

“A sticking plaster over a burst artery”

An explanatory theory of moral distress:
Frontline workers experience of supporting
rough sleepers with a mental illness through
austerity, welfare reform and the COVID-19
pandemic.

Victoria Hall

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Abstract

For a decade, prior to the COVID-19 pandemic, frontline homelessness workers in England have worked within national and local policies of welfare reform and austerity, within which there was a major cut to public spending. After the COVID-19 outbreak frontline workers began working within policies relating to the pandemic and homelessness. There is little empirical research on how these policies have impacted frontline workers who support rough sleepers with a mental illness as previous research focuses on people experiencing homelessness and/or mental illness during austerity and welfare reform, rather than the experience of the frontline homelessness worker. The purpose of this empirical research was to explore the experiences of homelessness frontline workers supporting rough sleepers with a mental illness post austerity, welfare reform and during the COVID-19 pandemic in the Midlands geographical area. Using a constructivist grounded theory approach, ten frontline workers, who worked within a variety of statutory and third sector organisations, took part in sixteen semi-structured interviews. The study offers an explanation of how working within welfare reform, austerity and COVID-19 has affected frontline workers who support rough sleepers with a mental illness. An explanatory theory of moral distress was co-constructed with the research participants. The frontline workers worked within disconnected systems across, housing, health, social care and the department of work and pensions, with the COVID-19 pandemic exacerbating this. They were frequently restricted in supporting their service users as they saw fit. This caused them to experience moral distress. The findings have significance going forward as due to the cost-of-living crisis, homelessness **may** increase, and planned cuts to public services will put additional pressure across housing, health, and social care services, which in turn will impact on homelessness organisations and frontline workers in the sector. If **this** does occur without any increase to funding to homelessness and mental health services, along with changes to policy and legislation, frontline workers will be under even higher risk of experiencing moral distress.

Key Words: Constructivist Grounded Theory, Homelessness, Rough Sleepers, Mental illness, Frontline workers, Austerity, Welfare Reform, and COVID-19.

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Glossary of Terms

Employment and Support Allowance (ESA): This is a financial benefit paid to working-age people who are unable to work due to illness and/or disability (Gov.UK 2022a).

Disability Living Allowance (DLA): This is a financial benefit paid to people aged 16 to 65 who have extra support needs due to their illness/ and or disability. This is being phased out and replaced by Personal Independence Payment (Turn2us.org 2022a).

DWP: Department for Work and Pensions is a ministerial department that is responsible for welfare (benefit) payments in the UK (Gov.UK 2022b).

Personal Independence Payment (PIP): This is a new financial benefit (replacing DLA) paid to people who have extra support needs due to their illness and/or disability. To make a claim people need to make a phone call, fill in a form and attend a medical assessment (Barry et al 2018). Similarly, to DLA it is a non means tested benefit (Gov. UK 2022c).

Universal Credit (UC): This is the flagship new benefit under the welfare reform agenda. Gov.UK (2021a) explains that it replaces six other benefits, Housing Benefit, Income based Job Seekers Allowance, Income related Employment and Support Allowance, Income Support, Child and Working Tax Credit.

Work Capability Assessment (WCA): This determines what obligations claimants must adhere to when claiming benefits based on the assessment results which is carried out by a 3rd party on behalf of the DWP. Claimants may be found fit to work, and stop receiving sickness benefit, have “limited capability for work related activity” and have to comply with certain conditionality requirements to carry on receiving sickness benefit or “limited capability for work” where claimants have little obligation towards getting work ready (Disability Rights UK 2012).

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Chapter One: Introduction

1.1 Introduction and Background and Research Context

Austerity as a fiscal policy was introduced by the Conservative government in 2010 to reduce the shortfall in government debt after the worldwide banking crises of 2008, which resulted in cuts across public services and reform made to welfare benefits (HM Treasury 2015). Austerity has meant cuts across services including social care, housing, and health (Feantsa 2011). Welfare reform radically affected the UK's social security system and there were changes made across all types of benefits paid to working aged people including those paid for employment, housing, and disability (House of Commons Library 2022). Literature suggest that the measures implemented were damaging to vulnerable populations and disproportionally affected poorer communities (Oxfam 2013, Beatty and Fothergill 2016, Alston 2018, Human Rights Watch 2019). Health inequalities have widened since welfare reform (Barr et al 2016, Marmot et al 2020). Mental health inequalities are stark amongst people experiencing homelessness with mental illness rates very high compared to the general population (Hertzberg and Boobis 2022).

Homelessness services have been affected by austerity and the welfare reform agenda. Since 2010 there has been a large increase in people rough sleeping (Department for Levelling Up Housing and Communities 2022a) with a collective argument that that austerity and welfare reform are responsible for the increase (Loopstra et al 2016, Fitzpatrick et al 2018a, Fitzpatrick et al 2019). Cuts to homelessness spending by local authorities has been severe with a 27% reduction between 2008/9 to 2017/18 (Thunder and Bovill Rose 2019). There is an increasing amount of people with complex needs becoming homeless including those with mental illness (Office for National Statistics 2019a). The COVID-19 pandemic and the public health response of national lockdowns has also recently affected the delivery of homelessness services (Boobis and Albanese 2020).

There is a paucity of research that explores how of all the above affects people who work supporting people experiencing homelessness and therefore this thesis presents a grounded theory study of the experiences of frontline workers who support people experiencing rough sleeping and mental illness who were working within the policy contexts of austerity,

welfare reform and COVID-19. It epitomises an often-unheard voice on supporting people experiencing homelessness with complex needs. This is particularly important due to the fear that rates of homelessness will rise further due to the current cost of living crisis and the current conservative government planned response to this.

The chapter begins by presenting and discussing in more detail the main areas that informed the research question and aim. This section is split into four key areas 1) austerity and welfare reform 2) homelessness, rough sleeping, and the surrounding legislation and policy 3) mental health service provision and surrounding legislation and policy 4) COVID-19 and the 'Everyone In' initiative'.

I move on to discuss the rationale of the study and my own background and reasons for undertaking the study. Finally, the chapter discusses the structure of the thesis.

1.2 Austerity in the UK since 2010

The basic economic definition of austerity is to reduce government expenditure and increase taxes (Fender 2020) and this economic response was used across Europe and the USA at the outset of the global recession (Bello 2013) which caused controversy as a policy response to the crisis (Konzelmann 2014, Fender 2020). Farnsworth and Irving (2011) argued that the crash had unique circumstances and therefore had greater implications than the fiscal crises that preceded it. The response to the financial crash was therefore viewed as important. The Conservative led coalition government during 2010 implemented austerity as its main fiscal response within the United Kingdom (Poinasamy 2013) of which within the EU, the UK was at the forefront of using (Clarke and Newman 2012). In keeping with an anti-collectivist paradigm, the UK government cut its expenditure as part of its austerity plan (Hayes 2019), with cuts to services (Unison 2019) and local authority budgets (Innes and Tetlow 2015, Gray and Barford 2018). The recession itself had also had a detrimental impact on already deprived areas within the UK (Athwal et al 2011) and many local authorities reported seeing an increase in demand for support from social services which was attributed to the impact of the recession (Tunstall and Fenton 2009). Cuts were made to all government departments during 2010 and 2015 and the Department of Local Government and Communities (currently called the Ministry of Housing, Communities and

Local Government) took the brunt losing over 50% of its funding (Gray and Barford 2018). Budgets cuts, as part of the wider austerity strategy, has impacted negatively on the commissioning and provision of homelessness services across local authority areas (Blood et al 2020) and at the same time there has been cuts to mental health budgets (McNicoll 2015).

Critics claim that austerity, as policy in the UK, has been used with *“exceptional vigour”* Blythe (2013:230). Pimlott, Giles, and Harding (2010) support that when compared to other countries affected by the banking crisis, the austerity measures implemented within the UK were considered severe. The UK government however argued that austerity, as an economic policy, was needed for *“rebalancing our economy away from debt and towards saving and long-term investment”* (Osborne 2009).

Opponents of austerity also argued that austerity measures disproportionately affected the poor (Oxfam 2013, Alston 2018, Human Rights Watch 2019). The UN, in 2016, completed an enquiry into the rights of disabled people in the UK and found that the changes that the government had made for eligibility to welfare benefits and adult social care were *“grave and systematic”* (United Nations 2016:20). Critiques argued that that the austerity measures taken in the UK were not based on economics but *“radical social re-engineering”* Alston (2018:2), with political ideology disguised as welfare reform (Grover 2015, Morrisson 2021). Another point of view is that the banking crisis and the subsequent austerity measures imposed by the government was a facade by elitists to *“shrink the (social) welfare state, deregulate labour markets and emphasise private markets as the drivers of growth”* (Farnsworth and Irving 2018:461). Anti-collectivists however argue that *“freedom, individualism and inequality”* is important, with freedom being crucial in preserving the market economy, and that liberty of one person means others will have inequitable experiences (George and Wilding 1985:19). The cause of poverty therefore is the fault of the poor (Dixon 2012).

1.2.1 Welfare reform

Part of the austerity measures implemented included a welfare reform agenda. In his emergency budget in 2010, George Osborne stated the greatest area on which the UK

government spent money was on the welfare budget, noting how, from 2000 to 2010, welfare spending had increased by 45% and needed constraining (Osborne 2010). The initial Welfare Reform Act (2012) was passed on the 8th of March 2012, followed by the Welfare Reform and Work Act (2016). The reforms are acknowledged to be one of the largest carried out on welfare in the UK since the 1940s (Homeless Link 2018a, Ramesh 2011). At present, welfare benefits are not fully devolved within the UK; the Department of Work and Pensions (DWP), under the instruction of the Secretary of State, currently has overall responsibility for the whole of the UK Welfare benefit system (Gov.uk 2019a). The DWP is responsible for administering a variety of welfare benefits (Machin and McCormack 2021) including sickness and disability benefits. The reforms included a raft of changes to welfare benefits, one major change was a variety of benefits being amalgamated into one named Universal Credit (Shelter 2018). Universal Credit, along with Personal Independence Payment, was central to the coalition government welfare benefit changes (Hobson 2020), and both these benefits can be paid to people if they are claiming due to sickness and disability; including people who are experiencing mental illness. There are no national statistics available regarding people who are experiencing homelessness and claiming benefits (Gray, Argodale and Rodriguez-Guzman 2021). However, Batty et al (2015) found when researching the experience of single homeless people and benefit sanctions, 92% of participants were claiming benefit. Another study found 79% of people experiencing or had recently experienced rough sleeping were claiming benefit and half of this figure were claiming Universal Credit (Ministry of Housing, Community and Local Government 2020a).

