into a prize draw to win a £50.00 Amazon gift voucher. This was felt to be a reasonable amount without over-influencing participation. The participant information sheet detailed that email addresses that were provided, would be downloaded and stored in a password-protected file, separate from the questionnaire data. Following random selection of a winner of the prize draw, all personally identifiable information was destroyed to ensure anonymity and confidentiality of the data going forwards. Recruitment took place between November 2018 and February 2019.

Once an adequate sample had been achieved (determined by sample sizes recruited in similar research conducted e.g. Bodner et al., 2011; Maguire et al., 2012, and an a priori power calculation), the lead link professionals were contacted and informed that the online link for the questionnaire would be deactivated in two weeks. This provided an opportunity for any staff who had been keen to participate, to do so as a priority. Subsequently, the data was downloaded into an Excel spreadsheet and analysed using the statistical package, SPSS v24.

2.3.5 Data Analysis

An a-priori power analysis calculated using G*Power version 3.1.7 (Faul, Erdfelder, Lang & Buchner, 2007) to carry out a linear multiple regression (random model) with 22 predictors, identified that at least 190 participants were needed to test a two-tailed hypothesis with 80% power and 5% significance level, assuming that a medium effect size ($p^2 = 0.13$) would be achieved. However, given the number of potential participants eligible for recruitment from the health services identified in the local area and considering the sample sizes typically recruited in research exploring staff attitudes towards marginalised client-groups (between 30-57; Bodner et al., 2011; Maguire et al., 2012), 66 staff members participated.

On exploration, the data was normally distributed and linear, with no missing data, or unusual outliers. Accordingly, multiple one-way analyses of variance (ANOVA's) and chi-square cross tabs analyses were conducted on the continuous and categorical variables respectively, in order to explore differences between mental health staff, physical health staff and staff working across both settings. This demonstrated that data for mental health staff and staff with experience of working across both mental health and physical health settings was consistent. Accordingly, the data from these two groups were pooled and compared against data from

physical health staff using independent samples t-tests. Correlational analyses were conducted on the data to identify variables significantly associated with predictors of stigmatising attitudes for both mental health and physical health professionals. As a data reduction method to improve the statistical power of the analyses, only significant variables were then entered into a multiple linear regression, identifying associations between professional factors and psychological factors with stigmatising attitudes, burnout and effective working with complex clients. Particular focus was directed to the effect sizes reflected by the analyses because they provided an indication of how important each variable was in contributing to the observed effect, as well as a standardised measure of the magnitude of the observed effect, independent of sample size (Sullivan & Feinn, 2012).

2.4 Results

2.4.1 Participant Characteristics

Data from 66 participants were analysed as part of the study (50 staff with mental health experience, 16 physical health staff). There were no significant differences between physical health staff and staff with mental health experience with regard to age, gender and ethnicity. The mean age of the total sample was 41.35 years (SD = 12.71), 72.73% were female and 89.39% were from a White ethnic background. Comparisons with ethnicity and professional discipline across physical health staff and staff with mental health experience were not explored using chi-square crosstabs analyses as originally intended, given that the expected frequencies for over 20% of the counts were less than 5 (Field, 2013). This violates the assumptions of a chi-square analysis and undermines the validity of the test (Table 1).

Table 1

Comparison of demographic, professional and psychological variables across physical health and mental health work settings (n = number of participants).

	Health Setting (Total *n* = 66)		Test of Significance		95% CI	Effect Size (Cramer V, *d*)
	Mental Health Experience (n=50)	Physical Health (n=16)	t or χ^2	*p*		
Age, years, mean (SD)	40.84 (11.80)	41.00 (13.81)	-.05	.96	[-7.24, 6.92]	.01
Gender, n, (%)						
Female	37 (74.00)	11 (68.75)	.77	.68	[.04, .32]	.11
Male	13 (26.00)	5 (31.25)				

	Mental Health Experience	Physical Health	T or χ^2	p	95% CI	Effect size (Cramer V or *d*)
Ethnicity, n, (%)			N/A			
White	46 (92.00)	13 (81.25)				
Asian/ Asian British	1 (2.00)	2 (12.50)				
Black/African/ Caribbean	2 (4.00)	0 (0)				
Mixed Ethnic Groups	0 (0)	1 (6.25)				
Other Ethnic Group	1 (2.00)	0 (0)				
Experience with homeless clients, n, (%)						
None	6 (12.00)	2 (12.50)	3.07	.38	[.10, .47]	.22
Limited experience	17 (34.00)	9 (56.25)				
Moderate experience	18 (36.00)	4 (25.00)				
Very experienced	9 (18.00)	1 (6.25)				
Years professional training, mean (SD)	5.44 (6.10)	4.63 (1.96)	.52	.60	[-1.19, 2.81]	.04
Years working post-core qualification, mean (SD)	10.14 (10.61)	14.69 (15.44)	-1.32	.19	[-11.41, 2.32]	.34
Days specialist training, mean (SD)	19.84 (34.54)	9.19 (24.89)	1.14	.26	[-8.05, 29.35]	.35

	Mental Health Experience	Physical Health	T or χ^2	p	95% CI	Effect size (Cramer V or *d*)
Professional discipline, n, (%)			N/A			
Doctor	5 (10.00)	11 (68.75)				
Psychiatrist	0 (0)	0 (0)				
Psychologist	18 (36.00)	1 (6.25)				
Physical health nurse	2 (4.00)	4 (25.00)				
Mental health nurse	13 (26.00)	0 (0)				
Occupational therapist	4 (8.00)	0 (0)				
Social worker	1 (2.00)	0 (0)				
Support Worker	1 (2.00)	0 (0)				
Psychological Therapist	2 (2.00)	0 (0)				
Physiotherapist	0 (0)	0 (0)				
Other	4 (8.00)	0 (0)				
AHIQ, Attitudes mean (SD)						
Total	161.55 (19.44)	136.38 (22.88)	4.31	**<.001**	[13.49, 6.86]	1.19
Enjoyment	61.71 (13.22)	48.19 (13.72)	3.52	**.001**	[5.85, 21.20]	1.00
Security	49.69 (4.43)	44.06 (6.43)	3.93	**<.001**	[2.77, 8.50]	1.02
Acceptance	27.51 (2.16)	25.15 (3.02)	2.85	**.01**	[.63, 4.02]	.90
Purpose	13.90 (2.42)	11.44 (2.10)	3.64	**.001**	[1.11, 3.81]	1.09
Enthusiasm	8.73 (1.98)	7.50 (1.16)	2.36	**.02**	[.19, 2.28]	.76

	Mental Health Experience	Physical Health	T or χ^2	p	95% CI	Effect size (Cramer V or *d*)
Burnout - MBI-HSS, mean (SD)						
Emotional exhaustion	18.57 (9.71)	21.00 (10.48)	-.85	.40	[-8.13, 3.27]	.24
Personal accomplishment	38.20 (5.86)	36.63 (7.90)	.86	.40	[-2.11, 5.27]	.23
Depersonalization	3.82 (3.57)	6.63 (7.47)	-2.48	**.02**	[-8.89, -.73]	.48
Negative Evaluative Beliefs (EBS), mean (SD)						
Self-Self	1.29 (2.94)	1.19 (2.23)	1.22	.90	[1.51, 1.70]	.04
Self-Other	.33 (.92)	.06 (.25)	1.81	.08	[-.03, .56]	.40
Other-Self	1.31 (2.95)	1.06 (3.09)	.28	.78	[-1.47, 1.96]	.08
Total	3.08 (6.27)	2.31 (4.64)	.45	.65	[-2.64, 4.18]	.14
Effective Working (EWCC), mean (SD)	38.84 (6.08)	32.06 (5.64)	3.94	**.001**	[3.34, 10.21]	1.16
Lack of Support (NSS), mean (SD)	1.31 (1.76)	3.88 (2.96)	-3.28	**.004**	[-4.21, -.93]	1.06

d (t-tests)= 0.20 small effect size, *d* =0.50 medium effect size, *d* = 0.80 large effect size.

Cramer's V (chi-square); 0.1 = small effect size, 0.3 = medium effect size, 0.5 = large effect size.

2.4.2 Hypothesis 1 – Differences between physical health staff and staff with mental health experience on professional and psychological factors

Professional factors. Contrary to hypotheses, independent samples t-tests demonstrated no significant difference between staff with mental health experience and physical health staff in number of years of core professional training, number of years working post core training, number of days specialist training and levels of experience working with homeless clients (Table 1). These findings suggest that both staff with mental health experience and physical health staff, have equivalent access to specialist training opportunities, similar levels of experience of working with homeless clients and consistent professional working pathways in terms of duration of training and working clinically.

Psychological factors. Data from the EBS (negative evaluative beliefs), MBI-HSS (burnout; depersonalisation subscale) and NSS (lack of support) were slightly positively skewed, which is likely to reflect the nature of the sample, given that they were health professionals. Accordingly, the bootstrapping function was selected for these variables across each of the analyses, providing bias corrected confidence intervals. The assumption of homogeneity of variances between groups was met. The results were consistent with hypothesis 1, where significant differences were found between physical health staff and staff with mental health experience, such that staff working in physical health settings held significantly more stigmatising attitudes than staff with mental health experience. This was also consistent for each of the individual subscales of the AHIQ (Table 1) and effect sizes ranged from large to very large. Physical health staff showed significantly higher levels of depersonalisation (one of the burnout subscales of the MBI-HSS) compared to staff with mental health experience and this achieved a large effect size. However, no significant differences were found between health settings for either emotional exhaustion or personal accomplishment subscales of the MBI-HSS (Table 1). Results demonstrated lower confidence in working effectively with complex clients in physical health staff compared to staff with mental health experience and this achieved a very large effect size. Additionally, perceived lack of support (NSS) was significantly higher for physical health professionals compared to staff with mental health experience, achieving a very large effect size. As anticipated, there were no significant differences in total negative evaluative beliefs (EBS) scores or in either of the three subscales found between mental health and physical health settings. This is likely to reflect the

fact that the sample comprised health professionals and therefore they might be assumed to hold more positive person evaluations, given that they have chosen a caring occupation.

