Journal of Social Distress and Homelessness

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/ysdh20

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To cite this article: Christel Schneider, Natalia Masztalerz, Christopher W. Hobson, Maharin Ahmed & Katherine H. Shelton (2022): 'It's intense' – A mixed-methods analysis of how the early COVID-pandemic impacted on the wellbeing of practitioners in a UK homeless organization, Journal of Social Distress and Homelessness, DOI: 10.1080/10530789.2022.2141870

To link to this article: https://doi.org/10.1080/10530789.2022.2141870

Published online: 24 Nov 2022.

JOURNAL OF SOCIAL DISTRESS AND HOMELESSNESS
https://doi.org/10.1080/10530789.2022.2141870

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RESEARCH ARTICLE

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'It's intense' – A mixed-methods analysis of how the early COVID-pandemic impacted on the wellbeing of practitioners in a UK homeless organization

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ABSTRACT

Knowledge about the wellbeing of medical professionals working through the COVID-19 pandemic and its practice implications is expanding extensively. It remains, however, sparse for 'essential' (aka *critical*) community practitioners. We addressed this gap using a repeated-measures analysis of COVID-pandemic wellbeing experiences of critical, homeless-sector practitioners. An explanatory sequential mixed-methods design, capitalizing on a pre-pandemic needs-analysis, longitudinally followed 42 practitioners (30 support staff and 12 project managers) in a single, national UK-based homeless-support organization. Practitioners completed measures, prior to and six months into the COVID-pandemic, of: mental wellbeing, secondary traumatic stress (STS), burnout and compassion satisfaction. Our qualitative questions captured practitioners' wellbeing, working practice and support experiences in COVID-times. While the pandemic detrimentally impacted on levels of STS, burnout, and general wellbeing in support staff, managers' mental and professional wellbeing remained consistent with their pre-pandemic scores. Our qualitative analysis identified intense stressors in support staff (not shared by project managers) which hampered client-practitioner relationships and encouraged 'them-and-us' support staff-manager dynamics. The identified nuanced (and contrasting) stressors experienced by practitioners in a national UK homeless-support organization offer insight into what residual and new wellbeing challenges need to be addressed in research and practice as we recover and progress from the pandemic.

ARTICLE HISTORY
Received 1 December 2021
Revised 1 October 2022
Accepted 20 October 2022

KEYWORDS
Homelessness workforce; professional wellbeing; secondary traumatic stress; burnout; mixed-methods

1. Introduction

A rapidly growing body of research is increasing our understanding of the impact working in the COVID-19 pandemic had on the mental health and wellbeing of essential medical practitioners, both in the UK (e.g. Gilleen et al., 2021) and across the world (e.g. Vanhaecht et al., 2020). Much less is known about the impact the COVID-era is having on those equally "essential" (aka *critical*; UK Department for Education, 2021) practitioners working with vulnerable people in wider health and social care community settings (Parry et al., 2022; Sumner & Kinsella, 2021). The current study focussed on one such neglected group where current mental health and wellbeing needs are under-researched: those working in the homeless and supported housing sector (henceforth homeless sector). These support professionals are known to be equally susceptible to psychological burden, both now and prior to the pandemic (Lemieux-Cumberlege & Taylor, 2019; Olivet et al., 2010; Schneider et al., 2022; Waegemakers Schiff & Lane, 2019), and yet are overlooked in support and research resources (Aykanian, 2022).

The UK homeless sector covers a breadth of support provision and practitioners (Blood et al., 2016; Wolf & Edgar, 2007). It includes crisis intervention with people, often with varied or complex needs (e.g. with experiences of addiction, debt, abuse-related trauma, or mental distress; Alma Economics, 2019) who are street homeless or 'rough sleeping,' as well as preventative services that support similarly vulnerable people to 'escape' or transition from inappropriate housing or living environments. While for many practitioners working in the homeless sector is rewarding (Ferris et al., 2016; Wirth et al., 2019), the working terrain is not easy. Practitioners are likely to encounter challenging behavior and difficult client-practitioner relationships (Tiderington, 2019). Moreover, routes to housing and support 'solutions' for clients are hampered by limited financial and other resources, as well as overly bureaucratic and restrictive legislative frameworks which need to be negotiated in multi-disciplinary settings (Blomberg et al., 2015; Lemieux-Cumberlege & Taylor, 2019; Peters et al., 2022). To add to the mix, practitioner caseloads are often high, training and supervision not always

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adequate, and wages low (Olivet et al., 2010; Tidierington, 2019; Wirth et al., 2019). Not surprisingly, the sector is associated with high rates of attrition and staff turnover (Fitzpatrick et al., 2017; Kidd et al., 2007; Waegemakers Schiff & Lane, 2019).

The enduring stressors practitioners are exposed to have led to raised negative mental health and wellbeing markers. Homeless-sector practitioners are vulnerable to heightened levels of stress and depression (Lemieux-Cumberlege & Taylor, 2019); STS (presented in symptoms akin to traumatic-stress disorders; including, intrusive imagery and thoughts; Chrestman, 1995; Petrovich et al., 2021; Schneider et al., 2022); feelings of helplessness or ineffectiveness (in relation to changing clients' situations; Wirth et al., 2019); emotional exhaustion and detachment (Stalker et al., 2007); and, in some cases, burnout (characterized by exhaustion, cynicism and professional inefficacy; Lenzi et al., 2021; Maslach & Leiter, 2016; Olivet et al., 2010; Waegemakers Schiff & Lane, 2019).