Hills (2015:15) identified that during the time of welfare reform the government began to use a rhetoric, where people who worked were “*strivers*”, and those that didn’t were “*skivers*”, which was an attempt to generate an us and them mentality within the general public. This is clear when the then chancellor was talking about the welfare state “*for too long, we’ve had a system where people who did the right thing, who got up in the morning and work hard felt penalised for it, while people who did the wrong thing got rewarded for it*” (Osborne 2013). Opponents of welfare reform were critical that this type of expression stops the public from beginning to understand the real issues around welfare (Power, Devereux and Ryan 2022).

Part of welfare reform agenda included benefit claimants being paid benefits based on compliance with set conditions such as attending work focused interviews, applying for jobs, and attending training, to encourage claimants into work (Dwyer and Wright 2014). This conditionality for receiving benefits also applies to people claiming benefits whilst experiencing homelessness and mental illness. Critics argued that the emphasis was one of the “*harshest regime of conditionality and benefit sanctions in the history of the UK benefit system*” (Reeve 2017:1). Sanctions to receiving benefits are applied if the DWP believe that the claimant has failed to do something (such as attending a work focused appointment, job interview or refusing a job offer). Sanctions can be a reduction in the amount of benefit paid, which in certain circumstances can be applied for up to six months (Department for Work and Pensions 2021, Turn 2 us 2023). For single people claiming Universal Credit aged over 25 years old, the current daily sanction rate is £11.00 (Turn 2 us 2022b).

1.2.2 Welfare Reform and Mental Illness

Over this period the changes made to sickness and disability benefits were substantial and are highlighted by (Kennedy, Murphy and Wilson 2016) in the table 1.1 below.

Table 1.1: Changes to sickness and disability benefit due to welfare reform

Employment and Support Allowance: Removal of the work-related activity group which was an extra premium of £29.05 per week for claimants who would need support to go back to work.
Disability Living Allowance: Replaced by Personal Independence Payment, which has stricter eligibility criteria. Disability Living Allowance had two components for mobility and care and was paid to those who were deemed to have low middle and high rate needs. Personal Independence is also paid in two components, for daily living and mobility. It is paid to those with standard and enhanced needs of care so those who previously met the low needs rate are no longer eligible for this benefit. Claimants now also must go to a medical assessment which is carried out by a third-party service provider.
Universal Credit: All means tested benefits and tax credits are being replaced by this benefit, 230,000 single adults are projected to lose between £28 and £58 per week due to the removal of disability premiums from a claimant’s applicable amount.

People who have an illness and/or disability and claim sickness benefit, such as Employment and Support Allowance or Universal Credit, complete a work capability assessment form and attend a medical assessment, from this information the DWP decide whether a person is fit

for work or not (Turn to us 2022c). The DWP use a biopsychosocial model in sickness benefit assessment. This was developed by Waddel and Aylward (2005) after the DWP commissioned research into implementing a new assessment process. There was controversy about the conception of the model, partly due to funding from an American insurance company, which use a similar model in assessing income insurance claims (Stewart 2018a). Critics argue the model '*totally disregards diagnosis, prognosis, prescribed medication and past medical history*' (Stewart 2018b: 6). The work capability assessment process has been heavily criticised by a range mental health charities including Mind, the Mental Health Foundation, and the Royal College of Psychiatrists, for being flawed and failing to accurately assess people (Kempster 2014). Stewart (2018b) claimed it was intentional to exclude people claiming who had mental ill health, as this population was placing a burden on the welfare budget.

Over 50% of people who live in poverty have a disability, which is attributed to the extra expenses people with disabilities have (Tinson et al 2016), for example, a person experiencing mental illness may avoid public transport and need to pay for a taxi for essential journeys. Welfare benefits, such as Personal Independence Payment (PIP) or the Disability Living Allowance (DLA) are paid to people who are deemed to have extra needs due to their illness/disabilities (Tinson et al 2016 and Citizens Advice 2022). As discussed above, part of the welfare reform agenda replaced the DLA with PIP (Department for Work and Pensions 2015a). There are administration differences between PIP compared with the preceding benefit of the DLA, differences include having a point scoring system, which determines eligibility of the benefit, and a face-to-face medical assessment (Department for Work and Pensions n.d). The change in benefit and its administration process has been difficult for people claiming due to mental illness, with the face-to-face assessment provoking anxiety amongst claimants (Machin and McCormack 2021).

Assessments are carried out by a health professional who is completely independent from the patients care team and the DWP (Capita 2022). Findings from the assessment are sent to a DWP case manager who decides, based on the information provided, if the claimant is eligible for PIP (Department for Work and Pensions 2015b). The decision-making process for PIP has been heavily criticised for being flawed (UK Parliament 2021) and a high number of

claimants have had decisions reversed in their favour when they appealed against a negative decision (Disability Rights UK 2019). PIP can be awarded for a fixed amount of time before being reviewed, and government statistics show that 79% of people claiming due to a mental illness were given PIP short term, which is briefer compared to other conditions awarded (Department for Work and Pensions 2022).

There are high economic costs to working age adults if they have mental ill health (OECD 2019). It is estimated that during 2019 mental illness cost the UK 117.9 billion (£100.8 billion in England) which was 5% of GDP (McDaid and Park 2022). During 2019 7% of illness within the UK was attributed to mental illness (McDaid and Park 2022). Commonly, working age adults, who are receiving treatment from mental health services, are claiming welfare benefits (Boardman, Dogra and Hindley 2015). The Office for National Statistics (2017) demonstrate that during 2017 the third largest spend on welfare was to those with an illness or disability after pensions and family benefits; 46.5% of sickness and illness benefit claims in the UK during 2014 were attributed to mental illness, which is an increase of 103% since 1995 (Viola and Moncrieff 2016). Due to benefits reforms The Office for Budget Responsibility (2016) forecast that the government would save £11.8 billion by 2021. The Disability Benefits Consortium (2019) estimate that, because of welfare reform compared with 2010, a disabled person receives £870.00 less income a year, however spending on sickness and disability benefits have increased markedly since 2012 (Joyce 2019). Furthermore, it has been found that there is a high correlation between people claiming sickness and disability benefits and having a low education status (Banks, Blundell and Emmerson 2015). There were also many changes that affected housing costs due to welfare reform (Hobson 2020) (see Table 1.2).

Table 1.2: Changes to housing related benefit due to welfare reform

The Bedroom Tax: Housing benefit reduced for people living in social housing with too many bedrooms that their household needed.
Council Tax Support: Council Tax Benefit was stopped, and local authorities became responsible for their own scheme.
Local Housing Allowance for private rented tenants: Rates payable are now linked to the consumer price index rather than the average rent in the local authority area.
The Social Fund: Ended.
Benefit Cap: A limit on the amount each household can claim in benefit.

Mental health and homeless charities began, and continue to, campaign about the reforms, arguing that the agenda pushes their vulnerable populations into poverty (Rethink Mental Illness 2015, Dawes 2015, Royal College of Psychiatrists 2019). The All-Party Parliamentary Group on Health in All Policies (2021) claim ten years of living within austerity has had a “profound” effect on people with low incomes and are concerned about people with mental health conditions living in poverty. Other critics claim that changes to benefits are “misguided in poor law notion, rooted in classical political economy, that people must be kept in poverty if they are workless” (Grover 2015:1576) and the changes to welfare have caused a culture of fear amongst people with disabilities, described by Stewart (2018a:579) as a “psychological tyranny”.

The government and its agencies have continually disputed these claims, stating that the vulnerable in society are safeguarded by the reforms (Cameron 2010, Duncan Smith 2014, Department for Work and Pensions 2015a, Gov.UK 2019b).

1.3 Homelessness

Homelessness is a global issue which has increased over the last ten years (United Nations 2020). Worldwide there are thought to be over 100 million people experiencing homelessness (United Nations-Habitat 2005). Homelessness however is not a globally defined term and there are inconsistencies on how countries record statistics on the issue (OECD 2021). Within Europe, the European Federation of National Organisations working with the homelessness (Feantsa 2018:1), defined homelessness as:

- “People living rough
- People in emergency accommodation
- People living in accommodation for the homeless
- People living in institutions (not been able to leave due to lack of suitable housing)
- People living in non-conventional dwellings due to lack of housing
- Homeless people living temporarily in conventional housing with family and friends”

For OECD countries, during 2020, people recorded as experiencing homelessness made up less than 1% of the population, however within England this was slightly higher at 1.25%

(OECD 2021). Large numbers of people in England have presented at their local authorities needing homelessness support. Between the 1st of October 2021 and the 31st of December 2021, 64,890 households were assessed as being homeless or threatened with homelessness (Department for Levelling up, Housing and Communities 2022b). This population was owed a statutory duty, which means that the local authority has a “*duty to provide assistance*” to the person and/or family (Department for Levelling Up, Housing and Communities and Ministry of Housing, Communities and Local Government 2018). However, on the 31st of December 2021 96,410 households were reported to be in temporary accommodation (Department for Levelling up, Housing and Communities 2022b).

Destitution is known to be increasing within the UK, with single adults most at risk (Fitzpatrick et al 2020). Since 2010, rough sleeping rates have increased, with a peak in numbers during 2017 (Department for Levelling Up, Housing and Communities 2022a). However, despite rough sleeping rates increasing, general rates of homelessness have been consistent in numbers (Office for National Statistics 2019a) and being asked to leave a private rented tenancy is a common reason for becoming homeless in England (Office for National Statistics 2019a).

Being homeless can be viewed through a variety of lenses including sociological and psychological; for example, sociology could examine the issue regarding having “*no fixed abode*”, however, if viewed through a psychological lens, emotions about “*not feeling welcomed or accommodated*” could be explored (Scanlon and Adlam 2022: 3).