2.4.3 Hypothesis 2 – Associations between demographic, professional and psychological variables

Bivariate Pearson's correlations were used to assess the associations between predictor variables (psychological factors and professional factors) and the primary outcome variable, stigmatising attitudes. Secondary associations were explored between professional factors (experience and training) and psychological factors (attitudes, lack of support, evaluative beliefs) with burnout (MBI-HSS emotional exhaustion, personal accomplishment and depersonalisation) and effective working with complex clients. These correlations were undertaken using pooled data of mental health staff and staff working across both settings (Table 2) and separate correlations were run for the data from physical health professionals (Table 3). Variables were linear and bootstrapping was used to obtain bias corrected accelerated 95% confidence intervals for skewed data.

Table 2

Associations of attitudes, burnout and confidence working effectively with complex clients with professional and psychological variables for mental health staff and staff working across both physical health and mental health settings (n=50).

	AHIQ Total		EWCC		Emotional Exhaustion		Personal Accomplishment		Depersonalisation	
	r	*p*	*r*	*p*	*r*	*p*	*r*	*p*	*r*	*p*
AHIQ Total	-	-	.40	**.005**	-.51	**<.001**	.47	**.001**	-.45	**.001**
AHIQ Enjoyment	.94	**<.001**	.45	**.001**	-.46	**.001**	.54	**<.001**	-.41	**.003**
AHIQ Security	.70	**<.001**	.21	.15	-.39	**.005**	.18	.20	-.34	**.02**
AHIQ Acceptance	.49	**<.001**	.06	.70	-.44	**.001**	.12	.43	-.23	.10
AHIQ Purpose	.77	**<.001**	.38	**.008**	-.26	.07	.22	.12	-.27	.06
AHIQ Enthusiasm	.53	**<.001**	.11	.45	-.28	**.05**	.19	.18	-.34	**.01**

	AHIQ Total		EWCC		Emotional Exhaustion		Personal Accomplishment		Depersonalisation	
	r	*p*	*r*	*p*	*r*	*p*	*r*	*p*	*r*	*p*
MBI Emotional Exhaustion	-.50	**<.001**	-.12	.41	-	-	-.39	**.005**	.33	**.02**
MBI Personal Accomplishment	.47	**.001**	.47	**.001**	-.44	**.002**	-	-	-.33	**.02**
MBI Depersonalisation	-.45	**.001**	-.14	.33	.34	**.02**	-.33	**.02**	-	-
EWCC	.40	**.005**	-	-	-.12	.41	.47	**.001**	-.14	.33
Negative evaluative beliefs (EBS) Self-Self	.07	.64	-.10	.51	-.09	.54	-.10	.51	.12	.40
Negative evaluative beliefs (EBS) Self-Other	-.32	**.03**	-.09	.55	.18	.22	-.38	**.007**	.25	.08
Negative evaluative beliefs (EBS) Other-Self	-.03	.84	-.18	.23	.07	.63	-.24	.10	.26	.07
Negative evaluative beliefs (EBS) Total	-.04	.76	-.14	.33	.02	.89	-.22	.12	-.21	.15

	AHIQ Total		EWCC		Emotional Exhaustion		Personal Accomplishment		Depersonalisation	
	r	*p*	*r*	*p*	*r*	***p***	*r*	*p*	*r*	*p*
Lack of support (NSS)	-.05	.73	.003	.99	.40	**.004**	-.11	.44	-.01	.95
Experience working with homeless clients	.18	.22	.38	**.007**	-.31	**.03**	.19	.18	.04	.79
Years core-professional training	-.07	.65	-.12	.42	-.09	.52	-.04	.80	-.16	.27
Years working post-qualification	.06	.70	.17	.25	-.20	.18	.03	.83	-.10	.47
Days of specialist training	.24	.10	.15	.30	-.34	**.02**	.24	.09	-.30	**.03**
Age	.12	.43	.10	.49	-.20	.17	.04	.81	-.15	.32

Effect size (*r*): small >.10, medium >.30, large >.50

Staff with mental health experience - psychological factors.

Associations with AHIQ. In line with hypothesis 2, two of the domains of burnout (MBI-HSS emotional exhaustion and depersonalisation) were significantly negatively correlated with AHIQ total scores, indicating that as emotional exhaustion and depersonalisation increase, positive attitudes reduce. The effect size for the relationship with emotional exhaustion was large and accounted for 25% of the variance in stigmatising attitudes. The effect size for the relationships with depersonalisation was medium-large and accounted for 20% of the variance in staff attitudes. Alongside this, personal accomplishment (burnout subscale) was positively significantly correlated with staff attitudes, suggesting that more positive attitudes are associated with greater personal accomplishment. There was a positive significant association between effective working with complex clients (EWCC) and staff attitudes, achieving a medium-large effect size, which demonstrates that positive attitudes were associated with confidence to work effectively with complex clients (Table 2). The EBS self-other subscale achieved a medium effect size, reaching statistical significance with staff attitudes, indicating a relationship between negative evaluations of others and less positive attitudes (negative correlation). Neither EBS total scores or the other-self, self-self evaluations demonstrated a significant relationship with staff attitudes. Interestingly, no significant relationship was identified between attitudes and lack of support for staff with mental health experience.

Associations with EWCC. Contrary to hypotheses, the association between effective working with complex clients with evaluative beliefs and perceived lack of support achieved very small effect sizes and these relationships did not reach statistical significance. In relation to burnout (MBI-HSS emotional exhaustion, personal accomplishment and depersonalisation), the relationship between effective working with complex clients was non-significant for emotional exhaustion and depersonalisation, but significant for personal accomplishment. This achieved a medium-large effect size, indicating a relationship between a greater sense of personal accomplishment and working more effectively with complex clients.

Associations with burnout (MBI-HSS subscales). The findings demonstrated that personal accomplishment was negatively, significantly correlated with self-other evaluative beliefs, achieving a medium-large effect size, demonstrating that as people feel more accomplished, they are less likely to make negative evaluations about others. Both emotional exhaustion and depersonalisation

did not appear to be associated with negative evaluative beliefs, suggesting that there may not be a relationship between person evaluations and these particular constructs of burnout. Out of the three MBI-HSS scales of burnout, emotional exhaustion was the only construct positively significantly associated with perceived lack of support. This achieved a medium-large effect size, which suggests that perceived levels of support at work may have a particular effect on people's experiences of emotional exhaustion.

Staff with mental health experience - Professional & demographic factors. Staff attitudes were not significantly correlated with any of the professional factors. However, more experience of working with homeless clients was negatively significantly associated with emotional exhaustion (MBI-HSS subscale, medium effect size) and positively significantly correlated with effective working with complex clients (EWCC), indicating that greater familiarity in working with homeless clients is associated with lower levels of emotional exhaustion and more effective working with complex clients. Age, years core professional training and years working post-core qualification were not significantly associated with any of the psychological factors (attitudes, burnout and effective working with complex clients). Days of specialist training was significantly negatively correlated with emotional exhaustion and depersonalisation (MBI-HSS), achieving medium effect sizes, indicating that additional training may have an effect of reducing the likelihood of experiencing these types of burnout.

Physical health staff - psychological factors.

Associations with AHIQ. The results showed that for physical health staff all three subscales for burnout (MBI-HSS emotional exhaustion, personal accomplishment and depersonalisation), were significantly correlated with staff attitudes (Table 3). This suggests that higher levels of emotional exhaustion (very large effect size) and depersonalisation (very large effect size) were associated with less positive attitudes and higher levels of personal accomplishment were associated with more positive attitudes (very large effect size). There was a significant, positive correlation between staff attitudes and effective working, indicating that positive attitudes were associated with working more effectively with complex clients in physical health staff. Further to this, the findings revealed a

negative association between total evaluative beliefs (EBS) and staff attitudes (medium-large effect size) suggesting that more negative person evaluations (EBS) were associated with less positive attitudes towards homeless clients. Staff attitudes and lack of perceived support (NSS) were negatively correlated, indicating that experiences of having poorer support was associated with stigmatising attitudes and achieved a medium-large effect size.

Associations with EWCC. Effective working with complex clients was significantly associated with burnout (all three subscales of MBI-HSS) for staff working in physical health and each association achieved a very large effect size. This indicates that there is a relationship between lower levels of emotional exhaustion and depersonalisation, as well as higher levels of personal accomplishment with working effectively with complex clients. There were significant negative correlations between negative other-self evaluative beliefs (EBS; very large effect size) and total negative evaluative beliefs (very large effect size) with effective working with complex clients, suggesting that there is a relationship between holding more negative person evaluations and less effective working with complex clients. Results highlighted that having a lack of perceived support was significantly negatively associated with effective working with complex clients (very large effect size). This suggests that there is a relationship between poorer levels of support and less effective working with complex clients for physical health staff.

Table 3

Associations of attitudes, burnout and confidence working effectively with complex clients with professional and psychological variables for physical health staff (n = 16).