Little is known about how the COVID-pandemic has impacted working environments and practice in the homeless-sector. Recent studies in Canada and US have identified increased work-related stress and a decline in mental health and wellbeing (including depression, anxiety, burnout, post-traumatic stress, and compassion fatigue) and in job satisfaction (Aykanian, 2022; Kerman et al., 2022a; Pixley et al., 2022). In the first UK study, Carver et al. (2022) explored the qualitative experiences of homeless-service workers in Scotland, concluding the pandemic significantly impacted staff in both positive (e.g. bringing teams closer together) and negative ways (e.g. increased tensions between managers and staff). Apart from this evidence, our understanding of UK-provision draws mainly on rapid-response and practice reports from the early pandemic that signaled diminished practitioner wellbeing and increased practice challenges (Marshall, 2021). Montes (2021) proposed, for example, less frequent and 'natural' forms of communication imposed by the pandemic were fragmenting practitioner-client relationships. Moreover, early evidence identified increased dissonance between varying critical practitioner roles, not least in how differing experiences and communication challenges shaped and exacerbated the divide between those 'on the ground' (working directly with clients) and frontline managers (Chief Scientist Office, 2021; Montes, 2021). Whilst these reports offer important initial (albeit more anecdotal) insight into how professionals' practice and wellbeing were affected, more systematic and empirical evidence is needed to better understand and address the challenges the homelessness workforce contended with and the lessons we can learn.

This mixed-methods study draws on a unique opportunity to longitudinally follow-up the mental and professional wellbeing needs of frontline homeless-sector support and manager practitioners (both categorized as *critical* workers; Department for Education, 2021) six months into the COVID-pandemic (autumn 2020). It builds on a pre-pandemic (2019) scoping-needs analysis (drawing on established practice wellbeing measures) conducted in a national UK-based homeless-support organization (Schneider et al., 2022). In addition to repeating standardized wellbeing measures, practitioners were offered free response opportunities to capture if, and how, working practice was affected by the pandemic, and what, if any, additional support was needed. The following research questions were addressed: (1) How did the COVID-pandemic affect reported levels of mental and professional wellbeing, including STS, burnout, and compassion satisfaction? (2) What were the perceived contributory factors to changes in mental and professional wellbeing in critical support and manager practitioner groups?

2. Materials and methods

2.1. Study context and design

The host organization was a large UK, non-governmental homeless and supported housing organization (with approximately 450 staff). It provided a variety of housing and related support services for people (including adolescents) who are, or are at risk of, becoming, homeless. This included emergency housing provision, transitional supported housing, and outreach projects, as well as newly introduced *Housing first* initiatives (Tsemberis et al., 2004). Alongside housing, the organization offered preventative and rehabilitative support to address complex antecedents to homelessness (e.g. domestic abuse and mental health support, education, and employment initiatives).

An explanatory sequential (QUANT->qual) mixed-methods design (Morgan, 2014) was applied, where a small qualitative survey followed a larger quantitative component. The quantitative component drew on a repeated-measures design. At Time 1 (February – November 2019; Schneider et al., 2022) a critical practitioner sample (including support staff and their managers) completed a quantitative scoping-needs analysis. Staff were re-invited to complete the survey at Time 2, approximately six months into the pandemic (September - October 2020). At Time 2 and after the quantitative survey, participants completed the qualitative component.

At Time 2, the pandemic meant practitioners (and clients) were restricted to essential social and practice contact only (subject to UK governmental mandates and transitional guidance for social care sector; HM Government, 2020; https://www.gov.uk/government/publications/supported-living-services-during-coronavirus-covid-19). For the support staff this meant maintaining 'COVID–safe' personal interactions with clients by limiting face-to-face

interactions and supporting clients remotely when possible (via telephone or video communication). Moreover, staff rotas and office-based team working was reduced, and administrative tasks were completed via online platforms, again from home when possible. Managers predominantly undertook their managerial interactions and administrative tasks from home, visiting projects only when essential.

2.2. Participants and procedure

In 2019 (Time 1), 134 staff completed the (paper) survey prior to a training session for (predominantly) supported housing practitioners from different geographical locations across the national organization. These staff were re-invited (via email) to repeat the survey online (facilitated via Qualtrics, Provo, Utah, US) in 2020 (Time 2). On both occasions, the research was introduced as a "well-being study." We present the data of 42 practitioners with critical worker responsibilities (Department for Education, 2021) who participated in 2019 and 2020: including 30 support staff and 12 project managers (Table 1). Prior to Time 2, approximately 19 practitioners of the 134 original sample (14%) had left the organization, resulting in a response rate of 36.5%. The research was ethically approved by the University's Departmental Research Ethics Committee (reference EC.18.02.13.5222RA6) and adhered to the standards of the host organization.

Table 1. Sample demographics ($n = 42$).