Homelessness is a multifaceted issue with causes thought to be both structural and personal (Cromarty 2019, Mabhala, Yohannes and Griffith 2017), examples of structural causes are “*poverty, the housing market, the economy,*” and personal reasons include “*mental illness, alcoholism and substance abuse*” (Main 1998:42). There is however a growing consensus that these two factors interplay with one another. Personal reasons can cause homelessness, yet structural reasons can prolong homelessness (Piet et al 2014). Often people experience homelessness due to a variety of circumstances, such as relationship breakdowns, domestic violence, and eviction (Bowpitt et al 2011a). Ball et al (2020) concluded that structural causes can worsen physical and mental health illnesses of the person experiencing homelessness. Other researchers have concluded that people who

have had adverse childhood experiences, such as witnessing domestic violence, experiencing abuse and a parent in prison (British Psychological Society 2019), are at high risk of experiencing homelessness (Roos 2013). The risk increases for people experiencing more than one adverse childhood experience (Liu et al 2021). A survey on people rough sleeping in England found that 72% of respondents had either been expelled or frequently did not attend school, left school before the 16 or had been placed into care (Ministry for Housing, Communities and Local Government 2020a). Becoming homeless is heightened by *“identifiable, individual, social, and structural factors”*, at the core of which is experiencing poverty as a child (Bramley and Fitzpatrick 2018:112). The risk of experiencing homelessness as a single person or a couple without children living in the household increases if there is chaotic prior lifestyle (Wilson and Barton 2022). Frontline workers who support people experiencing homelessness in the UK argue that the causes are *“structural, sustained and predictable”* (Loney- Evans 2020a:6).

Experiencing homelessness is recognised as a form of social exclusion (Pleace 1998, Watson, Crawley and Kane 2016). The definitions of social exclusion are debated (Levitas 2000), however Fahmy, Sutton and Pemberton (2018: 439-440) propose that there are three main features of the term; *“being shut out from social, economic, cultural and political systems”*, it is generally viewed as a *“dynamic process”*, and it is illustrated by *“powerlessness denial of rights and diminished citizenship”*.

1.3.1 English Law and Homelessness

The responsibility of dealing with homelessness in England is with the national and local government (Local Government Association 2020). English law classes someone as homeless if he has no accommodation available for his occupation, in the UK or elsewhere, which he:

- (a) is entitled to occupy by virtue of an interest in it or by virtue of an order of a court,*
- (b) has an expressed or implied licence to occupy, or*
- (c) occupies as a residence by virtue of any enactment or rule of law giving him the right to remain in occupation or restricting the right of another person to recover possession.*

(2) A person is also homeless if he has accommodation but:

(a) he cannot secure entry to it, or

(b) it consists of a moveable structure, vehicle or vessel designed or adapted for human habitation and there is no place where he is entitled or permitted both to place it and to reside in it.

(3) A person shall not be treated as having accommodation unless it is accommodation which it would be reasonable for him to continue to occupy. (Housing Act 1996a).

Homelessness is therefore not just rough sleeping, people can experience homelessness by living in temporary accommodation such as hostels, bed and breakfast and night shelters or by experiencing hidden homelessness which includes sofa surfing or living in squats (Crisis 2022a). Along with rough sleeping, people living in these types of accommodation would be classed as core homeless, which demonstrates the most serious types of homelessness (Downie et al 2018). Furthermore, fifty percent of people who are classed as ‘core’ homeless are single (Fitzpatrick et al 2021).

1.3.2 The Single Homeless Population

People are classed as single homeless if they live in a household with no children. Homeless link (2018b:7) emphasise that single homeless people are less likely to be found as ‘Priority need’, under the Housing Act 1996, and therefore will not be found statutorily homeless and offered accommodation through local authorities which means they are more likely to rough sleep. People who are homeless face greater health inequalities; compared to the rest of the population they are more likely to have physical, mental and substance misuses illnesses (Homeless Link 2014, Field et al 2019, Ministry of Housing, Communities and Local Government 2020a, Crisis 2021). A person experiencing homelessness, along with not having a home, is deprived in other areas, e.g., not having a private space, or a secure base in their community (Somerville 2013). Life expectancy has fallen in disadvantaged areas in England (Office for National Statistics 2022a) and there is a high number of deaths in people experiencing homelessness and the figures are rising. During 2021 there was a 7.7% increase in deaths across England and Wales compared with the 2020 figure, there were 741 deaths of which 13.4% were attributed to suicide (Office for National Statistics 2022b). It is estimated that during 2020 and 2021 deaths in the homeless population within England and Wales were caused mainly by substance use (alcohol and illegal drugs), suicide and

COVID-19 (Office for National Statistics 2021, Office for National Statistics 2022b). Previous statistics have demonstrated that death rates were higher in cities compared to rural areas and were more likely in areas with greater deprivation (Office for National Statistics 2019b). There are other higher figures, during 2021 the museum of homelessness found through freedom of information requests, access to homelessness networks and information from the public that 1,286 people died whilst homeless across the UK which was an increase of 80%, compared to numbers of deaths recorded for 2019 (Museum of Homelessness 2022). On average a homeless male dies aged 44, 32 years earlier than other males in the general population (Office for National Statistics 2019b). Suicide rates are nine times higher than the general population (Thomas 2012). People experiencing homelessness are seventeen times more likely to suffer a violent experience which increases to one in three for people experiencing the most extreme form of homelessness and rough sleeping (Crisis 2022b). Furthermore, a high number of perpetrators of violence towards rough sleepers are members of the public (Sanders and Albanese 2016).

1.3.3 Rough Sleeping

It is estimated that over any one night in England 2,700 people are rough sleeping, 15,000 people are living in accommodation such as hostels, and 250,000 people are living in other forms of temporary accommodation such as a bed and breakfast (Shelter 2021a). During autumn 2021 the rough sleeper count was 38% higher than 2010, however the amount of people experiencing rough sleeping was lower than during 2020 (Department for Levelling up Housing and Communities 2022a).

The average demographic of a rough sleeper is a white single male aged 26-years old from the UK (Department for Levelling up, Housing and Communities 2022a). The main reason for a person becoming homeless and ending up rough sleeping is due to a relationship breakdown (Wilson and Barton 2022). Rough sleepers are deemed to be a vulnerable population (Wilson and Barton 2022) and often have concurrent complex needs (Barton et al 2019, Ministry of Housing, Community and Local Government 2020a). Overall, the support needs of people experiencing rough sleeping have increased since austerity was implemented (Blood et al 2020). Support needs commonly include mental illness, physical illness and substance misuse (Cromarty 2019, Ministry of Housing, Community and Local

Government 2020a). There is an increased risk of these co-morbidities developing the longer a person rough sleeps (Sanders and Albanese 2016), and people who experience mental illness are known to rough sleep for a longer amount of time, compared to rough sleepers with other conditions (Dumoulin et al 2016).

1.3.4 Policies to Combat Rough Sleeping

Throughout successive governments people experiencing rough sleeping have been a concern, and over the years a range of policies and legislation have been implemented aiming to reduce numbers. However, policy about homelessness is a contentious issue and there is constant dispute on the best policy response to combat homelessness and rough sleeping (Pattison and McCarthy 2020). Some of the main policies and legislation that have been used within England are set out in table 3 below.

Table 1.3: Main housing policy and legislation in England since 1977

Year of Policy/Legislation	Policy/Aim
Housing (Homeless persons) Act 1977	Local Authorities began to have a duty to accommodate some homeless people if they met the threshold of vulnerability (Downie et al 2018).
The Rough Sleepers Initiative 1990-99	Scheme to stop people rough sleeping originally within London (Wilson 2015) developed within the rest of England where there were increasing numbers of people sleeping rough (Wilson 2011).
Housing Act 1996	Homelessness legislation is covered under part 7 of the act, local authorities continue to have a duty to accommodate homeless people if someone is found having a priority need. Priority need can be applied in certain circumstances if someone has a mental illness. (Housing Act 1996b).
Social Exclusion Unit 1997-2010	Began to focus policy and solutions on people socially excluded including people experiencing homelessness.
Homeless Action Programme 1999-2002	Took over from RSI, Funding given to the whole of the England to solve rough sleeping (Crane and Warnes 2000).
Rough Sleepers Unit 1999-2002	Originally situated within the Social Exclusion Unit. Developed national rough sleeping policy across England (Wilson 2011).
Homelessness Directorate 2002	Focused on the cause and prevention of homelessness, liaised with local authorities in dealing with homelessness in their areas (Wilson 2011).
Homelessness Act 2002	Local authorities have a duty to create a homelessness strategy, Housing Options began (Homelessness Act 2002) Increased the eligibility of people who could be classed as

	priority need (Department for Levelling up, Housing and Communities 2018a).
Supporting People Programme 2003	Improve people's lives through housing related support services (included some resettlement services) people who were classed as socially excluded were eligible for this support (Jones and Pleace 2010).
Places of change programme 2005	To enable people who lived in homeless hostels and use day centres to move on successfully from services (Jones and Pleace 2010).
Adults facing Chronic Exclusion 2007	Scheme to test how to successfully engage with severely excluded adults (Cattell et al 2011).
No Second Night Out 2010	To prevent people rough sleeping began in London and then administered across England (Department for Communities and Local Government 2011).
Homelessness Reduction Act 2017	Two new duties 'prevention and relief duty' for local authorities (Shelter 2017) ' <i>enhanced legal entitlements for single homeless people in England</i> ' (Institute for Social Policy, Housing, Equalities Research 2017).
Rough Sleeper Initiative 2018	To reduce the number of rough sleepers across England. Task force from cross agencies and government. Funding to rough sleeping staff and local authorities deliver support (Evaluation Task Force 2022).
Duty to refer 2018	Public agencies such as prisons, Job centres and hospitals now have a duty " <i>to refer service users who think may be homeless or threatened with homelessness to local authority homelessness/housing options teams</i> " (Department for Levelling Up, Housing and Communities 2018b).

1.3.5 Reducing Rough Sleeping

The aim to reduce homelessness is now on the major political party agendas (Fitzpatrick et al 2018b), with the Homelessness Reduction Act 2017 being passed through parliament to combat the rise in rough sleeping. The conservative government's manifesto was to end rough sleeping by 2027 (Conservative and unionist party manifesto 2017, Barton et al 2019), however the current government now aims to achieve this by 2024 (Watts et al 2022). A report by the All party Parliamentary Group on Ending Homelessness (2022) states this is unlikely to happen without new interventions put in place, such as dealing with all types of homelessness. Despite the government focus on reducing homelessness, critics highlight the reduction in funding within the sector, and St Mungo's (2019) argue that over the last ten years there has been a 53% cut in monitory terms to single homeless services across local authorities, and a total reduction of one billion pounds to homeless services overall. A report by Homeless link (2022) concludes that since 2010 there has been a 38.9 % reduction

in homeless provision and a 26.3% decrease in available bed spaces for the single homelessness population. In September 2022 the government committed £2 billion pounds until 2025 in the latest homelessness and rough sleeping strategy (Department for levelling up, housing and communities 2022c).

The rough sleeper count is an indication of the number of rough sleepers (Sanders and Albanese 2016) and takes place annually during October and November (Wilson and Barton 2022). There are three approaches local authorities can undertake when completing a rough sleeper count.