	AHIQ Total		EWCC		Emotional Exhaustion		Personal Accomplishment		Depersonalisation	
	r	*p*	*r*	*p*	*r*	*p*	*r*	*p*	*r*	*p*
AHIQ Total	-	-	.63	**.009**	-.60	**.01**	.54	**.03**	-.67	**.004**
AHIQ Enjoyment	.95	**<.001**	.73	**.001**	-.57	**.02**	.60	**.01**	-.61	**.01**
AHIQ Security	.80	**<.001**	.38	.15	-.46	.08	.42	.11	-.49	.06
AHIQ Acceptance	.85	**<.001**	.23	.38	-.59	**.02**	.34	.20	-.63	**.009**
AHIQ Purpose	.68	**.004**	.38	.15	-.28	.29	.06	.81	-.55	**.03**
AHIQ Enthusiasm	.64	**.007**	.46	.08	-.53	**.03**	.29	.29	-.72	**.002**

	AHIQ Total		EWCC		Emotional Exhaustion		Personal Accomplishment		Depersonalisation	
	r	*p*	*r*	*p*	*r*	*p*	*r*	*p*	*r*	*p*
MBI Emotional Exhaustion	-.60	**.01**	-.59	**.02**	-	-	-.54	**.03**	.75	**.001**
MBI Personal Accomplishment	.54	**.03**	.63	**.009**	-.54	**.03**	-	-	-.54	**.03**
MBI Depersonalisation	-.67	**.004**	-.58	**.02**	.75	**.001**	-.54	**.03**	-	-
EWCC	.63	**.009**	-	-	-.59	**.02**	.63	**.009**	-.58	**.02**
Negative Evaluative Beliefs (EBS) Self-Self	-.20	.47	-.46	.08	.22	.41	-.24	.37	.35	.19
Negative Evaluative Beliefs (EBS) Self-Other	.01	.98	-.10	.72	-.15	.57	.05	.86	-.06	.83
Negative Evaluative Beliefs (EBS) Other-Self	-.37	.16	-.61	**.01**	.47	.07	-.73	**.001**	.40	.13

	AHIQ Total		EWCC		Emotional Exhaustion		Personal Accomplishment		Depersonalisation	
	r	*p*	*r*	*p*	*r*	*p*	*r*	*p*	*r*	*p*
Negative Evaluative Beliefs (EBS) Total	-.34	.20	-.63	**.009**	.41	.12	-.60	**.01**	.43	.10
Lack of support (NSS)	-.46	.07	-.76	**.001**	.76	**.001**	-.42	.11	.68	**.003**
Experience working with homeless clients	.52	**.04**	.45	.08	<.001	1.0	.25	.36	-.03	.91
Years core-professional training	.08	.77	-.08	.78	.14	.62	.37	.16	-.03	.90
Years working post-qualification	.38	.15	.25	.35	-.30	.25	.37	.16	-.44	.09
Days of specialist training	-.08	.77	.31	.25	-.17	.54	-.11	.68	-.25	.35
Age	.44	.09	.34	.20	-.45	.08	.39	.14	-.59	**.02**

Effect size (*r*): small >.10, medium >.30, large >.50

Associations with burnout (MBI-HSS). Total negative evaluative beliefs (EBS) and other-self negative evaluative beliefs were associated with burnout, achieving medium to very large effect sizes (MBI-HSS all three subscales). This suggests that there is an association between more negative person evaluations particularly other-self judgements, with higher levels of emotional exhaustion, depersonalisation and lower levels of personal accomplishment. Lack of perceived support was associated with greater levels of burnout (MBI-HSS all three subscales). The correlations between emotional exhaustion and depersonalisation with lack of support achieved very large effect sizes and achieved a medium-large effect size with personal accomplishment. This indicates that reduced levels of support are associated with higher levels of emotional exhaustion, depersonalisation and lower levels of personal accomplishment.

Physical Health Staff - Professional & demographic factors.

There was a positive association between age, experience of working with homeless clients and years working post qualification with staff attitudes (medium-large, large, medium-large effect sizes respectively). This suggests that there is a relationship between having more experience of working with homeless clients, being older and working more years post-qualification with holding more positive attitudes towards homeless clients. Alongside this, age, experience of working with homeless clients and specialist training were positively correlated with effective working with complex clients (medium-large effect sizes), indicating that being older, more familiar with homeless clients and having engaged with more days of specialist training is associated with more effective working with complex clients. Years working post-qualification and age were found to correlate with emotional exhaustion, personal accomplishment and depersonalisation, indicating there is an association between having worked for longer post qualification and being older in age with lower levels of emotional exhaustion and depersonalisation as well as higher levels of personal accomplishment.

2.4.4 Hypothesis 2 – Multivariate Associations between Professional and Psychological Factors

A hierarchical multiple regression model was explored for staff with mental health experience. Unfortunately, due to limited sample size (*n*=16), a regression model was not conducted for the data from physical health staff. Following outcomes from the correlational

analyses, significant predictors of stigmatising attitudes were entered into the hierarchical model in two blocks; professional factors (experience working with homeless clients and specialist training) in block one, and psychological factors (MBI-HSS, EWCC, EBS, NSS) in block two. As with the correlational analyses, the analyses were repeated using AHIQ total, the three MBI-HSS subscales and the EWCC in turn as the outcome variable (Tables 4-8).

Attitudes (AHIQ) as the primary outcome. A hierarchical multiple linear regression was carried out to see whether psychological factors (burnout, lack of support and evaluative beliefs), controlling for professional factors (experience and training) predicted stigmatising attitudes in staff working in mental health settings and staff working across mental health and physical health settings. Results are shown in Table 4 and show that the overall model was significant, with high levels of emotional exhaustion being associated with more stigmatising attitudes, even when the other variables were being controlled for. This achieved a small-medium effect size and accounted for 9% of the variance in staff attitudes. More effective working with complex clients also significantly predicted more positive staff attitudes when controlling for the effects of the other variables, which achieved a small-medium effect size and accounted for 5% of the variance in staff attitudes. The final model accounted for 47% of the variance in staff attitudes, which highlights the importance of the other included variables in having a cumulative impact on staff attitudes, which contributes to the overall model.

Table 4

Hierarchical multiple regression with staff attitudes as the primary outcome variable for staff with mental health experience.

Predictor	B	SE B	β	*p*	95% CI	Effect Size (sr^2)
Model 1						
Experience of working with homeless clients	2.76	3.24	.13	.40	[-3.77, 9.29]	.01
Specialist training	.11	.09	.19	.21	[-.06, .28]	.03
Model 2						
Experience of working with homeless clients	-.14	3.04	-.006	.94	[-6.28, 6.00]	<.001
Specialist training	-.009	.08	-.02	.90	[-.16, .14]	.01
MBI-HSS Emotional exhaustion	-.79	.30	-.40	**.01**	[-1.40, -.18]	.09
MBI-HSS Personal accomplishment	.20	.52	.06	.70	[-.84, 1.25]	.003
MBI-HSS Depersonalisation	-1.23	.73	-.23	.10	[-2.70, .24]	.04
EWCC	.90	.45	.28	**.05**	[-.001, 1.80]	.05
Negative evaluative beliefs (EBS) self-other	-2.78	2.74	-.13	.32	[-8.32, 2.76]	.01
Lack of support (NSS)	1.04	1.43	.09	.47	[-1.84, 3.93]	.006

Total R^2 = .47; Model 1: R^2 = .07, $F(2,47) = 1.78$, p = .18; Model 2: R^2 change = .40, $F(8,41) = 4.49$, p = .001
Effect size sr^2; small = .02, medium = .13, large = .26

Effective working (EWCC) as the primary outcome. The results are outlined in Table 5 and show that the overall model was significant (p<.05), accounting for 32% of the variance in effective working with complex clients. Specifically, greater prior experience of working with homeless clients and higher levels of personal accomplishment were shown to be the strongest predictors of more effective working with complex clients, achieving small-medium effect sizes. Experience of working with homeless clients accounted for 6% of the variance in effective working with complex clients and personal accomplishment accounted for 7% of the variance in effective working in complex clients. These results suggest that greater familiarity with a client-group may lead to more insight and understanding, which is associated with more effective working with complexity.

Table 5

Hierarchical multiple regression with effective working with complex clients as the primary outcome variable for staff with mental health experience.

Predictor	B	SE B	β	*p*	95% CI	Effect Size (sr^2)
Model 1						
Experience of working with homeless clients	2.54	.90	.38	**.007**	[.73, 4.35]	.14
Model 2						
Experience of working with homeless clients	1.71	.85	.26	**.05**	[-.003, 3.43]	.06
AHIQ Total	.06	.04	.20	.15	[-.02, .15]	.03
MBI-HSS Personal accomplishment	.32	.15	.31	**.04**	[.02, .61]	.07

Total R^2 = .32; Model 1: R^2 = .15, $F(1,48) = 8.00$, p = .007*; Model 2: R^2 change = .18 $F(3,46) = 7.16$, p < .001

Effect size sr^2; small = .02, medium = .13, large = .26

Emotional exhaustion (MBI-HSS subscale) as the primary outcome. The results in Table 6 showed that the overall model was significant (p<.001), with less positive attitudes being associated with greater levels of emotional exhaustion, achieving a small-medium effect size, even with the other factors being controlled for. Further to this, the findings demonstrated that greater levels of perceived lack of support significantly predicted higher levels of emotional exhaustion. The overall model accounted for 46% of the variance in levels of emotional exhaustion in staff with mental health experience, whilst staff attitudes accounted for 10% of the variance in levels of emotional exhaustion and lack of support accounted for 11% of the variance. This suggests that both attitudes and levels of support are important to consider when addressing levels of emotional exhaustion in staff teams.