Category	Sub-category	Frequency, n (%)
Gender	Females	26 (61.9)
	Males	16 (38.1)
Age classes (in years)	25–34	6 (14.29)
	35–44	15 (35.71)
	45–54	13 (30.95)
	55+	8 (19.05)
Highest Level of Education[†]	Level 1: NVQ level 1, GCSE's D–G	1 (2.38)
	Level 2: NVQ level 2, GCSE's A–C	0
	Level 3: NVQ level 3, A-levels	9 (21.43)
	Level 4–7: NVQ level 4 & 5, Foundation & Undergraduate degree, Master degree, Postgraduate certificate	31 (73.81)
	Other professional qualification(s)	1 (2.38)
Job Role	Support staff (e.g. support worker/ assistants)	30 (71.43)
	Project managers	12 (28.57)
Employment Status	Full-time (≥35 h/ week)	33 (78.57)
	Part-time (<35 h/ week)	9 (21.43)
No. of years employed by host organization (as of 2019)	Mean = 4.88 yrs, median = 0.83 yrs, range = 0.08–20 yrs	
No. of years working in homeless sector in total (as of 2019)	Mean = 10.22 yrs, median = 8.67 yrs, range = 0.17–25.5 yrs	

[†]Note, in England, Wales and Northern Ireland, there are nine qualification levels (entry level 0, and levels 1–8).

2.3. Quantitative measures

At both time points, the survey began with categorical demographic questions (Table 1), including whether staff had taken time-off for work-related stress in the preceding year while working at the host organization. Practitioners then completed the *Warwick-Edinburgh Mental Wellbeing Scale* (WEMWBS; Tennant et al., 2007); a 14-item measure asking respondents to rate a five-point Likert scale (1 = none of the time to 5 = all of the time) on various wellbeing indicators (e.g. "I've been feeling confident"). An overall score between 14 and 70 is obtained, with 70 indicating the most positive wellbeing. The scale had excellent internal consistency at both time points ($\alpha = 0.9$, 2019; $\alpha = 0.91$, 2020; George & Mallery, 2003).

The 30-item *Professional Quality of Life Scale* (Pro-QOL Version 5; Stamm, 2010), which measures positive and negative elements of working in the 'support profession,' was only completed by practitioners with client support responsibilities. The measure comprises three 10-item sub-scales, each rated on a five-point Likert scale (1 = never to 5 = very often): STS (through exposure to traumatic experiences of others'; e.g. "I find it difficult to separate my personal life from my life as a support professional"); burnout (characterized by feelings of ineffectiveness and hopelessness, e.g. "I feel 'bogged down' by the system."); and compassion satisfaction (positive elements derived from supporting others effectively; e.g. "My work makes me feel satisfied."). For each sub-scale a score between 10 and 50 was obtainable; higher scores indicated greater vulnerability for STS and burnout, and greater compassion satisfaction levels. All subscales had acceptable-to-excellent internal consistency at both time points ($\alpha = 0.71$–0.92; George & Mallery, 2003).

2.4. Qualitative COVID-related questions

After the quantitative component at Time 2 (2020), the survey included a qualitative response-opportunity (with no word limit) to capture participants' views and experiences in relation to two questions: (i) if and how the COVID-situation affected their work; and (ii) what, if any, further support they felt was needed. Forty of 42 practitioners (95.24%) responded. Responses culminated in 2731 words of text for analysis. Support staff shared approximately twice as many words on average (total of 2196 words; mean response length: 43.92 words) than managers (total of 535 words; mean response length: 24.32 words).

2.5. Data analyses

The quantitative analyses included related, independent, and one-sample *t*-tests (including robust

bootstrap confidence intervals, 1000 samples; Field, 2018) to examine survey differences; e.g. at the two survey time-points and to contrast scores against population (WEMWBS; Helme et al., 2019) and normative benchmarks (ProQOL; de La Rosa et al., 2018; Table 2). We also considered individual ProQOL scores against published vulnerability cut-off thresholds (de La Rosa et al., 2018; Table 3). We reported Cohen's *d* effect sizes; with 0.2 representing a small, 0.5 a medium, and 0.8 + a large effect (Cohen, 1988). Analyses were conducted in IBM SPSS Statistics, Version 27.

To address the second research question, the qualitative data were thematically analyzed (Braun & Clarke, 2013) and integrated abductively with the quantitative data; i.e. analysis consistently shifted between inductive and deductive inquiry of both data types to achieve a pragmatic, integrated understanding in relation to the research questions (Morgan, 2007, 2014). For example, questions were posed of the data to inform and explain identified wellbeing differences between 2019 and 2020 and between support staff and managers (e.g. what types of shared experiences were likely to contribute to STS or were people who took time-off for stress more likely to exhibit higher burnout than participants who did not).

For the qualitative analysis, CS and NM (who both had direct experience of working in homeless or wider supported housing sectors) independently conducted line-by-line coding, followed by a lower-level semantic (descriptive) theme development (Braun & Clarke, 2013). On comparing this initial theme development, an 85% theme-agreement was identified between the two authors. CS then conducted analysis through a more latent (interpretative) explanatory account (Braun & Clarke, 2013). Constant comparison techniques (pragmatically contrasting concepts and themes within and across qualitative and quantitative data; Corbin & Strauss, 2015) were additionally used to 'triangulate' and add interpretative depth to the emerging themes (Jick, 1979). Selective coding (Corbin & Strauss, 2015) was used in the later analyses stages to establish an over-arching theme to embrace subsidiary ones. For the final presented analysis, the first author shared and discussed theme titles and concepts with all authors until there was consensual agreement that levels of *rigor* and *meaningful coherence* quality criteria were met (Tracy, 2010).