- ***“A count-based estimate”***; this is the number of people found rough sleeping in a local authority area during one night between October and November.
- ***“An evidence-based estimate meeting”***; where local agencies use an evidence-based assessment to estimate the number of people rough sleeping during one night in October or November.
- ***“An evidence-based estimate meeting with a spotlight count”***; using evidence from the evidence-based estimate meeting (definition above), along with a smaller geographical area, covered by a street count (Department for Levelling up, Housing and Communities 2022a).

There are criticisms that the rough sleeper count methodology is flawed (Greenfield 2019) and that results are easily manipulated (Healy 2020). Of relevance is that the number of people placed in accommodation during the COVID-19 pandemic surpassed the estimates from the rough sleeper counts (Fitzpatrick et al 2021). This is demonstrated by figures from the National Audit Office (2021) which examined the numbers of rough sleepers accommodated nationally through the first lockdown of COVID-19. It was found that 33,139 people had been accommodated from March to November 2020, yet the official figure from the previous rough sleeper snapshot was that there was 4,266 people sleeping rough on a given night during autumn 2019 (Ministry of Housing, Communities and Local Government 2020b). The midlands geographical area was one of two areas identified outside London which had intensifying pressures due to rates of homelessness (Fitzpatrick et al 2018b).

1.3.6 Homeless Reduction Act 2017

The Homelessness Reduction Act (2017) was seen as a landmark within homelessness legislation (Garvie 2018), as until 2017 most single people experiencing homelessness were not given significance by local authorities (Fitzpatrick et al 2021). The Act was seen as important in supporting this population (Institute for Social Policy, Housing, Equalities Research 2017, Fitzpatrick et al 2021). A high number of people experiencing mental ill health has been supported under the act, during 2019/20 23% of households were supported (Fitzpatrick et al 2021). Local authorities now have prevention duties, which means they need to intervene earlier to prevent homelessness and not consider priority need and intentionality (Cromarty 2019). Other schemes that the government has used nationally to reduce rough sleeping include no second night out, to stop people spending more than one-night rough sleeping and street link which enables the public to alert organisations about someone rough sleeping in their area (Cromarty 2019). The rough sleeping strategy led to further funding to reduce rough sleeping and support the rough sleeping initiative (Cromarty 2019) however, some single homeless people are still not able to obtain housing (Fitzpatrick et al 2021, Watts et al 2022). Of people classed as being threatened with homelessness, 67% were single during 2020/2021, and all groups decreased during the pandemic, yet single homelessness increased by 3% (Fitzpatrick et al 2021).

1.3.7 Costs of Rough Sleeping

There are various estimations to the cost to society of rough sleeping. Pleace (2015) estimates that a single person who has no other support needs and rough sleeps for a year would cost £20,128. The Ministry of Housing, Community and Local Government (2020a) estimate the cost to be £12,260. The costs are attributed to the extra contact the person experiencing rough sleeping would have with public services such as the NHS and criminal justice system compared to someone who is not rough sleeping. It may be argued therefore that the cuts that have been made to homelessness services for the purposes of austerity are detrimental and more will be spent financially in the long run due to this.

1.3.8 Multiple Exclusion Homelessness

Multiple exclusion homelessness is defined as a person who has experienced homelessness along with at least one another profound social exclusion such as “*institutional care* (including patients on a mental health ward) *substance misuse... and street culture activities*” (Fitzpatrick, Bramley and Johnsen 2013:149). People classed as being excluded from multiple services often experience homelessness more than once (Bowpitt et al 2011a). There is a strong link between multiple exclusion homelessness and mental illness (Fitzpatrick et al 2011, 2013) with the mental health diagnosis often classified as severe (Pattison and McCarthy 2020). The MEAM (make every adult matter) coalition (2018a), which is made up of several charities, highlights that people who are in this group fall through gaps in service provision, as services often do not have a duty towards this group, however Clinks et al (2009) argue that the cost to society from this minority group is great. It is estimated that each individual within this population uses public services at a cost of £28,800 per year (Welford et al 2022). The dire consequence of not being able to access support and falling through gaps in service provision has been highlighted in a recent safeguarding review in the Northamptonshire area after the death of a rough sleeper named Jonathon. It was noted that there were 700 notes documented by different organisations within a year prior to his death, services involved were across, housing, health and social care and were criticised for the absence of joined up working and the failure to acknowledge that his needs were not only housing related (Ornelas 2021).

1.4 Mental Health

The World Health Organisation (2022a) defines mental health as “*a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community.*” There are various models of mental health, the two most prominent are the biological model and the social model. The biological model is often used by medical professionals, and as it deems the reason for mental illness to be biological, treatment is with medication (McLeod 2018). Deacon (2013) argues that the scientific community have not discovered an organic reason or indicator for any mental illness and that medication doesn’t work in treating the condition.

In contrast, the social model deems that mental illness is caused by societal influences and the way society is shaped (Mental Health Foundation 2019a, Goering 2015, Gerst and Gerst 2020) or by influences such as family dynamics or the family environment (Laing and Esterson 1964). However, it is asserted that the social model does not recognise the differences in disability types and the way people understand and interpret their disabilities (Owens 2015). There is research emerging which demonstrates that mental health is also affected by an individual's socio-economic circumstance and that there is a correlation between health and social inequalities (Friedli 2009, Marmot et al 2010). Health inequalities are subsequently costly to the economy with, for example, reduced work output and a larger benefit bill (Marmot et al 2010). Many mental health experts see poverty as the root of *"emotional distress"* (Albee 1999: 142), and mental illness rates have been found to be three times higher in countries that have high rates of income inequality (Pickett and Wilkinson 2010). The global burden of disease has demonstrated that the most common cause of disability world-wide is attributed to mental illness and substance abuse, with depressive and anxiety disorders most common (Whiteford et al 2013). One in six adults in England are estimated to have a mental illness (McManus et al 2016) and mental illness is more common in *"people living alone, in poor physical health and not employed"* (McManus et al 2016).

1.4.1 Health inequalities of people experiencing rough sleeping and mental ill health

Globally it is known that there are huge health inequalities and poor health outcomes for people experiencing homelessness including people who are rough sleeping (Stafford and Wood 2017, Public Health England 2020). People in the UK experiencing homelessness have low and increasing mortality rates and there no sign that these rates are improving (Thomas 2012). The rates are seen to be aggravated by difficulties in accessing health and social care services (Armstrong et al 2021, Rathod et al 2021, Gunner et al 2019, Hertzberg and Boobis 2022).

People experiencing severe mental illness such as schizophrenia, bipolar disorder and substance misuse also face poor health outcomes with a low life expectancy (Chang et al 2011). People experiencing mental ill health often have a comorbid physical health condition (NHS Digital 2016). In the UK it is estimated that over 26,000 people with a severe

mental illness die each year at a younger age than the rest of the population due to having a preventable diseases (Royal College of Psychiatrists 2023). Research has found people experiencing severe mental illness die 15-20 yrs. earlier than the general population (Nordentoft et al 2013). This figure of premature death is increasing in England (Office for Health Improvement and Disparities 2023). The link between mental ill health and reduced mortality is understood to be due to complex structural and personal factors which affect each other such as poverty and stigma which deters people seeking help (Public Health England 2018, Centre for Mental Health 2020).

It is commonly understood that mental health and homelessness are intricately linked and therefore a homeless person may be more likely to have a mental illness compared to the rest of society (Homeless Link 2014, Rees 2009, Diggle et al 2017, Hertzberg and Boobis 2022). The Mental Health Foundation (2019b) report that 45% of the homeless population have a mental health diagnosis and 80% admit to mental health difficulties. A national survey of people experiencing rough sleeping found that 82% of respondents reported to have a mental illness, most commonly depression and anxiety (Ministry of Housing, Community and Local Government 2020a) Personality disorders are also prevalent amongst this population (Shelter 2008, Diggle et al 2017). In the annual frontline worker survey of workers who support people experiencing homeless, it was a common occurrence for respondents to support people experiencing mental ill health, with the support needs of service users increasing (Marshall 2022), supporting the claim that *“poor mental health is a cause and consequence of homelessness”* (Crisis 2019). People with a mental illness have lengthier periods of rough sleeping compared with the rest of the homeless population. (Glew and Orchard 2016).

1.4.2 Mental Health Service Provision

Mental health services have had years of financial neglect (Farmer 2018), with austerity being viewed as harming mental health service provision in the UK (Cummins 2018). Compared to physical services, provision given to mental health services is poor (British Medical Association 2020), with the recession and austerity being seen as a challenging environment to implement any health policy reform (Hodgkin and Karpman 2010). There has been a considerable reduction in overnight hospital beds for people with mental ill

health. Using NHS data, Ewbank et al (2021) found that, from 1987/88 to 2019/20, mental health bed provision across all services has fallen by 73%, which is 20% higher than reductions in NHS beds overall.

It is known that rough sleepers face difficulties in accessing health services (Cromarty 2019, Elwell-Sutton et al 2017) with concerns being raised about a deficit of mental health support for this population (Barton et al 2019). The NHS was compelled to begin addressing health inequalities due to legislation within the Health and Social Care Act 2012 (Whiteford and Simpson 2016), however the NHS does not code (therefore have figures) on people they are treating as homeless (Field et al 2019) even though the NHS long-term plan, launched in 2019, had a specific commitment to add mental health support to homeless outreach teams in areas of England (Murdoch 2019). Historically mental ill health has not been treated on par with physical ill health and there is ongoing work to improve this (National Institute for Health and Care Excellence 2022). Table 1.4 below shows the changes to prominent mental health policy and legislation from 1983 to the present day.

Table 1.4: Main mental health policy and legislation in England since 1983

Year of Policy/Legislation	Policy/Aim
The Mental Health Act 1983 (amended 2007)	Primary legislation about the ' <i>assessment, treatment and rights of people with a mental health disorder</i> ' (NHS 2019a).
NHS and Community Care Act 1990	Move away from mental health institutional care. Health and local authorities needed to work together to treat adults with mental illness in the community (Social care institute of excellence 2012).
National Service Framework for Mental Health 1999	Set nationwide " <i>standard and service models</i> " for the treatment of adults with England with a mental illness. (Department of Health and Social Care 1999:5).
NHS Plan 2000	Modernising Health and Social Care combining resources to work together within local authority areas. Improvement to mental health services. (Department for Health 2000).
Mental Capacity Act 2005	To safeguard people who may lack capacity within their decision making (NHS 2021).
No Health Without Mental Health 2011	Enhance the ' <i>mental health and wellbeing of the population</i> '. To improve the outcomes and services for people who are experiencing a mental illness (Department for Health 2011).