Table 6

Hierarchical multiple regression with emotional exhaustion as the primary outcome variable for staff with mental health experience.

Predictor	B	SE B	β	*p*	95% CI	Effect Size (sr^2)
Model 1						
Experience of working with homeless clients	-2.36	1.49	-.23	.12	[-5.35, .64]	.04
Days of specialist training	-.07	.04	-.26	.08	[-.16, .008]	.06
Model 2						
Experience of working with homeless clients	-1.40	1.26	-.13	.27	[-3.93, 1.14]	.01
Days of specialist training	-.03	.04	-.12	.33	[-.10, .04]	.01
AHIQ Total	-.19	.06	-.37	**.006**	[-.32, -.06]	.10
MBI-HSS Personal accomplishment	-.20	.21	-.12	.35	[-.61, .22]	.01
Lack of Support (NSS)	1.87	.63	.34	**.005**	[.60, 3.13]	.11

Total R^2 = .46; Model 1: R^2 = .16, $F(2,47) = 4.48$, p = .02; Model 2: R^2 change = .30, $F(5,44) = 7.35$, p < .001

Effect size sr^2; small = .02, medium = .13, large = .26

Personal accomplishment (MBI-HSS subscale) as the primary outcome. The results revealed that the overall hierarchical regression model was significant (p<.001), accounting for 45% of the variance in levels of personal accomplishment in staff with mental health experience (Table 7). More effective working with complex clients was significantly associated with greater levels of personal accomplishment, which achieved a near medium effect size and accounted for 12% of the variance in levels of personal accomplishment. Greater levels of emotional exhaustion significantly predicted lower levels of personal accomplishment in staff, which achieved a small-medium effect size and accounted for 6% of the variance in levels of personal accomplishment. Finally, greater negative evaluative beliefs about others (self-other) were significantly associated with lower levels of personal accomplishment in staff, which achieved a small-medium effect size and accounted for 5% of the variance in levels of personal accomplishment.

Table 7

Hierarchical multiple regression with personal accomplishment as the primary outcome variable for staff with mental health experience.

Predictor	B	SE B	β	*p*	95% CI	Effect Size (sr^2)
AHIQ Total	.02	.05	.05	.73	[-.08, .11]	.002
EWCC	.37	.12	.38	**.004**	[.13, .61]	.12
Negative evaluative beliefs (EBS) self-other	-1.56	.76	-.25	**.05**	[-3.10, -.02]	.05
MBI-HSS Emotional Exhaustion	-.18	.08	-.29	**.04**	[-.34, -.01]	.06
MBI-HSS Depersonalisation	-.14	.21	-.09	.51	[-.57, .29]	.006

Total R^2 = .45, F(5,44) = 7.03, p< .001
Effect size sr^2; small = .02, medium = .13, large = .26

Depersonalisation (MBI-HSS subscale) as the primary outcome. The results revealed that the overall model was significant, with more positive attitudes being significantly associated with lower levels of depersonalisation (as characterised by cynicism and detachment; see Table 8). This relationship achieved a small-medium effect size and results highlighted that attitudes accounted for 7% of the variance in levels of depersonalisation. This highlights the importance of attitudes in predicting levels of depersonalisation in staff with mental health experience. Despite this, the overall model accounted for 26% of the variance in levels of depersonalisation, highlighting that although attitudes were shown to be the most influential factors associated with depersonalisation, all of the included variables in the final model have an important impact on levels of depersonalisation in staff.

Table 8

Hierarchical multiple regression with depersonalisation as the primary outcome variable for staff with mental health experience.

Predictor	B	SE B	β	*p*	95% CI	Effect Size (sr^2)
Model 1						
Days of specialist training	-.03	.01	-.30	**.03**	[-.06, -.003]	.09
Model 2						
Days of specialist training	-.02	.01	-.18	.21	[-.05, .01]	.03
AHIQ Total	-.06	.03	-.32	**.05**	[-.12, -.001]	.07
AHIQ Emotional Exhaustion	.02	.06	.07	.67	[-.09, .14]	.004
MBI-HSS Personal accomplishment	-.07	.09	-.11	.46	[-.24, .11]	.01

R^2 = .26; Model 1: R^2 = .09, $F(1,48) = 4.86$, p = .03; Model 2: R^2 change = .17, $F(4,45) = 3.93$, p = .008

Effect size sr^2; small = .02, medium = .13, large = .26

2.5 Discussion

The present study explored the potential relationships between a number of psychological and professional factors, in relation to working with homeless clients, across staff working in physical health and mental health settings. The primary focus was to investigate staff attitudes towards homeless clients and burnout, as well as to explore relationships with additional psychological and professional variables theoretically linked with these two constructs (namely; effective working, evaluative beliefs, support, experience and training). The results revealed three main findings: 1) staff with mental health experience showed significant differences from physical health staff on psychological factors; 2) a number of significant relationships exist between psychological and professional factors; 3) professional and psychological factors strongly predicted staff attitudes, burnout and effective working with complex clients.

2.5.1 Staff Attitudes

Attitudes and effective working. The study revealed that physical health staff held significantly more stigmatising attitudes towards homeless clients compared to staff with mental health experience. This finding is of key significance, because this is the first study of its kind directly comparing and contrasting staff attitudes across physical and mental health work settings. There is evidence to suggest that physical health staff may devalue mental health/substance-use difficulties, perceiving this to be inconsistent with their professional role (Ross & Goldner, 2009). In this way, physical health staff may be at risk of prioritising physical health issues and perceiving individuals with multifaceted needs as 'undeserving' and as a burden upon already very limited resources (Ross & Golder, 2009). Understandably, this reinforces problematic attitudes and aids marginalisation of complex client groups, such as homeless individuals. Alongside this, physical health staff also demonstrated significantly lower perceived effective working with complex clients compared to staff with mental health experience. Unsurprisingly, if staff have low perceived self-efficacy and low confidence in their abilities to work effectively with clients with multifaceted needs, then this is likely to impact attitudes towards the client-group in a bi-directional relationship. The results provide support for this assertion, given that there was an association between effective working and staff attitudes, which was even greater for physical health professionals compared to staff with mental health experience.

As described by social-cognitive theory, it is possible that the discrepancy between wanting to be an effective practitioner (taking personal responsibility), but feeling ineffective in promoting positive outcomes for this client-group, could lead to the experience of cognitive dissonance (Gawronski, 2012). It is possible that physical health staff implicitly hold a 'curative' model in mind in their work and may be less attuned to dimensions of recovery. Therefore, when clients are not observed to make linear progress, staff may find this threatening to their sense of efficacy. This may cause discomfort for staff and therefore result in attempts to reduce the magnitude of the dissonance. One way of doing this may be to change or justify the cognition/behaviour (Elliot & Devine, 1994; Losch & Cacioppo, 1990; Van Veen, Krug, Schooler, & Carter, 2009). An example of this might be to shift the assignment of responsibility from the staff member, to the client instead (e.g. 'It is not my fault I don't know how to support this person, they are too chaotic and not committed to their recovery anyway'). This transition is a self-defensive strategy, which reduces the experience of psychological discomfort when there is a discrepancy between a person's values and their behavioural decisions (Corrigan, 2004). This process may facilitate the development of stigmatising/problematic attitudes, which have severe consequences for the experiences of homeless clients accessing health services and may explain part of the reason why homeless people very rarely access services (Wen et al., 2007).

Empathy and experience of working with homeless clients. Interestingly, research shows that empathy is moderated by attitudes, such that people hold less empathy and less personal distress in response to others if they are perceived as 'responsible' and 'to blame' for their difficulties (Corrigan, 2004; Decety, Ecols, & Correll, 2010; Markham & Trower, 2010). Consequently, reduced empathy is likely to negatively impact effective working with homeless clients and reinforce stigmatising attitudes in a vicious cycle. Supporting this notion, psychologists have been shown to demonstrate more positive attitudes towards marginalised client-groups, for example; clients with emotionally unstable personality disorder (EUPD), than nurses and psychiatrists (Bodner et al., 2011). It has been hypothesised that a psychologist's understanding of the mechanisms underpinning self-sabotaging behaviours may contribute to greater levels of empathy. This reduces the likelihood of making problematic judgements (e.g. 'she is being manipulative'), conferring more positive attitudes towards the client-group (Bodner et al., 2011).

The results from the current study highlighted that prior experiences of working with homeless clients was found to be one of the strongest predictors of greater effective working with

complex clients. It could be posited that staff with more experience of working with homeless clients, are likely to have a better understanding of the difficulties commonly experienced in this client-group, which may foster greater levels of empathy. This may positively impact staff attitudes and contribute to greater levels of confidence to work effectively with this client-group despite the complexity. This notion has been supported by the literature (Bodner et al., 2011; Maguire et al., 2012; Nicol et al., 2016; Zrinyi & Balogh, 2004), whereby more experienced staff have been shown to demonstrate fewer negative attitudes and greater levels of empathy, which have contributed to improved quality of care for marginalised client-groups.

Person evaluations and effective working with complexity. Further to this, there was an association between greater other-self negative evaluative beliefs (perceived negative judgements about self from others) with more stigmatising attitudes, for physical health staff only. It is possible that other-self evaluations might be of particular importance in physical health, where staff showed poorer confidence to work effectively with clients with complex needs compared to staff with mental health experience. Perceived judgements or criticism from others influences self-confidence and self-efficacy (Iancu, Bodner, Ben-Zion, 2015), which is likely to affect abilities to work effectively. This notion was supported by the results, where less effective working was found to be one of the strongest predictors of holding more stigmatising attitudes. This could imply that confidence to work effectively influences the relationship between evaluative beliefs and stigmatising attitudes.