3. Results

3.1. Quantitative levels of general mental and professional wellbeing

To ascertain whether there were differences between respondents who participated at both time-points and those who opted not to participate in 2020, we undertook a preliminary, comparative analysis of WEMWBS and ProQOL scores in 2019. This was done at support staff and manager level. No statistical differences were found between any samples.

Table 2 displays WEMWBS and ProQOL scores and inferential statistics for 2019 versus 2020 and benchmark comparisons. A statistically significant decline in support staffs' mental wellbeing scores and an increase in STS levels between 2019 and 2020 were found. Support staff also evidenced a pronounced trend for higher burnout in 2020 (versus 2019). Managers showed comparable levels of general mental wellbeing, STS and burnout across time-points and no statistical differences were observed for compassion satisfaction between 2019 and 2020 for either support staff or managers (Table 2).

In relation to benchmark comparisons, support staffs' mental wellbeing scores were lower in 2020 than the pre-COVID population mean. No statistical differences were observed in managers. In 2019 and 2020, support staffs' STS levels were significantly higher than reported normative data; managers, on the other hand, presented comparable STS levels to the same norms in both years. In 2020, support staffs' burnout scores were statistically higher than the normative mean; again, no differences were observed in managers. Burnout levels in 2019 showed no statistical differences when contrasted with benchmark data for both support staff and managers. Finally, the remaining benchmark comparisons for compassion satisfaction showed no statistical differences for support staff and managers (Table 2).

For both participant groups, to contextualize the ProQOL data further we considered individual scores against cut-off scores (de La Rosa et al., 2018; Table 3). For STS and burnout, a score above 21 and 27, respectively, is proposed to indicate vulnerability of needing support or further professional assessment. For CS, a score below 33 may warrant further support. At Time 2, 50% (15 of 30) support staff and 37.5% (3 of 8) managers scored within the support vulnerability range for STS. For burnout, 43.33% (13 of 30) support staff and 25% (2 of 8) managers scored within the high range at the same time point. For compassion satisfaction, 23.33% (7 of 30) support staff and 12.5% (1 of 8) managers scored in the low, unpreferred range at Time 2. Table 3 provides an overview of all cut-score ranges for support staff and managers in 2019 and 2020.

The finding of significantly raised STS and burnout levels in support staff were abductively explored further by contrasting respective scores of participants who had time-off work for stress reasons against those who did not. Out of 30 support staff, seven indicated they had taken stress-related time-off in the year prior to the 2020 survey (23.33%; note one support practitioner preferred not to respond and no manager

Table 2. Descriptive statistics and inferential comparisons of pre-COVID and COVID-times WEMWBS and ProQOL sub-scales in support staff and managers (note, statistically significant comparisons are highlighted in bold).

				ProQOL					
		WEMWBS		Secondary traumatic stress		Burnout		Compassion satisfaction	
		2019	2020	2019	2020	2019	2020	2019	2020
Support staff (*n* = 30)	Mean, SE mean	52.17, 1.29	46.57, 1.53	20.07, .98	22.1, 1.25	22.9, 1	24.93, 1.04	37.93, .97	36.6, 1.27
	Mean difference, robust bootstrap confidence intervals (CI), test statistic *t* (df), *p* value, effect size *d*	**5.6, BCa 95% CI [3, 8.57], *t*(29) = 3.24, *p* = .003, *d* = 0.79**		**−2.03, BCa 95% CI [−3.9, −.36], *t*(29) = −2.23, *p* = .034, *d* = −0.38**		−2.03, BCa 95% CI [−3.9, -.17], *t*(29) = −2, *p* = .055, *d* = −0.37		1.33, BCa 95% CI [−1.72, 4.51], *t*(29) = 1.04, *p* = .309, *d* = 0.25	
	Benchmark comparative mean	51.4[a]		16.7[b]		22.8[c]		37.7[d]	
	Mean difference, robust bootstrap CI, *t*(df), *p*, *d*	.77, BCa 95% CI [−1.6, 3.07], *t*(29) = .59, *p* = .558, *d* = 0.11	**−4.83, BCa 95% CI [−8.07, −2.03], *t*(29) = −3.16, *p* = .004, *d* = −0.58**	**3.37, BCa 95% CI [1.63, 5.3], *t*(29) = 3.45, *p* = .002, *d* = 0.63**	**5.4, BCa 95% CI [3.31, 7.76], *t*(29) = 4.33, *p* < .001, *d* = 0.79**	.1, BCa 95% CI [−1.71, 2.05], *t*(29) = .1, *p* = .921, *d* = 0.02	**2.13, BCa 95% CI [.02, 4.13], *t*(29) = 2.05, *p* = .049, *d* = 0.37**	.23, BCa 95% CI [−1.76, 2.13], *t*(29) = .24, *p* = .812, *d* = 0.04	−1.1, BCa 95% CI [−3.77, 1.43], *t*(29) = -.87, *p* = .393, *d* = −0.16
Project manager (*n* = 12 for WEMWBS; *n* = 8 for ProQOL)	Mean, SE mean	48.5, 1.87	48.42, 2.12	19.25, 1.31	18.25, 1.65	25.13, 1.7	23.38, 1.1	37.5, 2.48	39.88, 1.61
	Mean difference, robust bootstrap confidence intervals (CI), test statistic *t* (df), *p* value, effect size *d*	.08, BCa 95% CI [−3.58, 3.65], *t*(11) = .036, *p* = .972, *d* = 0.01		1, BCa 95% CI [−1.5, 3.13], *t*(7) = .75, *p* = .479, *d* = 0.27		1.75, BCa 95% CI [−.75, 4.75], *t*(7) = 1.05, *p* = .329, *d* = 0.37		−2.38, BCa 95% CI [−5.13, -.13], *t*(7) = −1.62, *p* = .149, *d* = −0.34	
	Benchmark comparative mean	51.4[a]		16.7[b]		22.8[c]		37.7[d]	
	Mean difference, robust bootstrap CI, *t*(df), *p*, *d*	−2.9, BCa 95% CI [−6.15, .43], *t*(11) = −1.56, *p* = .148, *d* = −0.45	−2.98, BCa 95% CI [−6.98, .91], *t*(11) = −1.41, *p* = .188, *d* = −0.41	2.55, BCa 95% CI [.18, 5.05], *t*(7) = 1.95, *p* = .092, *d* = 0.69	1.55, BCa 95% CI [−1.2, 4.18], *t*(7) = .94, *p* = .377, *d* = 0.33	2.33, BCa 95% CI [−.68, 5.08], *t*(7) = 1.37, *p* = .212, *d* = 0.49	.58, BCa 95% CI [−1.3, 2.45], *t*(7) = .52, *p* = .618, *d* = 0.19	-.2, BCa 95% CI [−4.45, 4.55], *t*(7) = -.08, *p* = .938, *d* = −0.03	2.18, BCa 95% CI [−.7, 5.3], *t*(7) = 1.35, *p* = .218, *d* = 0.48