Care Act 2014	Local authorities can offer support to an adult experiencing mental illness if they meet an eligibility threshold (Rethink Mental Illness 2022).
Five Year Forward View for Mental Health 2016	Mental health services to be funded equally compared to physical health services, Wider policy aims include addressing inequalities within mental health (Mental Health Taskforce 2016).
NHS Mental Health Implementation Plan 2019	Extra funding for mental health services to improve service provision across mental health services, including services for adults experiencing severe mental illness, and rough sleepers in twenty geographical areas (NHS 2019b).
Health and Care Act 2022	Clinical commissioning groups replaced by sub regional integrated care systems (Bell 2021).

1.5 COVID-19

England had experienced 10 years of austerity when COVID-19 began (Fitzpatrick et al 2021). However, prior to the outbreak, destitution levels were increasing within the UK (Fitzpatrick et al 2020) and COVID-19 highlighted health inequalities within populations (Allwood and Bell 2020, Bambra et al 2020, Mishra et al 2021). People experiencing homelessness were seen as part of a high-risk group of becoming severely unwell if infected with COVID-19 due to often having co morbid illnesses (Pathway 2019). They were also deemed to be in immediate danger from the virus, as they were unable to stay at home as per lockdown policy for COVID-19 (Rahman 2020). Homelessness was then treated as a public health concern due to the risk of infected rough sleepers passing the virus on to the general population (Fitzpatrick et al 2021). As a result, there was enhanced joint working processes between health and homelessness services (Watts et al 2022).

Although not an official statistic, during COVID-19 the government assert that over 40,000 people, who were rough sleeping or at risk of doing so, were placed in temporary accommodation to protect them from the virus (Department for Levelling Up, Housing and Communities 2022d). This scheme was known as the 'Everyone In' initiative and support was offered to people who, in normal circumstances, would not receive any homelessness support, such as to people with no recourse to public funds (Watts et al 2022). From a public health perspective, the scheme was seen as successful as death rates for the homeless with COVID-19 were not greater than the rest of the population. 'Everyone In' was seen to have kept the numbers of people experiencing homelessness and dying from a

result of COVID-19 low (Office for National Statistics 2021), along with low infection rates of the disease (Fitzpatrick et al 2021).

The COVID-19 pandemic has increased demand and therefore the pressure on mental health services. The Care Quality Commission (2022) highlighted that the reduction in community mental health services correlated with an increase of 4.5% people being detained under the mental health act (NHS Digital 2021), suggesting that peoples' mental health deteriorated, due to a lack of adequate support in the community.

1.6 Future Fears

Going forward there are currently several factors that may negatively impact on homelessness rates within England. The UK leaving the European Union (EU) is a concern as EU nationals currently represent a significant number of people experiencing homelessness (Department for Levelling up, Housing and Communities 2022a). This group may find it hard to obtain the relevant immigration status and therefore may be prevented access to housing services and support (Oakley and Thunder 2018). COVID-19 is a concern as "*deep poverty and destitution*" were increasing before the pandemic (Watts et al 2022: xi) and charities have concerns that repercussions from the pandemic mean that more people will fall into poverty (Joseph Rowntree Foundation 2021) and homelessness rates will increase as a result (Fitzpatrick et al 2021). There are also concerns about the current cost of living crisis and homeless charities are warning that this will also negatively impact homelessness rates (Downie 2022).

1.7 Rationale for the Study

The aim of this research project was to understand how frontline workers, who support rough sleepers with a mental illness, experienced working within austerity, welfare reform and COVID-19. Homeless research has historically overlooked frontline staff (Waagemakers-Schiff et al 2021), which is possibly due to job pressures preventing frontline workers taking part (Loney-Evans 2020b). This means the experiences of frontline workers, who support rough sleepers with a mental illness, **who as a demographic face the greatest health inequalities** are often unheard within academic, policy and research discourse.

To aid the foundation of the project a broad research question was set. As with most qualitative research the approach used was inductive and the research was not limited by setting a hypothesis prior to data collection (Adler 2022). Grounded theory starts with an “*inductive logic*” and goes into “*abductive reasoning*” where the researcher checks and questions hypothesis until the most reasonable answer is reached (Charmaz 2008:157). Questions asked were intentionally left open-ended to allow for the participants’ experiences to be at the fore (Galleta 2013). The research purpose was to gain understanding of how frontline workers, who support people experiencing mental ill health and rough sleeping, found working within austerity, welfare reform and COVID-19. The resulting explanatory theory of “moral distress” was co-constructed with the participants. This allowed for in-depth and full understanding of the issues that the frontline workers face rather than descriptive findings (Glaser and Strauss 1967). Moral distress is a multifaceted occurrence which is difficult to explain (Mares 2016). There is little academic literature that explains the full moral distress process including its beginnings, development and outcomes (Mares 2016). It is understood by various frameworks such as individual frameworks of ethics (Jameton 1984, Ramos et al 2016, Tigard 2018, Caram et al 2022) social psychology (Rushton, Kaszniak and Halifax 2013) and Psychiatry (Brake and Nauta 2022). It can also be understood through organisational frameworks (Corley 2002). A critical discussion on the concept and theoretical background of moral distress is developed within the literature review chapter.

In England **frontline** workers have worked within a multitude of changing policy and legislation, across housing, health, social care and the DWP since 2010, and there is a dearth of literature that explicitly explores the experiences of this group of workers. This research is timely, as along with exploring working within the Homelessness Reduction Act (2017) which came into force during April 2018, most data was collected through the initial national lockdown due to the COVID-19 pandemic, and captured workers experience of this, along with working during the ‘Everyone In’ initiative.

1.7.1 Personal Background and Reasons for Undertaking the Study

As a child I grew up in a single parent household that claimed welfare benefits and lived in poverty. The area I was brought up in was deprived and I went to an inner-city state

secondary school, where the emphasis upon leaving was not educational achievement but finding a job in a local factory. I was aware, from a young age, that living in poverty marginalises and excludes people and some people have limited options in life. Looking back, my upbringing has had a profound effect on my education and career choices. My undergraduate degree explored psychological and sociological theories of health and wellbeing and this viewpoint has influenced the PhD research. I have had 21 years experience supporting and advocating for people who were experiencing homelessness and severe mental illness.

After completing a Higher National Diploma in care practice, I began to work as hostel support officer, supporting people who had been previously homeless and who had moved into temporary accommodation, to support to move on successfully into permanent accommodation. From there I spent thirteen years as an advocate for people experiencing severe mental illness in a local authority welfare rights team based on an acute mental health unit. I advocated and supported people in the areas of welfare benefits, housing (including homelessness) and debt. Following this I worked in a post commissioned by a clinical commissioning group to identify rough sleepers who had a mental illness and supported them to ensure they got access to appropriate services. I was in this post at the height of the number of people experiencing rough sleeping in England. Since beginning my PhD, I have continued to work, and volunteer at times, to support people who are experiencing multiple excluded homelessness and/or rough sleeping. Throughout my working history I have witnessed first-hand the failures and social injustices in the “safety net” of the system that is there to protect vulnerable people and these experiences have been a catalyst to my research project. I describe myself as a white working-class woman.

1.8 Structure of the Thesis

Chapter Two: Examines and discusses literature on what is already known about the research area. I discuss the place of the literature review in a grounded theory study and how the literature was reviewed pre, during and post data analysis. How the literature was found using different search strategies pre and post COVID-19 is explained, along with the types of literature included in searches. The literature is presented in themes. These are: the effect on welfare reform and austerity on mental health and homelessness, supporting

vulnerable people to claim welfare benefits, working within austere policy, the wider health and care system, digital exclusion, the coronavirus pandemic and 'Everyone in' initiative, workplace violence, compassion, distress of frontline workers, **system change** and finally moral distress. **Chapter Three:** Explains my axiological, ontological, and epistemological positioning and rationale of using constructivist grounded theory in my research design. **Chapter Four:** Begins by explaining issues that arose in carrying out the research, beginning with the outbreak of the COVID-19 pandemic. The chapter moves on to discussing my reflexivity whilst conducting 'emotionally demanding research' as an 'insider'. I justify the data collection method of semi-structured interviews and how I used documentary analysis to inform the interviews. I then discuss how data was collected and analysed. Finally, some of the ethical implications of the research are discussed. **Chapter Five:** A composite story is presented showing the barriers and obstacles frontline workers supporting mentally ill rough sleepers face. This is followed by the empirical research findings in which an explanatory theory, describing the moral distress of frontline workers supporting mentally ill rough sleepers through austerity, welfare reform and COVID-19, is presented. **Chapter Six:** The co-constructed explanatory theory is discussed further by explaining the different elements of the model. The chapter then moves onto implications for practice and policy and makes recommendations based on these. Finally, the chapter moves onto the contribution to knowledge the research has made and the strength and limitations of this study.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

As discussed in the previous chapter, the issues around homelessness, welfare reform, austerity and COVID-19 are complex and multi-faceted. This chapter will discuss, firstly how the literature review was carried out and the rationale for using the literature included in the review. This is followed by a critique of the place of the literature review in a grounded theory study.

The literature is presented in themes and all themes have relevance to answering the research question. The themes were identified prior to, during **and after** data collection. The literature themes included in the review were: the effect of welfare reform and austerity on mental health and homelessness, supporting vulnerable people to claim welfare benefits, working within austere policy, the wider health and social care system, digital exclusion, the coronavirus pandemic and 'Everyone In' initiative, workplace violence, compassion, distress of frontline workers, **system change** and moral distress.

2.2 Stages of the Literature Review

There is debate amongst grounded theory researchers about conducting a literature review prior to data collection (Harris 2015, Hussein, Kennedy and Oliver 2017, Charmaz 2014).