2.5.2 Burnout

Staff attitudes and burnout. The literature highlights a strong bi-directional relationship between stigmatising attitudes and burnout, such that problematic attitudes held towards a particular client group are associated with negative expectations for recovery (Salyers, Brennan, & Kean, 2013), making staff vulnerable to burnout (Holmqvist & Jeanneau, 2006; Maguire et al., 2012; Morse et al., 2012). Alongside this, when staff experience burnout, negative attitudes are likely to be reinforced, heightening emotional exhaustion, cynicism, detachment and less personal satisfaction/achievement (constructs of burnout; Pines & Maslach, 1978). This effect was supported by the current findings, where significant associations were found between stigmatising attitudes with emotional exhaustion, depersonalisation and personal accomplishment across mental health and physical health work setting. This highlights the

importance of the relationship between staff attitudes and burnout for staff regardless of healthcare setting (Maguire et al., 2012; Nicol et al., 2016). Interestingly, higher levels of emotional exhaustion most strongly predicted stigmatising attitudes and holding more stigmatising attitudes was also one of the strongest predictors of higher levels of emotional exhaustion. This raises the likelihood that stigmatising attitudes and emotional exhaustion share a bi-directional relationship, which negatively affects the efficacy of services being provided to clients with complex needs, through high staff turnover and reduced client-satisfaction/engagement (Hayes et al., 2004).

Burnout and lack of support. Alongside this, physical health staff showed significantly higher levels of depersonalisation (a subscale of burnout) and lower perceived levels of support, than staff with mental health experience. This underscores potential distinctions in working environments between mental health and physical health settings; where staff working in physical health may have fewer opportunities to access regular support than mental health staff (Nicol et al., 2016). This might contribute to lower levels of resilience and subsequent burnout (emotional exhaustion, personal accomplishment, depersonalisation) when working with complexity, as the work is likely to be challenging and emotive at times (James & Cowman, 2007; Maguire et al., 2012). Importantly, lack of support and burnout were significantly associated irrespective of healthcare setting, highlighting the importance of these factors for all healthcare staff. Throughout the literature, support and training have been highlighted as central components in addressing burnout and improving perceived self-confidence to affect positive change (Bambling et al., 2006; Ross & Goldner, 2009). The results from the present study provide further weight to the evidence-base, that enhanced support may facilitate the development of positive attitudes, improve resilience and self-efficacy, which could have a secondary impact of reducing risk of burnout in staff (Bland & Rossen, 2005). This is likely to be especially important for staff working with complex client-groups, such as homeless individuals, where presenting difficulties may be perceived as extremely challenging (e.g. substance-use, interpersonal conflicts) and difficulties with engagement may be rife (Hayes et al., 2004).

Burnout and effective working. There was a strong relationship identified between effective working with complex clients and personal accomplishment, which suggests that if people receive markers of their efficacy relating to their work, then they are more likely to experience a sense of achievement and personal satisfaction. These positive experiences enable staff to feel more motivated and invested in their work, which contributes to more effective working in a positively perpetuating cycle (Khamisa, Oldenburg, Peltzer, & Ilic, 2015; Leiter, 1993). A larger effect size was observed for the relationship between personal accomplishment and effective working with complexity within physical health staff compared to staff with mental health experience. This effect may be explained by the fact that physical health staff showed significantly less effective working with complex clients compared to staff with mental health experience. Therefore, it is possible that because staff feel less confident to work effectively with complexity, they may also experience a lesser sense of achievement and satisfaction from their work. Alternatively, this effect may not be so large for staff with mental health experience (although there is a relationship), because on the whole they are able to work more effectively with clients with complex needs and as a result their sense of accomplishment is less impacted.

The complexity of the interactions between multiple factors explored in this study related to homeless healthcare is evident and highlights a number of potential areas where interventions could be extremely beneficial in improving the support of the staff workforce, thereby enhancing the efficacy and efficiency of services. It is important to note that these hypotheses require further empirical testing and exploration, and the results should be interpreted with caution given the methodological limitations of the present study.

2.5.3 Strengths and Limitations

A major strength of this study is the contribution it makes to the limited evidence-base in the homelessness literature, particularly in relation to staff experiences. Staff recruited to participate in the study came from diverse health settings (CMHT's, A&E, renal outpatient departments, acute ward, homeless healthcare team), despite being limited by the local area. This improves insight and understanding of experiences across a relatively diverse population group, which has implications for generalisability. The present research is the first of its kind that directly compares and contrasts experiences and characteristics of physical health staff and mental health staff. In doing so, the results have revealed a number of important factors that may be potentially problematic in contributing to on-going marginalisation and exclusion of homeless clients from health services as well as staff burnout.

The current study has a number of limitations that warrant discussion. Due to the constraints of completing the project within a specified time-frame, the sample size was limited, affecting the overall power of the study. This in particular, has implications for the present study, given that several regression models were tested, thereby increasing the likelihood of Type I error. It is possible that with a larger sample size, the study would have been powered sufficiently to detect additional relationships that may have gone undetected in the present study. Accordingly, results should be interpreted with caution and the ability to generalise the findings to other services and staff groups may be restricted. In future research, sample size may be increased by expanding recruitment to more regions, recruiting over a longer time-frame, as well as utilising social media platforms to engage participants nationally. This would also enhance how representative the sample is, facilitating the ability to generalise the results. Despite this, it has been possible to generate effect sizes that can inform and contribute to subsequent research being conducted in the area. The use of effect sizes are often more meaningful in research because they provide an indication of how important each variable is in affecting the outcome, as they measure the magnitude of an observed effect (Sullivan & Feinn, 2012). Moreover, despite the limited sample size, statistically significant results were obtained in some analyses, reflecting very large effect sizes, which highlights the relative importance of the variables explored in the current study and prompts future research to replicate and extend the study. The low power also had implications for the statistical analyses, such that regression analyses were not explored for the full data set (physical health staff, n=16). Therefore, future research should aim to address these sample limitations.

The statistical design employed meant that causal relationships were not established. Instead, once greater insight into the relationships that exist between these variables have been established (including directionality), empirical designs can be employed to test causal effects. Further to this, because the present study presents an original piece of research, there was limited literature to draw upon in order to inform and shape hypotheses and predictions. This meant that in addition to abstracting relevant theory from existing literature to inform the project, the researcher drew upon their own personal perspectives (shaped by a number of social/cultural constructs), which could have led to bias.

There may also have been additional confounding variables that may not have been controlled for, but may have had an impact on the findings. For example, the EWCC questionnaire utilises language specifically exploring staff confidence in relation to working *psychologically* with clients. It is possible that physical health staff would not be expected to work psychologically within their professional role and understandably indicate low confidence working in this way, however, express high levels of confidence and efficacy in working with homeless clients within their professional remit. It is also important to consider that staff experiencing significant levels of burnout were unlikely to have participated in this study, given that they would be more vulnerable to experiencing low motivation, cynicism and exhaustion. Accordingly, levels of burnout indicated within the study may be considerably lower than actual experiences of burnout in health professionals. Within this study, there were several participants with no experience of having worked with homeless individuals; as a result, responses may have been provided considering hypothetical situations, which may not be reflective of actual attitudes and perceived self-efficacy. A final potentially confounding factor might be whether participants had actively chosen to work with homeless individuals. It might be assumed that participants seeking out employment in homelessness services may hold more positive, empathetic attitudes and a greater degree of insight into this client-group's needs, which may contribute more effective working and a reduced risk of burnout.

2.5.4 Clinical Implications and Future Directions

With consideration to the outcomes of this study, there are several important clinical implications that warrant further investigation. Firstly, the stark distinctions between the attitudes and experiences of physical health and mental health staff highlight the importance of further exploration between the two settings. They suggest that physical health staff may face more challenges and issues that have the potential to negatively impact service delivery for homeless clients (and more generally for complex clients with multifaceted needs), than staff from a mental health background. This highlights the importance of developing interventions that can support staff in their work, particularly in relation to complex client-groups where multifaceted needs are likely to exist. Further to this, this study raises the importance of how homeless clients access and experience health services; for example, if homeless clients are more likely to avoid services and allow their symptoms to escalate, they may be more likely to present in health services for the first time in A&E (Ku, Scott, Kertesz, & Pitts, 2010; Kushel, Perry,

Bangsberg, Clark, & Moss, 2002; Lynch & Greaves, 2000). Compounding the problem, if the staff in A&E are at risk of holding stigmatising attitudes, experiencing burnout and are not very confident in working effectively with clients who present with complexity, homeless clients may be more vulnerable to experiences that are perceived as discriminatory and unhelpful (Wen et al., 2007). Within the literature, it has been documented that these negative experiences of healthcare services lead to future avoidance of services (Canavan et al., 2012; Klop, Evenblij, Gooties, de Veer, & Onwuteaka-Philipsen, 2018; Wen et al., 2007), further marginalisation and traumatisation of homeless clients. Further to this, the nature of the work for staff working in A&E might contrast to community mental health settings, whereby A&E staff are limited in opportunities to facilitate quality interactions with clients due to pressures in service structures to ensure high client turnover. Conversely, within the community, staff may have more opportunities for contact with the same client, facilitating relationship development and high quality interactions.

Future research should address the sample size limitations in the current study, in order to improve the validity and reliability of the findings. With a larger, more diverse sample, the generalisability of the findings can be improved and evidence-based models could be developed in relation to staff attitudes towards homeless clients. This might include exploration of mediation models across physical health staff and staff with mental health experience. Interestingly, the data from the EWCC (effective working with complex clients) provided a unique, new construct relating to professional experiences, that was conceptually distinct from other measures. This scale provided clinically relevant and meaningful insights that have extended our understanding of the challenges staff face when working with complexity. Accordingly, it will be important to publish this scale with validation data, so that future research can benefit from its utility. This may provide better opportunities to conceptualise the challenges that staff face when working with complexity and how this impacts the efficacy and efficiency of service-delivery.