[a]2018/2019 population mean (*n* = 11,922; Helme et al., 2019).
[b,c,d]Normative mean (*n* = 5612; de La Rosa et al., 2018).

Table 3. High, middle and low cut-score ranges for ProQOL's three sub-scales (de La Rosa et al., 2018) for support staff and managers.

		Support staff ($n = 30$)		Project managers ($n = 8$)	
		2019	2020	2019	2020
Secondary traumatic stress	High (21–50)	40% (12 of 30)	50% (15 of 30)	37.5% (3 of 8)	37.5% (3 of 8)
	Middle (14–20)	46.67% (14 of 30)	40% (12 of 30)	62.5% (5 of 8)	37.5% (3 of 8)
	Low (0–13)	13.33% (4 of 30)	10% (3 of 30)	0% (0 of 8)	25% (2 of 8)
Burnout	High (27–50)	20% (6 of 30)	43.33% (13 of 30)	25% (2 of 8)	25% (2 of 8)
	Middle (20–26)	50% (15 of 30)	30% (9 of 30)	62.5% (5 of 8)	62.5% (5 of 8)
	Low (0–19)	30% (9 of 30)	26.67% (8 of 30)	12.5% (1 of 8)	12.5% (1 of 8)
Compassion satisfaction	High (42–50)	20% (6 of 30)	20% (6 of 30)	12.5% (1 of 8)	37.5% (3 of 8)
	Middle (34–41)	70% (21 of 30)	56.67% (17 of 30)	62.5% (5 of 8)	50% (4 of 8)
	Low (0-33)	10% (3 of 30)	23.33% (7 of 30)	25% (2 of 8)	12.5% (1 of 8)

indicated time-off for stress). These seven practitioners reported significantly higher burnout ($M = 30.14$, $SE = 2.2$; −6.87, BCa 95% CI [−11.11, −2.23], $t(27) = -3.13$, $p = .004$, $d = -1.42$) and STS ($M = 28.14$, $SE = 3.71$; −8.05, BCa 95% CI [−17.06, -.65], $t(27) = -3.04$, $p = .005$, $d = -1.78$) as well as lower compassion satisfaction levels ($M = 31.57$, $SE = 3.25$; 6.66, BCa 95% CI [.26, 13.97], $t(27) = 2.34$, $p = .027$, $d = 1.14$); than the 22 practitioners who indicated they had not taken time-off (burnout: $M = 23.27$, $SE = 1.03$; STS: $M = 20.09$, $SE = .96$; compassion satisfaction: $M = 38.23$, $SE = 1.25$).

3.2. Qualitative explanatory results

Over-arching theme: A contrasting practice and management landscape

The qualitative component evidenced that ways of working were affected by the pandemic for both support staff and their managers. There were, however, marked differences in the practice experiences of these two groups. An over-arching theme: *A contrasting practice and management landscape*, was judged to explain these differences. The theme was further dimensioned by two sub-themes: *On the ground it's intense*, and *Above the ground it's different;* these are exemplified below.

Sub-theme 1: On the ground it's intense

Support staff (who, in contrast to project managers, were more directly involved in the daily support of clients), predominantly positioned the COVID-impact in terms of intense challenges and stressors. Five layers of intensity were identified.

Shifting client-practitioner dynamics

The first layer was the complex dynamics introduced in the working relationships support staff had with their clients. For example, against the backdrop of clients psychologically struggling to adjust to the ever-challenging pandemic situation (to the point that some would "act out" through "aggressive behavior" or "turning to drugs or alcohol"), practitioners were faced with educating clients about, and sometimes "enforcing", shifting COVID-safety regulations that were difficult to understand or were resisted.