Within most qualitative research, literature reviews are conducted before the research project begins (Hallberg 2010), however, this is discouraged within classical grounded theory as *"an effective strategy is, at first literally to ignore the literature of theory and fact on the area under study, in order to assure that the emergence of categories will not be contaminated"* (Glaser and Strauss 1967:37). Classical grounded theorists Glaser and Strauss (1967) expect the researcher to be impartial and have no prior knowledge of the research area, to prevent any assumptions made prior to data collection; and therefore, to postpone a literature review (Thornberg 2012, Charmaz 2014, Hussein, Kennedy and Oliver 2017). Strauss and Corbin (1998) concurred that a literature review, prior to data collection, is an unwarranted task, as the purpose of research is intended to understand new phenomenon. Constructivist grounded theory rejects this, and it is argued that literature review should be conducted in a flexible manner throughout the research process, as the ultimate version of the review should be explicit in supporting the research aims and

objectives, as well as the findings (Charmaz 2014). The argument of when to complete the literature review is futile and the researcher “*should tailor the final version of the literature review to fit the specific purpose and argument*” (Charmaz 2014:307). Others claim that doing a literature review before data collection helps with theoretical sensitivity (Thistoll, Hooper and Pauleen 2016). Some researchers, in recognising the challenge of the literature review, have proposed ways to minimise the risk of existing literature tainting the research area. Thornberg (2012:249) proposes being “*informed*” by literature and theoretical frameworks during a grounded theory study, whilst using strategies to stop the literature overtly influencing the research project, whilst Hussein, Kennedy and Oliver (2017:1206) use a dynamic integrative reflexive Zipper framework which is a framework that encourages literature searches to take place frequently and begin at the earliest opportunity.

It is recognised that, due to institutional expectations, delaying a literature review is not practical for PhD researchers (Charmaz 2014). In keeping with this premise, and also because of requirements for my PhD proposal, reviews and ethical applications, I reviewed literature prior, during and after data collection and analysis. As will be discussed in more detail in the methodology chapter, the original aim of this thesis was to explore how people, who were experiencing mental ill health and were being treated within a secondary mental health service, who were homeless and rough sleeping, and the staff who support them, experienced the welfare reform agenda and austerity measures. Due to the COVID-19 pandemic this aim changed to explore how frontline staff, who supported rough sleepers with a mental illness experienced working within welfare reform, austerity, and the COVID-19 pandemic. After amending the research question and design subsequent literature searches were carried out to identify new gaps in knowledge because of the pandemic.

2.2.1 Pre COVID-19 Search Strategy

I began searching literature that explored how people with a mental illness and/or were homeless, along with the staff that supported them, experienced the welfare reform and austerity measures. As the welfare reform agenda began in 2010 only literature after this time frame was included and due to the inimitability of the welfare state and how welfare reform and austerity measures have been implemented, only literature from the UK was included. Due to homelessness law devolution in the UK and policy differences within the

devolved nations (Crisis 2022c), only homelessness literature about England was included. The De Montfort University academic library base was used for literature searches as I had access to this as a student. Google scholar was also used for literature searches to supplement the academic database. See tables 2.1 and 2.2 below for the search terms use pre and post COVID-19.

Table 2.1 Search terms used for the literature searches prior to the COVID-19 pandemic

Key Search Terms searched on the library data base and Google scholar from November 2018 to July 2019
Mental illness and welfare reform Mental illness, welfare reform and homelessness Mental illness and homelessness and welfare reform Welfare reform and homelessness Mental illness and welfare reform Mental illness* welfare reform* and homelessness* Delayed discharge* mental illness* and psychiatry* Mental health* delayed transfer of care* and psychiatry*
Key Search Terms searched on DMU's library data base and Google scholar during August 2019
Mental health, homelessness and welfare reform Mental illness, homelessness, and welfare reform Mental disorder, homelessness, and welfare reform Inpatients, homelessness, and welfare reform Psychiatric patients, homelessness and welfare reform Psychiatric inpatients, delayed discharge, and welfare reform. Psychiatric patients, delayed discharge, and austerity Welfare reform* and homelessness* Mental illness* and welfare reform* Mental illness* Mental health* benefits* Homelessness* homeless*

2.2.2 Post COVID-19 search strategy

After the aim of the thesis was altered, due to the COVID-19 pandemic, search terms were broadened to emphasise frontline worker literature.

Table 2.2: Search terms used for the literature review after the outbreak of COVID-19

Key Search Terms searched on the library data base and Google scholar during April 2020
Frontline workers and mental health Frontline workers and homelessness Frontline workers and welfare Frontline worker and homelessness and mental health Mental illness and welfare reform

Mental illness and welfare reform and homelessness
Mental illness* and welfare reform* and homelessness*
Mental illness, Homelessness, and welfare reform
Mental disorder, homelessness, and welfare reform
Inpatients, homelessness, and welfare reform
Psychiatric patients, homelessness and welfare reform
Psychiatric inpatients, delayed discharge, and welfare reform
Psychiatric patients, delayed discharge, and austerity
Welfare reform* and homelessness*
Personal independence payment
COVID-19* and homelessness*
Everyone In and COVID-19
Frontline workers and COVID-19
Key Search Terms searched on the library data base and Google scholar during April 22
Frontline workers and homelessness

Data analysis and the final research findings led to new literature being reviewed. Also, in keeping with constructivist grounded theory, literature related to theoretical frameworks can be useful in part of the comparative analysis process and data analysis (Charmaz 2014)

These terms are in table 2.3

Table 2.3: Search terms used for the literature searches during and after data analysis

Key search terms on the library data base and google scholar during and post data analysis October 20- February 2023
Moral Distress*
Moral distress* and homelessness workers* and homeless sector*
Moral distress in healthcare.
Moral distress in frontline work
Moral distress in social work
Workplace violence
Workplace violence* and homelessness workers*
Violence from patients
Violence towards healthcare workers
Violence towards social workers
Violence towards frontline workers
Digital exclusion*
Digital exclusion* and homelessness*
Digital exclusion* and welfare* and benefits*
Compassion
Compassion* and homelessness workers*
Compassion in health care
Compassion in frontline work
Compassion in social work

Compassion and nursing

System change

System change* in homelessness services*

System change* in mental health service*

2.2.3 Rationale for Included Literature

The main aim prior to the COVID-19 pandemic was to explore how people who were homeless and/or had a mental health condition have experienced austerity and the welfare reform agenda along with the staff that support them. To be included in the literature review pre data collection and analysis, the literature had to meet one or more of the following criteria:

- To explore how people experiencing homelessness and mental ill health, and the NHS staff who support them, worked with within austerity and welfare reform.
- To explore how people experiencing homelessness and mental ill health and the NHS staff who support them found, working with and accessing other services (Including health and social care and the DWP).

During and after data analysis the literature review was widened to include:

- How homelessness frontline workers experienced working within COVID-19.
- To explore distress and moral distress in frontline workers.
- Violence towards frontline workers.
- Compassion in frontline workers.
- System change.

During data analysis, theoretical frameworks that could possibly explain the data results were explored, these frameworks are discussed in more detail in chapter four.

2.2.4 The Inclusion of Hand Searched and Grey Literature

Hand searching, for example reference lists in articles and other theses, and examination of grey literature was also carried out throughout the research process. There are many types of literature that may be classed as 'grey' (Adams, Smart and Huff 2017, Paez 2017), and the grey literature included in this literature review was from charity and government research findings, government policies, and strategies. This was due to the number of publications on homelessness, rough sleeping and mental health published from these sources. A common

criticism of grey literature is that it is not peer reviewed and therefore of questionable quality (Mering 2018). However, this type of literature is easily accessible due to being available online and may add depth to findings (Mahood, Eerd and Irvin 2014). I ensured that the literature included was produced by established sources in the sector, any potential biases in these sources are discussed with each individual study. Grey literature was generally found from empirical research references or social media, particularly Twitter and therefore I had no particular search strategy for inclusion.

2.3 The Effect of Welfare Reform and Austerity on Mental Health and Homelessness

Rough sleeping has increased in the UK since 2010, with its highest level during 2017

(Department for Levelling Up, Housing and Communities 2022a). For several years Fitzpatrick et al (2016a, 2018a, 2020) have explored destitution in the UK and have recently estimated that this has increased by 35% since 2017 (Fitzpatrick et al 2020). The original report (Fitzpatrick et al 2016a) used mixed methods to generate data. This included a literature review, interview and focus groups with 50 key informants across all four UK areas, a survey of 2,000 members of the public, analysing existing database for quantitative data for trends and profiles of people in hardship/destitution, and case studies of destitution in the UK. The reports that followed replicated key elements of data collection. The baseline used to classify contemporary destitution in the UK was if the following applied:

- *“Shelter (they have slept rough for one or more nights)*
- *food (they have had fewer than two meals a day for two or more days)*
- *heating their home (they have been unable to heat their home for five or more days)*
- *lighting their home (they have been unable to light their home for five or more days)*
- *clothing and footwear (appropriate for the weather)*
- *basic toiletries (such as soap, shampoo, toothpaste, and a toothbrush)”.*

“Or their income is so extremely low that they are unable to purchase these essentials themselves.” (Fitzpatrick et al 2020:13).

Single people are at most risk of destitution (Fitzpatrick et al 2020), which aligns with previous homeless research that single people are *“hidden from advice, support and*

statistics” (Reeve 2011:2). The welfare benefit system was seen as contributing to levels of destitution within the UK due to amounts paid, how benefit claimants are sanctioned, delays with payments (seen as worsening under Universal Credit) and severe debt recovery practices administered (Fitzpatrick et al 2018a). Over half the people experiencing destitution stated they had a health condition or disability and a fifth were classed as having other high needs such as being homeless, or misusing substances (Fitzpatrick et al 2020). The data concluded in these reports are estimated based on the number of people using ‘*crisis services*’ (Fitzpatrick et al 2020:8). Conversely many rough sleepers may not be represented in these figures due to barriers in accessing services for people experiencing rough sleeping (Dobson 2019, Cromarty 2019, Cream et al 2020), however the data used in these reports are vast and clearly indicate that welfare benefits, particularly Universal Credit, is exacerbating destitution rates (including rough sleeping) within the UK. In their mixed method study using case studies, focus groups and survey-based interviews, Ball et al (2020) found that a fifth of 242 of people who were experiencing homelessness at the time of the research, attributed becoming homeless to issues with welfare benefits.

In a study by Watts et al (2019), participants, who worked within the voluntary, statutory, and social housing sector in Newcastle, believed that welfare cuts have increased rates of homelessness and heightened the risk for others. Workers were critical about specific reforms; the bedroom tax on housing benefit, benefit cap and freezing benefit rates were seen as very problematic. Another study by Loopstra et al (2016) concluded that welfare cuts are strongly linked with the amount of people requesting homeless support, in exploring why homelessness rates have increased since 2010 researchers examined data from 323 local authorities and examined statutory homeless rates with economic activity and unemployment rates along with central and local government spending. A decrease in 10% economic activity is connected to 0.45% in homelessness claims per 1000 households (Loopsta et al 2016). A key strength of this study is the amount of data examined; however, it is likely that the results are not a true reflection of the link between homelessness and welfare reform due to the researchers only examining data on statutory homeless figures, it is possible that the homeless correlation data would be higher if it included other homelessness data sources.