2.6 Conclusions

There appear to be potentially clinically important relationships between staff attitudes, burnout and effective working in relation to homeless clients, which could have a significant baring on the efficacy of service delivery in the NHS for homeless clients. These relationships may be particularly influential for staff working in physical health settings compared to staff with mental health experience, such that physical health staff appear to be more vulnerable to experiencing lower levels of support, greater levels of burnout, more stigmatising attitudes and lower perceived confidence to work effectively with complex client-groups. It is possible that these factors share complex interactions and warrant further exploration to support the current findings and to extend them by exposing causal relationships.

Appendix A Articles included for synthesis

Title	Year Location	Author	Design Participant characteristics	Relevance to Realist Review
1. Survival analyses of social support and trauma among homeless male and female veterans who abuse substances	2006 US	Benda	Quantitative, non-randomised study Gender: Mixed Veterans Living situation: No permanent residence in past 30 days	Exploration of the relationships between trauma and social support with housing tenure in male and female substance-users
2. Homelessness in the UK: who is most at risk?	2018 UK	Bramley & Fitzpatrick	Quantitative descriptive study Gender: Mixed Living situation: Individuals with any history of homelessness	Consideration of risk factors associated with homelessness. Critical review of factors such as social support and domestic violence
3. Drug and alcohol use of the homeless within the homeless health outreach team: is there an association between drug of choice and mental health diagnosis?	2012 Australia	Campbell & Lloyd	Quantitative non-randomised study Gender: Mixed Living situation: No current permanent residence	Exploration of the relationship between mental health problems and substance-use

4. Service provision and barriers to care for homeless people with mental health problems across 14 European capital cities	2012 Europe	Canavan et al.	Mixed methods study Gender: Mixed Living situation: No current permanent residence	Reasons for why homeless people avoid services. Impact of substance-use on service-use in homeless people
5. Marginalization and associated concepts and processes in relation to mental health/illness	2014 Australia	Cleary, Horsfall, & Escott	Grey literature-commentary Gender: Mixed	The impact of mental health related stigma on people's experiences. Exploration of people's experiences of social isolation and the use of maladaptive coping (antisocial behaviour and experiences of the criminal justice system)
6. Housing retention in single-site housing first for chronically homeless individuals with severe alcohol problems	2013 US	Collins, Malone, & Clifasefi	Quantitative non-randomised study Gender: Mixed Living situation: Chronic homelessness	Exploration of predictors of repeat homelessness in a housing first programme

7. Identifying mental and physical health correlates of homelessness among first-time and chronically homeless veterans	2015 US	Creech et al.	Quantitative non-randomised study Gender: Mixed Veterans Living situation: Recurrent and chronic homelessness	Exploration of factors associated with health and mental health with recurrent/chronic homelessness in war veterans
8. Perspectives of homeless people on their health and health needs priorities	2007 Canada	Daiski	Qualitative Study Gender: Mixed Living situation: No current permanent residence	How homeless people perceive their health needs. Key factors, such as social isolation, stigma and maladaptive coping are discussed in relation to their experiences of homelessness.
9. Does active substance use at housing entry impair outcomes in supported housing for chronically homeless persons?	2011 US	Edens, Mares, Tsai, & Rosenheck	Quantitative non-randomised study Gender: Mixed Living situation: Chronic homelessness	The relationship between substance-use, mental health problems and criminal justice involvement is explored for people classed as chronically homeless
10. Explaining homelessness: a critical realist perspective	2005 UK	Fitzpatrick	Grey literature – commentary Gender: Mixed	Exploration of causal factors for homelessness. Highlights mental health

			Living situation: No permanent residence	problems and substance-use as key factors
11. Pathways into multiple exclusion homelessness in seven UK cities	2013 UK	Fitzpatrick, Bramley, & Johnsen	Quantitative descriptive study Gender: Mixed Living situation: No permanent residence	Exploration of factors associated with pathways into repeat homelessness. Substance use and mental health problems are highlighted as being heavily implicated
12. Prevalence and risk factors for homelessness and utilization of mental health services among 10,340 patients with serious mental illness in a large public mental health system	2005 US	Folsom et al.	Quantitative descriptive study Gender: Mixed People with severe mental illness (SMI) Living situation: No permanent residence	Risk factors for homelessness for individuals with severe mental illness. Prevalence estimates for substance-use and mental health disorder classifications.
13. Homelessness in schizophrenia	2012 International	Foster, Gable, & Buckley	Grey literature – review Gender: Mixed Individuals with schizophrenia Living situation: Current or historic experiences of no permanent residence	Exploration of the relationship between schizophrenia, substance-use, social isolation and involvement with the criminal justice system

14. Role of gender, substance use, and serious mental illness in anticipated postjail homelessness	2014 US	Fries, Fedock, & Kubiak	Quantitative non-randomised study Gender: Mixed Incarcerated individuals Living situation: Incarcerated in jail	Exploration of the relationships between mental illness, substance-use and criminal justice involvement
15. Untangling the complex needs of people experiencing gambling problems and homelessness	2013 Australia	Holdsworth & Tiyce	Qualitative study Gender: Mixed Living situation: No current permanent residence	Exploration of the experiences of homeless people in relation to substance-use, gambling, mental illness and social isolation.
16. Breaking the cycle of homelessness: housing stability and social support as predictors of long- term well-being	2015 Australia	Johnstone, Parsell, Jetten, Dingle, & Walter	Quantitative non-randomised study Gender: Mixed Living situation: People residing in crisis/specialist homelessness accommodation	Exploration of the relationship between social support and mental well-being in homeless individuals
17. Homeless chronicity and health-related quality of life trajectories	2005 US	Kertesz	Quantitative non-randomised study Gender: Mixed Living situation: Individuals with	Exploration of the implications of experiencing chronic homelessness on mental health and associations

among adults with addictions			no permanent residence compared to housed individuals	with substance-use and social isolation
18. Care avoidance among homeless people and access to care: an interview study among spiritual caregivers, street pastors, homeless outreach workers and formerly homeless people	2018 Netherlands	Klop, Evenblij, Gootjes, de Veer, & Onwuteaka-Philipsen	Qualitative study Gender: Mixed Living situation: Current and historic experiences of no permanent residence	Exploration of the factors leading to care avoidance in homeless people. Discussion around mistrust of services, which has implications for social isolation and recurrent homelessness
19. Barriers to health and social services for street-based sex workers	2005 US	Kurtz, Surratt, Kiley, & Inciardi	Mixed methods study Gender: Female Sex-workers Living situation: Varied between no permanent residence and housed individuals	Factors associated with marginalisation of sex workers from health services. Substance-use, social isolation and emotional distress are discussed
20. Towards an integrative theory of homelessness and rough sleeping	2017 UK	Maguire	Grey literature – book chapter Gender: Mixed Living situation: No permanent residence	Discussion of a psychological model for conceptualising repeat homelessness. Summary of the importance of attachment issues,

				emotion regulation and cognitive theory in the development of mental health problems. The relationship between psychological problems and problematic behaviours are considered (substance-use, violence)
21. Affordable housing, homelessness, and mental health: what heath care policy needs to address	2015 US	Martin	Grey literature – commentary Gender: Mixed Living situation: No permanent residence	Exploration of the relationship between mental illness and relationship breakdown, and implications for social isolation
22. Risk factors associated with recurrent homelessness after a first homeless episode	2014 US	McQuisition, Gorroochurn, Hsu, & Caton	Quantitative non-randomised study Gender: Mixed Living situation: No permanent residence	Comparisons of risk factors for recurrent, chronically and stably housed individuals. Relationships between mental health problems, substance-use, criminal justice involvement and social isolation are discussed
23. Causes of homelessness prevalence: relationship between	2017 Japan	Nishio et al.	Quantitative non-randomised study Gender: Mixed Learning disability	Exploration of the barriers preventing transition out of homelessness for people with mental health problems and/or cognitive difficulties. Implications of

homelessness and disability			Living situation: No current permanent residence	problematic relationships and social isolation on likelihood of homelessness are discussed
24. Problem gambling and homelessness: results from an epidemiologic study	2015 US	Nower, Eyrich-Garg, Pollio, & North	Quantitative descriptive study Gender: Mixed Living situation: No current permanent residence	Exploration of the relationship between mental health problems, gambling and substance-use in homeless people
25. Rates and risk factors for homelessness after successful housing in a sample of formerly homeless veterans	2008 US	O'Connell, Kasprow, & Rosenheck	Quantitative randomised controlled trial Gender: Mixed Veterans Living situation: Current and historic experiences of no permanent residence	Exploration of risk factors for homelessness after receiving previous housing support. Mental health problems and substance-use are discussed in relation to resumed homelessness
26. What role does employment play in dual recovery? A qualitative meta-synthesis of cross-cutting studies treating substance use treatment, psychiatry and	2017 International	Oute & Bjerge	Qualitative Study Gender: Mixed Living situation: Varied	Discusses the implications of having mental health problems and substance-use difficulties on capacity to work. How this process contributes to homelessness

unemployment services				
27. Pathways into homelessness: understanding how both individual and structural factors contribute to and sustain homelessness in Canada	2014 Canada	Piat et al.	Qualitative study Gender: Mixed Living situation: No current permanent residence	Exploration of the relationship between childhood adversity and trauma with mental illness and substance-use. Implications for social support and problematic coping are discussed
28. Paranoia and maladaptive behaviours in homelessness: The mediating role of emotion regulation	2018 UK	Powell & Maguire	Quantitative non-randomised study Gender: Mixed Living situation: No current permanent residence	Exploration of the role of psychological processes that contribute to homelessness, such as paranoia, emotion dysregulation and impulsivity. Maladaptive coping as a result of psychological distress are discussed (substance-use and aggression)
29. Homelessness: a problem for primary care?	2003 UK	Riley, Harding, Underwood, & Carter	Grey literature – review Gender: Mixed Living situation: No permanent residence	Consideration of attitudes in health staff that impact access to services for homeless people. Exploration of the implications of substance-use on service-use for homeless people