> [M]ost of our support work is around helping the service users to understand why they should and shouldn't do certain things and how/why they should keep themselves safe. As many of the service users don't have the skills or ability to understand such an intense situation, this has caused much conflict between service users and defiance against COVID lockdown rules. **(Support staff, 34)**

> It is very difficult to keep measures in place and for service users to follow guidelines putting others at risk. **(Support staff, 30)**

Reconciling risk and client relationships

Reconciling day-to-day practice roles and responsibilities while trying to maintain positive relationships with clients was an additional challenge for support staff. Practitioners, for example, expressed unease and uncertainty about working on projects that were perceived to be COVID-unsafe and in terms of how current practice strains (e.g. enforcing government safety guidance) could affect longer-term client relationships.

> Working with [CLIENTS] on the "frontline" does have its increased risk of infection due to breaches in guidelines by service users. **(Support staff, 41)**

> Having to deal with breaches of rules and explain consequences on a regular basis. […] I felt at times like the enemy with the service users especially when during lockdown we had to report breaches to the police. **(Support staff, 17)**

Challenges of less 'natural' communication

Working relationships were further complicated and intensified by the inability to interact with clients and colleagues in preferred and more 'normal' ways. The reduced or fluctuating face-to-face interaction made a difficult job more difficult. In terms of client-staff communication and relationships, clients appeared unable or less willing to engage and 'share' using online or phone alternatives to preferred more 'personal' interaction methods. In contrast, when face-to-face interaction could happen, previous engagement and communication levels were re-established.

> Lack of face-to-face support with service users makes it very difficult to do my job. This creates a lot more

> stress. This role is should not be performed from home and, as a result, I feel more frustrated and less confident as a worker. **(Support staff, 13)**

> Support working from home is really intense and [CLIENTS] issues harder to deal with. […] No longer able to see [CLIENTS] as effectively as before. Once covid restrictions were lifting and I began seeing [CLIENTS] again, they were talking to me for 2–3 h at a time because they had so much going on that they hadn't told me on the phone. Now we are going back into lockdown again unless we can meet outside they are not going to have that outlet yet again. **(Support staff, 15)**

For staff teams, the removal of the more instant and 'natural' interaction that happened in offices or housing projects afforded comparable communication challenges that intensified the pressures experienced on the ground. With reduced opportunities for better "working together" (through, for example, more freely sharing experiences and ideas, 'offloading' and peer support), support staff expressed they felt more isolated and less confident in their roles.

> Working from home can be difficult as you don't have resources or colleagues at your disposal as you would otherwise have when office based. **(Support staff, 36)**

> I appreciate everyone is busy, but I do feel there's been a disconnect with colleagues and teams as no formal on-line catch ups/meetings have taken place. **(Support staff, 24)**

Limited and unpredictable resources

Another source of strain that intensified frontline working experiences and relationships was the limited and unpredictable resources available in COVID-times. On one level, this included inevitable staff shortages (e.g. due to illness or shielding) which meant available team members needed to cover more shifts. On another level, strain was experienced in relation to a lack of availability of internal (organizational) and external support provisions (e.g. volunteering opportunities and local libraries).

> [WITH] staff shortages, all the team in the project do extra hours each week to cover. Eventually this will burn people out. **(Support staff, 26)**

> [I] am unable to offer regular support due to needing to distance myself from some service users for their safety and my own as well as not being able to access all of the previously easily accessible local services which had subsequently closed or had limited working hours. **(Support staff, 34)**

Management out of touch?

A final stressor that added to the intensity and frustration support staff experienced, was the limited and inconsistent support they felt they received from their managers. Management was consistently discursively positioned as a collective 'them' group who lacked insight and understanding about the transience and intensity of working on the "frontline" and what was being asked of 'us' on a day-to-day basis. As a result, managers were perceived to be detached, non-responsive, and inflexible to practice issues raised (e.g. they failed to "soften" or make allowances in terms of organization targets and practice "expectations" in COVID-times).

> On top of this [INTENSE WORK] for a long while some of us had children at home too. Instead of taking this into account we were receiving emails upon emails upon emails about training etc etc and quite frankly it was the stress that was tipping things onto the edge of being unmanageable. I feel like there is a belief that when working from home we have a comfortable time of things watching TV and drinking tea. I can honestly say I have never been busier in my life. **(Support staff, 15)**

> The pressure and expectations from management have not softened as a result of the pandemic which has caused elevated stress levels as some things I feel I am unable to achieve due to resources not being available but this is not accepted as a valid reason for being unable to complete certain task […] I feel that management could have been more supportive and made allowances for changes that were beyond our control. I also feel that they did not offer any level of understanding relating to the ever-changing needs of the service users and the challenging behaviours we have been faced with. **(Support staff, 34)**

Sub-theme 2: Above the ground it's different

For project managers, the COVID-impact on practice appeared less intense. Managers conveyed their practice and managerial support in terms of "being different" rather than experiencing "intense" difference. While there was an indication of new and challenging contextual factors (e.g. workload increase or shifting and uncertain government guidance), relative to their pre-COVID managerial and administrative responsibilities, responses focussed on how home working and 'less natural' online communication platforms impacted on their ability to fulfill their role. For some, it improved the frequency and accessibility of team communication, for more, it was a less preferred environment that afforded new personal and interactional challenges.