Other studies have examined welfare conditionality, where receiving benefits is linked to *'responsible'* behaviour (Welfare conditionality 2022). Sanctions are applied if the DWP believe that the claimants fail to do something (such as attending a work focused appointment, job interview or refusing a job offer). Sanctions include a reduction in benefit paid (Department for Work and Pensions 2021). For single claimants of Universal Credit aged over 25 years old the current daily sanction rate is £11.00 which is deducted directly from benefit awarded (Turn 2 us 2022b). Consequentially, sanctions are being used as a punishment towards people experiencing homelessness, as they are not able to meet unrealistic work conditionality agreements (Reeve 2017).

Following a literature review on why people claim sickness benefit, Lindsay and Houston (2011:713) add to this debate by concluding that the welfare reform agenda focuses on changing claimant's behaviour which places, *"the blame for worklessness solely on characteristics and choice"*. Dwyer et al (2015:19) argue that welfare and housing policy is focused on costs and *"punishing the irresponsible behaviour"* of those that claim welfare. Following interviews with 44 key informants from voluntary and statutory services, who supported people experiencing homelessness, and 108 single homeless people (some of whom had complex needs), the researchers concluded that homeless people were not able to access accommodation due to the apparent faults of the homeless person and this perceived fault allows policy makers to disregard system failure. Frontline staff saw homelessness being caused by personal circumstances, yet structural reasons were blamed by the person experiencing homelessness (Dwyer et al 2015).

An examination of how sanction rates are applied to working aged single homeless people by Reeve (2017) concluded that sanctions are being used to punish the poor; Reeve surveyed 1,013 and interviewed 42 homeless service users who had been sanctioned in the previous year. It was found that this population was being set unrealistic conditionality agreements. Roulstone (2015) examined the new eligibility criteria for Personal Independence Payment against Stone's (1984) book the *'Disabled State'*, in which Stone argues that the word disability is manipulated easily. The comparison was carried out by examining language used by the government and people with disabilities, along with previous reports and research on welfare and disability. Roulstone (2015) concludes that

there is a connection between Stone's thesis and the new eligibility criteria to receive PIP, due to the neoliberal narrative that people fake illness and disability and have become dependent on the welfare state. He further argues that reducing the number of people classed as disabled amounts to "*state violence to a number of disabled people*" (Roulstone 2015:673). When examining the effect of the welfare reform on individuals, Barr et al (2016:339) concludes the work capability assessment has "*serious, adverse, consequences for mental health*" after he completed a multivariable regression study across 149 local authorities to see if there was a deterioration in mental state once people had benefits reassessed.

2.4 Homelessness Monitor Reports 2011-2015

Since 2011, Crisis and the Joseph Rowntree foundation have produced an independent longitudinal annual report (apart from 2014) with Heriot-Watt university which explores how financial and social policy impacts on homelessness rates within England (Fitzpatrick et al 2011, 2012, 2013, 2015, 2016b, 2017, 2018b, 2019, Fitzpatrick, Watts and Simms 2020, Fitzpatrick et al 2021, Watts et al 2022). The researchers use mixed methods in the research design which includes an updated literature review, interviews with key informants, statistical analysis on economic, social and homelessness trends and an online survey of local authorities in England. The data in the reports are vast and the reports examine a wide range of government policies and factors that affect homelessness, including the wider economy, the housing market, and welfare. In terms of this literature review, findings regarding welfare reform were the focus.

The early reports predicted an increase in homelessness rates due to the impact of welfare reform and the recession in England (Fitzpatrick et al 2011, Fitzpatrick et al 2012). Welfare reform policies of concern identified were housing benefit and housing allowance, capping benefit amounts, increasing conditionality to receive benefit, the work programme and Universal Credit benefit reform; although, interestingly in the early days of welfare reform key informants were positive about Universal Credit (Fitzpatrick et al 2011). During this time homeless rates began to rise (Fitzpatrick et al 2012, Fitzpatrick et al 2013, Fitzpatrick et al 2015). In the 2015 report, the authors reported that London local authorities were facing increasing demand on homelessness services which they struggled to meet, this was partly

attributed to the benefit cap and people struggling to afford the cost of housing in the area (Fitzpatrick et al 2015). Another point highlighted was that, as local authorities were struggling to deal with households classed as having priority under the Housing Act (1996), those classed as having no priority were not given any significant support (Fitzpatrick et al 2015). This is relevant, as single homeless people are often not given any precedence for support when approaching local authorities for homelessness support (Reeve 2011, Dobie, Sanders and Teixeira 2014, Rowe and Wagstaff 2017) and therefore have no option but to sleep rough (Reeve 2011).

2.4.1 Homelessness Monitor Reports 2016 to 2019

Homelessness rates, at this time, continued to grow (Fitzpatrick et al 2016b, Fitzpatrick et al 2017), as did the numbers of people rough sleeping (Fitzpatrick et al 2018b). Demand for homelessness services was greatest within the southeast and the midlands during 2017 (Fitzpatrick et al 2018b). Participants began to attribute the growth in homelessness rates to the continuing of welfare reform (Fitzpatrick et al 2016b).

Concerns began to be raised by participants in the monitoring study about the administration and roll out of Universal Credit, with an early concern being the housing element of the award being paid directly to the claimant rather than the landlord (Fitzpatrick et al 2016b). Some claimants would find it hard to budget and not pay this element to their landlord. Concerns continued to be expressed in the 2019 report (Fitzpatrick et al 2019). Key problems reported by participants about Universal Credit included the waiting period of five weeks for an initial payment, people getting into rent arrears whilst waiting for payments, and reduced income due to a high direct deduction from payments to pay other debts. The researchers acknowledged that the government has begun to address Universal Credit concerns, yet participants were concerned about how the continuing roll out of welfare changes would affect homelessness rates in the future (Fitzpatrick et al 2019). Interestingly, it found that although there has been a decrease of 2% in rough sleepers across England during 2017 there was a 28% increase within the midlands geographical area (Fitzpatrick et al 2019). Nationally, there was a demonstrated 32% decrease in roughs sleeping in areas that had implemented the rough sleeping strategy during 2017-18 (Ministry of Housing Community and Local Government 2019a). This could,

however, be due to the way the statistics are collected, as the Ministry of Housing, Communities and Local Government (2019b: 8) have stringent guidelines for when people can be counted as a rough sleeper, for example, the person must be “*bedded down*” or about to. This means that if the local authority member undertaking the rough sleeper count sees someone who they believe to be homeless, but they are walking about, they cannot be included on the count.

2.5 Supporting Vulnerable People to Claim Welfare Benefits

Evidence from quantitative and qualitative research demonstrates that claiming benefits, since the welfare reform agenda began, is known to have a detrimental effect on the mental health of benefit claimants (Clifton et al 2013, Barr et al 2016, Shefer et al 2016, Rethink Mental illness 2017, Cheetham, Moffatt and Addison 2018, Mills 2018, Bond, Braverman and Evans 2019, Wickham et al 2020), and those claiming sickness benefit are at a disadvantage of being awarded benefits if they are claiming due to a mental illness (Mattheys, Warren and Bambra 2017, Pybus et al 2019, Pybus et al 2020). Pybus, Pickett and Lloyd (2017) argue that the ‘*unseen*’ nature of mental illness creates a barrier in receiving benefits. A survey by Loney-Evans (2020a), on behalf of the Frontline Network which offers support to people who are in paid positions assisting the homeless, found that over 91% of participants who took part in a survey thought that claiming Universal Credit had been a detrimental experience to those they were supporting, This is supported by Watts et al (2019) whose frontline worker participants reported that the administration of Universal Credit was not suitable to people with vulnerabilities.

There is little research however that focuses on the experiences of frontline workers supporting homeless mentally ill rough sleepers through the process. There are, however, a few studies that have been conducted in small areas of England which explore the experiences of benefit claimants along with the frontline staff from a variety of job roles, including homelessness workers supporting vulnerable people through this process. The research is concentrated mainly in the north of England, and this may be due to the north having several local authorities with high deprivation (Social Mobility Commission 2020).

Cheetham, Moffatt and Addison (2018) explored the impact of claiming Universal Credit on vulnerable claimants. There were seventy total participants, 33 participants were Universal Credit claimants and were deemed as being vulnerable due to illness or life circumstances (including people experiencing homelessness and mental illness) and 37 participants were staff members from agencies that supported the Universal Credit claimants. Staff participants worked in a variety of organisations including the local authority and the third sector. Participants took part in interviews and focus groups. Staff participants felt that dealing with Universal Credit whilst supporting service users was impacting negatively on their workload, due to the time it took to resolve issues. Staff participants also reported feeling an emotional toll supporting people through the Universal Credit System and were at the receiving end of the frustrations experienced by those they were supporting. The authors predicted staff would leave organisations due to the ongoing pressure of this. The researchers concluded that, *"claiming Universal Credit was seen as a truly distressing process, with profoundly negative consequences for the claimants"* (Cheetham, Moffatt and Addison 2018:35).

The negative impact on work time, due to welfare reform and austerity, was similarly found in the study by Watts et al (2019) who explored how Newcastle City Council and stakeholders were preventing homelessness against a backdrop of austerity and welfare reform. Frontline workers from across the voluntary, statutory, and social housing sector reported that they had to spend time sorting out difficulties caused by the reform rather than focus on other tasks and questioned the cost effectiveness attributed to the local authority due to this as they were sorting out problems caused by welfare reform rather than being able to carry out their jobs.

Mattheys, Warren and Bambra (2017) concluded that people who have mental health illness are disproportionately affected by austerity and saw the economic response as increasing inequality and worsening mental health. There were 28 participants in this study. Seventeen of the participants were people claiming welfare benefit due to mental ill health and there were 11 'stakeholder' participants. The stakeholder participants worked for local authorities, advice agencies, drop-in centres, and charities that ran supported accommodation for people experiencing homelessness. Through semi-structured

interviews, participants in this study identified that the benefit assessment process was problematic to those claiming because of a mental illness; claimants had difficulties explaining their needs and having their needs understood. Caution needs to be taken however with the results as the research was carried out before the roll out of Universal Credit, if the research was conducted now that this finding would differ due to Universal Credits administration process.