30. Suicidal behavior in a national sample of older homeless veterans	2012 US	Schinka, Schinka, Casey, Kasprow, & Bossarte	Quantitative non-randomised study Gender: Mixed Veterans Living situation: No permanent residence	Exploration of the implications for suicidal behaviours and mental ill-health on housing tenure
31. International homelessness: policy, socio-cultural, and individual perspectives	2007 International	Shinn	Grey literature – review Gender: Mixed Living situation: Varied, no permanent residence	Exploration of the relationship between the breakdown in relationships with mental illness and homelessness
32. Barriers to mental health treatment among chronically homeless women: a phenomenological inquiry	2017 US	Spicer	Qualitative study Gender: Female Living situation: Chronic homelessness	Exploration into the experiences of stigma, mental illness and homelessness in women. Relationships between substance-use and isolation with these factors are considered
33.Reasons for job loss among homeless veterans in supported employment	2017 US	Stacy, Stefanovics, & Rosenheck	Quantitative non-randomised study Gender: Mixed Veterans Living situation: No permanent	Exploration of the relationship between mental illness and substance-use within the context of employment sustainability

			residence in the past 90 days	
34. Conduct disorder behaviors, childhood family instability, and childhood abuse as predictors of severity of adult homelessness among American veterans	2013 US	Tsai & Rosenheck	Quantitative non-randomised study Gender: Mixed Veterans Living situation: No permanent residence for 30 days	Exploration of how childhood adversity leads to the development of mental health problems, which puts people at risk of becoming socially isolation and subsequently homeless.
35. Pathways to housing: supported housing for street-dwelling homeless individuals with psychiatric disabilities	2000 US	Tsemberis & Eisenberg	Quantitative non-randomised study Gender: Mixed Living situation: No permanent residence	Exploration of the impact of mental health problems and substance-use on housing tenancy stability
36. Dutch homeless people 2.5 years after shelter admission: what are predictors of housing stability and housing satisfaction?	2016 Holland	Van Straaten et al.	Quantitative non-randomised study Gender: Mixed Living situation: No current permanent residence	Exploration of the relationship between mental health difficulties, social isolation, aggression, substance-use and involvement with the criminal justice system with being homeless

37. Posttraumatic stress disorder and interpersonal process in homeless veterans participating in a peer mentoring intervention: associations with program benefit	2018 US	Van Vorhees, Resnik, Johnson, & O'Toole	Mixed methods study Gender: Mixed Veterans Living situation: No current permanent residence	Exploration of the relationship between mental health problems and disconnectedness from health services and peer mentors. Consideration for the impact of societal stigma on how homelessness is perceived by veterans

Appendix B ERGO Approval Letter

Approved by Faculty Ethics Committee - ERGO II 31667 - Raman S. 23/04/2019, 15:27

Approved by Faculty Ethics Committee - ERGO II 31667

ERGOII

Sun 12/08/2018 22:05

To:Raman S. <S.Raman@soton.ac.uk>;

Approved by Faculty Ethics Committee - ERGO II 31667

ERGO II – Ethics and Research Governance Online https://www.ergo2.soton.ac.uk

Submission ID: 31667
Submission Title: Attitudes towards Homeless People, Beliefs and Burnout among NHS Staff in Physical and Mental Health Work Settings
Submitter Name: Shalini Raman

Your submission has now been approved by the Faculty Ethics Committee. You can begin your research unless you are still awaiting any other reviews or conditions of your approval.

Comments:

- Thank you for your care in revising your documents for ethical consideration.
  Good luck with your research moving forwards.
- Thank you for making the requested changes. Good luck with your project!

Appendix C IRAS Approval Letter

[redacted]

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

05 November 2018

[redacted]

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Attitudes towards Homeless People, Beliefs and Burnout among NHS Staff in Physical and Mental Health Work Settings**
IRAS project ID:	**245184**
Sponsor	**The University of Southampton**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Appendix D Questionnaire Survey

Demographic Information and Professional Details

Please check the box which best applies to you. In cases where you have selected 'other' please specify further details in the text box provided below.

1) Age ……. Years

2) Gender

Male ☐ Female ☐ Other ☐

3) Ethnicity

a) Black or Black British
Caribbean
African
Any other Black background within (a)
b) White
British
Irish
American
Any other White background
c) Asian or Asian British
Indian
Pakistani
Bangladeshi
Any other Asian background within (c)

d) Mixed
White & Black Caribbean
White & Black African
White & Asian
White & Hispanic
Any other mixed background
e) Other ethnic groups
Chinese
Japanese
Hispanic
Any other ethnic group
Do not state

If selected 'other', please provide details…….

4) What health setting do you work in?

Mental health ☐ Physical Health ☐ Both ☐

5) Email Address……

6) What experience do you have of working with homeless clients?

No previous contact with homeless	Limited experience of working with	Moderate experience of working with	Very experienced working with
☐	☐	☐	☐

7) Number of years core professional training

(Whatever you deem your core professional training to be)

……. Years

8) Number of years working professionally post-core qualification

……. Years

9) Number of days completed in specialist training in a relevant area related to homelessness e.g. trauma training/substance misuse training

……. Days

10) Professional discipline

Physical Health Nurse	Mental Health Nurse	Doctor	Psychiatrist
☐	☐	☐	☐

Psychologist	Occupational Therapist	Physiotherapist	Social Worker
☐	☐	☐	☐

Other

☐

If you checked 'other', please provide details……

Attitudes to Homeless Individuals Questionnaire

The following questions relate to attitudes towards homeless clients. Please tick the box that most accurately reflects how you feel.

	Never	Seldom	Occasionally	Often	Very Often	Always
1. I like homeless clients						
2. I feel frustrated with homeless clients						
3. I feel drained by homeless clients						
4. I respect homeless clients						
5. I feel fondness and affection for homeless clients						
6. I feel vulnerable in homeless client's company						
7. I have a feeling of closeness with homeless clients						
8. I feel manipulated or used by homeless clients						
9. I feel uncomfortable or uneasy with homeless clients						
10. I feel I am wasting my time with homeless clients						
11. I am excited to work with homeless clients						

12. I feel pessimistic about homeless clients						
13. I feel resigned about homeless clients						
14. I admire homeless clients						
15. I feel helpless in relation to homeless clients						
16. I feel frightened of homeless clients						
17. I feel angry towards homeless clients						
18. I enjoy spending time with homeless clients						
19. Interacting with homeless clients makes me shudder						
20. Homeless clients make me feel irritated						
21. I feel warm and caring towards homeless clients						
22. I feel protective towards homeless clients						
23. I feel oppressed or dominated by homeless clients						
24. I feel that homeless clients are alien, other, strange						
25. I feel understanding towards homeless clients						
26. I feel powerless in the presence of homeless clients						

27. I feel happy and content in homeless clients' company						
28. I feel outmanoeuvred by homeless clients						
29. Caring for homeless clients makes me feel satisfied and fulfilled						
30. I feel exploited by homeless clients						
31. I feel patient when caring for homeless clients						
32. I feel able to help homeless clients						
33. I feel interested in homeless clients						
34. I feel unable to gain control of the situation with homeless clients						
35. I feel intolerant. I have difficulty tolerating homeless clients' behaviour						

Evaluative Beliefs Scale

Below is a list of beliefs people sometimes report. Please read each one and tick how much you believe is true. Please give your 'gut' response.

	Agree strongly	Agree slightly	Unsure	Disagree slightly	Disagree strongly
Other people are worthless					
I am a total failure					
People think I am a bad person					
Other people are inferior to me					
People see me as worthless					
I am worthless					
Other people are total failures					
Other people are totally weak and helpless					
People see me as a total failure					
Other people are bad					
I am totally weak and helpless					

People see me as unlovable					
I am a bad person					
People see me as totally weak and helpless					
Other people are unlovable					
Other people look down on me					
I am an inferior person					
I am unlovable					

EFFECTIVE WORKING WITH COMPLEX CLIENTS QUESTIONNAIRE

This questionnaire explores staff confidence in working with homeless clients. Please check the appropriate options below.