> Working mainly from home and keeping staff and [CLIENTS] up to date with project processes. Not negatively affected- just different. **(Manager, 3)**

> Working from home has helped me manage this [WORKLOAD INCREASE] better but it also means I am not taking regular breaks and meetings can be back-to-back. I have no distractions at home and […] I find myself engrossed in emails, meetings and calls. **(Manager, 8)**

The qualitative contrast with support staff experiences was also apparent in narratives about how project managers felt supported by their managers and the

wider organization in the pandemic. While project managers acknowledged these were challenging times, with only two exceptions, they talked highly of the support they were receiving and how the organization was adapting.

> [ORGANISATION] has adapted well to the COVID-19 pandemic. I always feel safe when attending a project and have the full support of my line manager […]. Home working has worked well and I am still able to attend project to support my teams. Managers meeting are taking place more frequently and communication between the team has improved. I have felt fully supported and appreciated by [ORGANISATION] throughout the pandemic. **(Manager, 6)**

> [ORGANISATION] have done everything they can do in this situation and it's not all bad, I quite like working from home. **(Manager, 32)**

4. Discussion

The initial stages of the COVID-pandemic had a marked and contrasting impact on the mental and professional wellbeing of *critical* support and managerial staff in a large, UK-based homeless-support organization. While support staff maintained similar levels of compassion to pre-COVID times, their general and professional wellbeing deteriorated six months into the pandemic. Importantly, this included increases in STS relative to pre-COVID and higher levels of STS and burnout against normative benchmarks in 2020, whereby a considerable number of support staff reached 'vulnerable' cut-off ranges both for STS (50%), and burnout (43%). Conversely, project managers remained consistent with their pre-pandemic baseline levels in STS, burnout, general wellbeing, as well as client compassion. These quantitative data were triangulated with a rigorous qualitative analysis that added explanatory detail. For support staff, the pandemic introduced challenging stressors not experienced by managers. Reduced and fluctuating client face-to-face contact, hampered by 'depersonalized' remote communication, meant client-practitioner relationships were more intense and, at times, fraught and collegial support less accessible. Support staff were called on to guide, and frequently challenge, vulnerable clients struggling to live with restrictions the pandemic introduced. The working environment was further intensified by staff shortages (leading to increased workload), restricted wider support resources for clients (e.g. reduced social and vocational outlets) and concerns for personal COVID-safety. Against this troubled landscape, support staff felt unsupported by their managers who were collectively positioned as a detached and non-responsive 'them.' In contrast, project managers felt adequately supported by their managers and, while their working roles were perceived to be "different," they were less intensely affected.

While our sample size was smaller than preferred, the convergence of raised STS and burnout in support staff and our inductive qualitative analysis of practitioner narrative offers solid evidence additional wellbeing support is needed in the host organization. Higher STS and burnout are associated with increased vulnerability to wider, more sustained mental health difficulties, such as depression and anxiety (as evidenced in other professions; Bock et al., 2020; Koutsimani et al., 2019; Yilmaz et al., 2022), and to higher staff turnover and service attrition (Fitzpatrick et al., 2017; Kidd et al., 2007; Waegemakers Schiff & Lane, 2019). In addition, COVID-era professional wellbeing findings in "frontline" homelessness workforces in other countries (e.g. Kerman et al., 2022a, 2022b), and recent qualitative narratives shared by practitioners in Scotland (Carver et al., 2022) offer further indication of our findings resonate across the sector.

That support staff participants retained levels of compassion and emotional engagement despite an increase in STS aligns with previous literature (e.g. Stalker et al., 2007; Wirth et al., 2019). People entering the homelessness workforce are likely to have heightened motivation for, and compassion towards, supporting vulnerable people, and being emotionally affected by a working environment does not necessarily mean people stop caring (Ferris et al., 2016; Kulkarni et al., 2013; Parry et al., 2022). Raised burnout, on the other hand, is likely to signal a transition to professional disaffectedness and apathy (Maslach & Leiter, 2016). That seven support staff, who reported time-off-work due to stress, presented higher burnout and STS and lower compassion satisfaction levels (than those who did not report stress-related time-off) adds support to this finding.

Typically, higher compassion and job satisfaction are argued to act as protective buffers for staff wellbeing that enables practitioners to professionally function and maintain the client-centeredness 'identity' encouraged and expected in the sector (Ferris et al., 2016; Kosny & Eakin, 2008; Makic, 2015; Parry et al., 2022). In a COVID-era, however, this heightened personal investment (and feelings of responsibility) to sustain client-centeredness may exacerbate the 'heavier burden' already experienced (Parry et al., 2022; Tiderington, 2019). For example, practitioners who place the client at the center of their practice may also need to 'enforce' COVID-regulations or place themselves at personal risk. This is likely to create an emotional dissonance difficult to resolve (as one support staff put it: "I felt at times like the enemy with the service users").

A further COVID-era practice strain identified was the role 'depersonalized' interactions had on client-

staff relationships. Reduced face-to-face contact and reliance on remote, online platforms were far from optimal in establishing the 'deeper working relationship' sought (and paramount; Tiderington, 2019) in vulnerable people support provision (Montes, 2021). For example, engaging, building rapport, 'reading' a person (and their situation), and assessing and managing risk are essential parts of the job (Tiderington, 2019); but less likely to effectively happen 'remotely' (for similar observed difficulties in mental health care in COVID-times, see Johnson et al., 2021 and Feijt et al., 2020; cf., Marcus et al., 2022). Moreover, COVID-induced social restrictions meant support staff were denied access to usual forms of collegial support. For example, off-loading, sharing experiences, and learning with peers are intricately implicated in feelings of professional efficacy and confidence, and are likely to act as a vent for emotional exhaustion (Parry et al., 2022; Tiderington, 2019; Wirth et al., 2019). As the sector builds on the flexible forms of working that have emerged from COVID-era working, applied research is needed to ascertain how this can be achieved without endangering client and staff relationships.

Support staff's practice was further challenged by managers who they perceived to be detached, out-of-touch, or unresponsive to what was happening 'on the ground' (for similar findings see Carver et al., 2022; Chief Scientist Office, 2021; Montes, 2021). Whether the emergent 'them-and-us' discourse and working relationships were evident prior to the pandemic is unclear, but hierarchical role differences and contrasting pandemic-practice priorities, and the less preferred, impersonal ways of managing (e.g. online team interactions) evidently exacerbated tensions. For example, while managers held critical 'duty-of-care' responsibilities that complied with ever-shifting governmental guidance and legislation, support staff were likely to be more concerned with in-project experiences and client-staff relationships. In repairing fragmented support staff-manager relationships that are perhaps inevitable from the COVID-era, leadership strategies and training that encourage a mutual understanding of respective roles and responsibilities need to be developed in the host organization.

4.1. Limitations and strengths

While our longitudinal design is the first to systematically contrast pre-COVID and COVID-times practitioner wellbeing in the UK homeless sector, some caution is advised in the interpretation of the results. A first, important limitation is the survey response in COVID-times (37% of baseline sample) was less-than-optimal (leading to a small, under-powered sample). The attrition is likely to be linked to intensive practice demands experienced at Time 2 (due to pandemic restrictions), as well as the technical hurdles introduced with the survey only being accessible online. A further consideration is that, although the ProQOL is an established, widely used professional-wellbeing measure, concerns have been raised regarding its psychometric properties, not least its internal validity (Geoffrion et al., 2019; Hemsworth et al., 2018). However, while these practical and sampling issues need to be reflected on, it is equally important to note our qualitative explanatory analysis adhered to established quality criteria (Tracy, 2010). Moreover, through our abductive mixed-methods approach, qualitative and quantitative analysis from the same samples were successfully triangulated (Jick, 1979; Morgan, 2014); thereby bolstering the study's internal and external validity.

Second, that our analysis incorporated only one (albeit large, national) homeless service-provider, further questions the extent our findings are transferable across the sector. At the same time, however, recent studies where ProQOL wellbeing measures were administered in other countries, to larger, more varied samples (Aykanian, 2022; Kerman et al., 2022a) have identified COVID-era wellbeing stresses and strains (including similar STS and burnout means). Additionally, our findings resonate with a recent practitioner experiential qualitative analysis elsewhere in the UK (Carver et al., 2022), and initial COVID-times practice reports (e.g. Montes, 2021). A final consideration is how the "wellbeing" surveys were positioned and interpreted by different but small practitioner groups. For example, the repeated-measures design may have encouraged bias to attracting more vulnerable support staff wanting to 'vent' their views, or managers keen to confirm their 'loyalty' to the organization. These design and epistemological issues can be addressed in future studies by extending the sample and introducing semi-structured interviews to extend and enrich our understanding of practitioner experiences.

4.2. Practice implications and conclusion

At a time when we remain affected, but not dominated, by the pandemic, it is an opportunity to reflect on how our findings can contribute to repairing residual damage in the sector, as well as inform how we can prepare for future, similar challenges. For the host organization, a first reflection is the negative impact the pandemic has had on the mental and professional wellbeing of homeless-sector practitioners; specifically, those 'working on the ground.' There is clear indication of a need to ringfence and offer evidenced-based resources, to repair and rebuild wellbeing and confidence. At the very least, this is likely to include opportunities for 1:1 counseling, intensified training and reflective practice opportunities, lower-

level stand-alone interventions (such as wellbeing advice and support, e.g. Reeve et al., 2021), and the availability of appropriate practice supervision (Peters et al., 2022). A further reflection is how the COVID-practice context, including the imposed parameters on more personalized communication and interaction, fragmented client and team relationships, and contributed to 'them-and-us' barriers between practitioners and managers. To what extent strains were caused or exacerbated by the pandemic remains uncertain, but there is a clear need for these relationships to be reflected on and restored through training and reflective practice. Equally, an important practice and research priority is to draw on the lessons we can learn to preempt scenarios of future pandemic (or similar) challenges (e.g. how to approach re-enforcing governmental-guidance frameworks while retaining good client-practitioner relationships). Finally, it is important to remember the practitioners of the current study were *critical,* vulnerable, and 'neglected' prior to the COVID-pandemic (Schneider et al., 2022). Against the unique challenges to have emerged from the pandemic, we are reminded of the compassion, commitment, and resilience of the workforce. We equally need to remember the ongoing need for recognition, resourcing, and funding in the homeless sector, irrespective of the COVID-pathogenesis.

Acknowledgements

We are very grateful to the practitioners who participated in this research. We also thank Ummul Humayra, Abigail O'Shea, Mira Osman, and Naomi Lea for their contributions to the 2019 data collection. The research was funded by the host organization where it took place.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Data availability statement

The data that support the findings of this study are available on request from the first author. The data are not publicly available due to restrictions, i.e., their containing information that could compromise the privacy of research participants.

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