1. What improvement to the quality of life of this client group do you believe that you can make?

1	2	3	4	5
None	A little	Some	Quite a lot	A great deal

2. How competent do you feel when dealing with individual's difficulties?

1	2	3	4	5
Not at all	A little	Quite	Very	Extremely

3. How well prepared / trained do you feel to work psychologically with this client group

1	2	3	4	5
Not at all	A little	Quite	Very	Extremely

4. How well supported do you feel when working psychologically with this client group?

1	2	3	4	5
Not at all	A little	Quite	Very	Extremely

5. How confident do you feel about enabling clients to improve strategies or ideas to help them cope in the future?

1	2	3	4	5
Not at all	A little	Quite	Very	Extremely

6. How often do you believe that you will never be able to help this client group make long-term change?

1	2	3	4	5
Never	Sometimes	Half of the time	Most of the time	Always

7. At these times, how much stress /distress do you feel?

1	2	3	4	5
None	A little	Some	Quite a lot	A great deal

8. To what extent do you believe your interventions are structured and focussed?

1	2	3	4	5
Never	Sometimes	Half of the time	Most of the time	Always

9. To what extent do you believe your interventions have clear goals?

1	2	3	4	5
Not at all	Sometimes	Half of the time	Most of the time	Always

10. Generally, how stressful do you find work with this client group?

1	2	3	4	5
Not at all	Slightly	Quite	Very	Extremely

11. How often do you become stressed as a result of difficult interactions with individual clients

1	2	3	4	5

Never	Sometimes	Half of the time	Most of the time	Always

12. How distressed do you feel at these times

1	2	3	4	5
Not at all	Slightly	Quite	Very	Extremely

13. How rewarding do you find the work with this client group?

1	2	3	4	5
Not at all	Slightly	Quite	Very	Extremely

MBI Human Services Survey

How often:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

How often 0-6	Statements:
1. _____	I feel emotionally drained from my work.
2. _____	I feel used up at the end of the workday.
3. _____	I feel fatigued when I get up in the morning and have to face another day on the job.
4. _____	I can easily understand how my recipients feel about things.
5. _____	I feel I treat some recipients as if they were impersonal objects.
6. _____	Working with people all day is really a strain for me.
7. _____	I deal very effectively with the problems of my recipients.
8. _____	I feel burned out from my work.
9. _____	I feel I'm positively influencing other people's lives through my work.
10. _____	I've become more callous toward people since I took this job.
11. _____	I worry that this job is hardening me emotionally.
12. _____	I feel very energetic.
13. _____	I feel frustrated by my job.
14. _____	I feel I'm working too hard on my job.
15. _____	I don't really care what happens to some recipients.
16. _____	Working with people directly puts too much stress on me.
17. _____	I can easily create a relaxed atmosphere with my recipients.
18. _____	I feel exhilarated after working closely with my recipients.
19. _____	I have accomplished many worthwhile things in this job.
20. _____	I feel like I'm at the end of my rope.
21. _____	In my work, I deal with emotional problems very calmly.
22. _____	I feel recipients blame me for some of their problems.

(Administrative use only)

EE Total score: _____ DP Total score: _____ PA Total score: _____

EE Average score: _____ DP Average score: _____ PA Average score: _____

Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate by circling how often you felt or thought a certain way.

	Never	Almost Never	Sometimes	Fairly Often	Very Often
1) In the last month, how often have you been upset because of something that happened unexpectedly?					
2) In the last month, how often have you felt that you were unable to control the important things in your life?					
3) In the last month, how often have you felt nervous and “stressed”?					
4) In the last month, how often have you felt confident about your ability to handle your personal problems?					
5) In the last month, how often have you felt that things were going your way?					
6) In the last month, how often have you found that you could not cope with all the things that you had to do?					
7) In the last month, how often have you been able to control irritations in your life?					

8) In the last month, how often have you felt that you were on top of things?					
9) In the last month, how often have you been angered because of things that were outside of your control?					
10) In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?					

Staff Support Scale

Please tick the box that best represents your experiences related to the support you receive from colleagues within your team/service.

	Never	Sometimes	Frequently	Very Frequently
1) Lack of opportunity to talk openly with other colleagues about problems within the team/service				
2) Lack of opportunity to share experiences and feelings with other colleagues within the team/service				
3) Lack of opportunity to express to colleagues within the team/service my negative feelings towards clients				

THIS IS THE END OF THE SURVEY

THANK YOU FOR YOUR PARTICIPATION

Appendix E Participant Information Sheet

IRAS Reference: **245184**

Version 3, Date: 05.11.2018

Attitudes towards Homeless People, Beliefs and Burnout among NHS Staff in Physical and Mental Health Work Settings

Information Sheet

Although homeless people are significantly more likely to experience physical health and mental health problems than individuals within the general population, we see a very small minority of this client-group accessing health services.

Key factors affecting engagement in health services by this client-group, are attitudes and beliefs held by staff and staff burnout, given the complexity and multifaceted difficulties that homeless people can present with in services.

The purpose of this research is to explore staff attitudes and beliefs towards homeless clients, staff burnout and staff levels of confidence in working with homeless clients.

Who is doing the research?

My name is Shalini (Shal) Raman and I am a postgraduate Clinical Psychology student at the University of Southampton. I am being supervised by Dr Nick Maguire and Dr Sarah Kirby (psychologists at the University of Southampton). This research will form part of the criteria that I am evaluated against for my doctoral qualification.

Why have I been asked to participate?

You have been invited to participate in this study because you are a clinical health professional working in either a physical health or a mental health setting.

What will happen to me if I take part?

If you volunteer to take part in this study then you will be directed to follow the website link at a time convenient to you, in a comfortable, quiet environment,

where you can access the online system. You will be presented with this same information sheet and you will be asked to tick the box indicating that you give your consent to participate in the research. On doing so, you will be directed to the next page where you will be asked to provide your demographic information, professional discipline and whether you work in a mental health or physical health setting. In addition, you will be invited to complete six short questionnaires exploring attitudes towards homeless clients, evaluative beliefs about homeless clients, perceived confidence in working with homeless clients, staff burnout, staff support and stress experienced by staff.

This will take approximately 20 minutes to complete. It will be necessary for you to complete the full survey within one sitting, as responses will not be saved if the web browser is closed without submitting and finalising for all the questions.

Are there any benefits in my taking part?

The main benefit will be helping us to understand factors that might affect staff attitudes towards homeless clients and staff burnout. Having this insight may help to inform staff support strategies and training opportunities, equipping staff to manage complex client-groups with sustained levels of resilience.

You will also be entered into a prize draw to win a £50.00 Amazon Voucher to compensate you for your time.

Are there any risks involved?

The questionnaires explore sensitive information and therefore it is possible that participation may raise concerns or queries. If this is the case, then you are invited to contact the researcher, or to contact the Samaritans for confidential advice and support on **116 123**, or to withdraw from the study.

Will my participation be confidential?

Yes, all of the data will be anonymised. The email addresses that are provided in order to contact the winning participant of the prize draw, will be stored in a separate file from the data and on selection of the winner, email addresses will be destroyed. All information will be kept secure in accordance with the University policy, in compliance with the General Data Protection Regulation (2018).

The University of Southampton is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information at https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page.

The researcher will keep your contact details confidential and will not pass this information to The University of Southampton. The researcher will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from The University of Southampton and regulatory organisations may look at your research records to check the accuracy of the research study. The University of Southampton will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

The researcher will keep identifiable information about you from this study for 10 years after the study has finished.

What happens if I change my mind?

You have the right to withdraw at any time during your participation, and this will not affect your inclusion in the prize draw. Please contact the researcher (details below) by **30th December 2018** if you wish your responses to be destroyed. After this date, all available data will be selected for inclusion in the analysis.

What will happen to the results of the research?

Once the data has been analysed, a report will be written and may be considered for publication to a peer-reviewed journal. The results will also be disseminated with the link lead professionals in each of the health services that recruitment took place, and a summary write up of the results will be made available to each department, which will include a link to the published report.

Taking Part

If you would like to take part, please type the following link into your web browser :

https://www.isurvey.soton.ac.uk/28315

Where can I get more information?

If you would like more information about the study, then please email me at s.raman@soton.ac.uk, or you can contact my supervisor, Nick Maguire at nick.maguire@soton.ac.uk.

What happens if something goes wrong?

In the case of concern or complaint please contact the Research Integrity and Governance Manager on 023 8059 5058 or at rgoinfo@soton.ac.uk.

The University has insurance in place to cover its legal liabilities in respect of this study.

Thank you for taking the time to read the information sheet and considering taking part in the research.

Appendix F Debriefing Statement

IRAS ID: 245184

Version 3, Date: 03.09.2018

Attitudes towards Homeless People, Beliefs and Burnout among NHS Staff in Physical and Mental Health Work Settings

Debriefing Statement

The purpose of this research was to explore staff attitudes and beliefs towards homeless clients, staff confidence in working with homeless clients, staff support, perceived stress and staff burnout in mental health professionals and physical health professionals.

It is expected that staff with more negative evaluative beliefs, less experience of working with homeless people, increased perceived stress and limited support will be more at risk of burnout and holding stigmatising attitudes. It is also predicted that there will be an association between stigmatising attitudes and burnout, such that staff that are experiencing burnout will be more likely to be at risk of holding stigmatising attitudes and vice versa; staff that hold stigmatising attitudes towards homeless clients may be more at risk of burnout.

Your participation in this research will inform our understanding of the variables that affect the development of stigmatising attitudes and negative evaluative beliefs in staff who work with complex, marginalised client-groups. It is hoped that this will provide insight into the strategies that may be valuable in supporting health professionals adequately to reduce burnout and training interventions that may prove effective in challenging/modifying problematic attitudes and beliefs and improve confidence and efficacy in working with homeless clients that often present with a number of complexities.

The results of the research will be shared with the lead professionals in your departments once the data has been analysed and written summaries will be made available to the relevant teams for your reference.

Appendix F

If your participation in the survey raised any concerns or queries, please do not hesitate to contact the researchers by email: Dr Nick Maguire; nick.maguire@soton.ac.uk, or Shal Raman; s.raman@soton.ac.uk

In the unlikely case that you have experienced any distress as a result of your participation in this study, please do not hesitate to seek confidential advice and support through your GP or the Samaritans on **116 123**.

Thank you for your participation in this research.

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: +44 (0)23 8059 3856, email fshs-rso@soton.ac.uk

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