Similarly, a triangulated study using surveys and a focus group by Bond, Braverman and Evans (2019) strongly endorses that the current benefit system is detrimental to those that are claiming due to a mental illness. Participants were 617 people with mental ill health who had experience of claiming sickness benefit, including Universal Credit and PIP. Other participants were 95 carers of someone with mental ill health and 73 people who worked in a professional capacity with people with mental illness. Findings suggested that high numbers of participants found accessing and navigating the benefit system was detrimental to mental health, due to issues such as filling out forms, providing evidence and attending appointments. The mental health professionals who participated in the study suggested that service user's mental health recovery can be delayed due to service users dealing with the benefits system rather than focusing on their wellbeing. This study is useful, as previous studies have not addressed the issues of claiming benefit primarily due to mental illness and includes the views of staff supporting people through this process. However, there are several weaknesses to the study, a major weakness is the study design and using surveys to collect part of the data. It is a common symptom of mental illness to have poor concentration and motivation to complete tasks (Mind n.d, NHS 2019c, Mental Health Foundation 2022) and although this would not have necessarily affected the staff participants findings, the authors have failed to acknowledge that this may have adversely affected the overall results. Participants were members of a money and mental health research community that is facilitated by a charity, who have lived experience of either having a mental illness or are a carer of someone who has a mental illness, so there was possible bias in their responses. It would also have been interesting for the authors to have specified their participants location within the UK, along with their diagnosis, to see if either of these issues put people at a further disadvantage.

Most of the research on benefit claimants focus on participants who self-disclose mental illness or have a common mental illness such as depression and anxiety (National Institute for Health and Care Excellence 2011), rather than those who have had a medical diagnosis or people experiencing severe mental illness. There is a high prevalence of mental illness with people experiencing homelessness (Shelton 2009, Rees 2009, Homeless Link 2014), however, there is no specific national data recording method on the needs of people rough sleeping in England (Dumoulin et al 2016) even though, within this population, severe mental illness/disorder is high (Dumoulin et al 2016, Hynes, Kilbride and Fenton 2019). Ball et al (2020) noted that if people who are homeless had a negative interaction with the DWP this impacted negatively on the individuals' dealings with other agencies and vice versa.

2.6 Working Within Austere Policy

Austerity and welfare reform means that frontline workers become the *"de facto guardians of a much-diminished welfare state"* (Koch 2021:245) and there is debate within the literature about how frontline workers protect their resources. One argument is that frontline workers are negatively using their discretion within their job role to do this (Alden 2015a, Alden 2015b, Koch 2021), whilst, in direct contrast other research by Dobson (2020) and Hastings and Gannon (2021) suggest that frontline workers are resisting austerity by working harder to support people using their services. However, Dobson (2020: 17) is critical of such comparisons as it denies ontological complexities and does not explain why *"human agents act and behave they do"*.

Some of the research looked at austerity and welfare reform using Lipsky's (2010) conceptual framework of street level bureaucracy. Lipsky's (2010) framework states that street level bureaucrats work directly with the public, enforce government policy, yet have discretion within they complete their work. He acknowledges that *"the poorer people are, the greater the influence the street level bureaucrats tend to have over them"* (Lipsky 2010:6) which suggest that they hold great power over people experiencing homelessness and rough sleeping.

Using Lipsky's framework Alden (2015a) examined the discretion and the subsequent execution of policy of participants who worked within local authority housing advice centres

across the UK. She firstly surveyed 272 participants who worked within local authority housing advice services across the UK, and then interviewed 27 participants from 12 different local authority advice centres, 18 of these participants were frontline workers. All participants including those working on the frontline interviewed reported a lack of control and emotional distance on the policies they were working within. Alden (2015a) does not explore the emotional distancing reported by participants in detail, but it could indicate that the participants are traumatised about the policies they are working within. A common symptom of post-traumatic stress disorder (PTSD) is “*emotional numbing*” (NHS 2018). Lipsky (2010) argues that street level bureaucrats’ distance themselves mentally from clients to cope with the realities of their work. In a further publication on Alden’s (2015a) research, participants were using their discretion negatively and gatekeeping services, “*to protect resources, limit workload and satisfy organisational led targets*”, which was attributed to organisational stresses (Alden 2015b:938), however it could be argued that these actions were a response from participants to emotionally protect themselves from work related stress.

Using data from interviews, from an earlier study on the costs of austerity cuts to local authorities and deprived communities, with 41 front-line workers from four local authorities, three in England (including the Midlands) and one in Scotland, Hastings and Gannon (2021) concluded that workers were making special efforts within their job role by working out of their job remit or by taking on extra work to continue to support people which meant that the worker ‘*absorbs*’ austerity to protect the people they are working with from feeling its full affect (Hastings and Gannon 2021:9). Likewise, Dobson (2020:10) found that frontline workers who worked across homeless and housing services during 2006-2010 (the early days of austerity) reported doing more for service users. A negative effect of the ‘absorption’ of austerity was that services, and therefore the workers, work more in isolation from other services. This was also a finding in a study by Daly (2016) whose research focused on the ways austerity and welfare reform were experienced by staff and service users who worked in a homelessness and resettlement service during the early days of austerity until 2014. She concluded that working within austerity impacted negatively on the relationship between people experiencing homelessness and support

workers (Daly 2016). In later work she asserted that austerity had become “*embodied*” in the working practices within frontline homelessness services (Daly 2018).

Looking at how austerity and its subsequent policies has affected homeless frontline workers, single people experiencing homelessness and service providers using constructivist grounded theory, one of Carmichael’s (2020) research questions was to discover what it was like to work in homelessness services since 2010. Carmichael (2020) used semi-structured interviews to interview homeless people and those who worked within homelessness services within local authorities and the third sector. It was concluded that, along with the increased pressure on service provision, the people using the service were deemed to have more complex needs than before austerity due to service cuts across health and social care. People who would have been assisted by other services prior to austerity were using homeless services, as there was no other support available. There was poor communication and little multidisciplinary working across and within both the local authority and third sector, and homelessness workers could not access other services. Frontline workers reported their work was increasingly crisis responsive and they could not spend the time needed with the people they were supporting to help them effectively move on. It was concluded that working within austerity changed the way in which the homeless practitioner’s “*felt about and related to their work*” (Carmichael 2020:263); working with the policies causing “*discord*” and the response to this was “*distress*” (Carmichael 2020:260). In the Frontline Network survey during 2018, 81% of participants felt their own wellbeing affected the relationship they had with the people they were supporting (King and Loney-Evans 2019), therefore, if frontline workers are distressed themselves, this could damage their relationship with those they are supporting.

2.7 The Wider Health and Social Care System

A burgeoning literature has found that staff working with the homeless face challenges when attempting to access and refer people to adult social care. People experiencing homelessness often have other complex needs including dual diagnosis of substance misuse and mental illness (Drake, Osher and Wallach 1991, Rethink 2009). Support services are often not set up to meet the needs of this population (Rethink 2009, Maryon-Davis 2016) and are “*at serious risk of falling through the cracks in service provision*” (McDonagh

2011:1). The government at the time, argued that The Care Act (2014), which became law in 2014, was the most radical change in care and support provision for over 60 years (Lamb 2014). The aim of the act was to support adults with either mental or physical illnesses and their carers (Shelter 2022a).

When looking at the act in its infancy and the needs of the homeless population, it was initially thought that social workers would have greater discretion when working within the Care Act 2014 guidelines, compared to previous legislation (Cornes et al 2016), yet research is demonstrating that people working in the homeless sector face barriers when trying to access adult social care support under the Care Act 2014. Mason, Cornes and Dobson (2017) summarised meetings between social workers and homelessness workers about implementing the act. Homelessness worker participants reported that they had little comprehension or training about the act which led to a sense of “*frustration and powerlessness*” when dealing with adult social care (Mason, Cornes and Dobson 2017:5). The homelessness workers in this study ultimately felt that they had to mould the person they were referring into the system, rather than the system work for the homeless people accessing it. The social worker participants, in these discussions, felt that their discretion to assist people was made more difficult due to shrinking resources from austerity cuts, yet the homeless participants felt the social workers had lots of discretion when carrying out their role (Mason, Cornes and Dobson 2017). Further research using a case study methodology with a group of participants who advocate on behalf of people experiencing homelessness and multiple exclusion demonstrated difficulties accessing assessment under the Care Act 2014 for people experiencing homelessness (Cornes et al 2018). One reason inferred for this difficulty, is that frontline workers may not have specific specialist qualifications and may find it difficult to oppose negative decisions made by those in adult social care who are seen as “*professionals*”. The difficulties in accessing this type of provision were seen to improve the working relationship between the advocate and those they are advocating for, with the service user grateful they had someone alongside them, also challenging social care practices (Cornes et al 2018:6).

Homelessness workers face obstacles when attempting to access services (including under the Care Act 2014) on behalf of the homeless hostel residents who were classed as having

medium to high support needs (Armstrong et al 2021). Staff participants reported that other health and social care services had a false impression about the level of support they were able to offer, with health and services stigmatising them along as well as the residents they were supporting. The above findings were similar to a study by Carver et al (2022) where frontline homelessness workers believed other sector workers found little value in their work. Participants reported feelings of burnout, due to working in isolation and feeling primarily responsible for the person they were supporting. The authors acknowledge that a weakness of the research is that the experiences are of hostel workers from one hostel, and provision and support within homeless hostels varies across England (Homeless link 2018b). Housing support workers have “*professional protectionism*” and do not recognise their own skill set due to feeling inadequate compared to other organisational workers (McDonagh 2011:12). There is also recognition that the realities of a housing support workers job role are different to what is on paper, due to the complexities of the work involved (Corney et al 2011). A survey of frontline homelessness workers found over a fifth did not think they were respected by other professions across health and social care (Marshall 2022).

In a study examining access to health care, Healthwatch (2018) spoke with 1,200 people experiencing homelessness and identified three main areas of concern when accessing services; “*difficulty in accessing services*”, which may be due to practical reasons such as not being able to access a telephone to make an appointment; “*difficulty in registering with a GP*”, where having appropriate identification is barrier; and “*difficulty getting holistic support*”, with respondents wanting to access various support in one place. The recent survey on homelessness frontline workers in the UK respondents reported substantial difficulties in accessing wider support services. The main barriers identified were high waiting lists and digital exclusion.

There are barriers to people experiencing homelessness and also receiving support for mental ill health. In a survey of 90 staff who worked within homeless hostels and supported housing, regarding the accessibility of NHS Mental Health support to people living in temporary accommodation, respondents reported difficulty in accessing mental health services and this was deemed to be due to budget cuts in the sector (St Mungo’s 2016a). Respondents thought the cuts had negatively affected the waiting list times, that people

needed to meet a high eligibility criterion to receive support and received little support once the eligibility criteria was met. Homeless link (2022) identified that 74% of respondents of frontline organisations experienced barriers to their service users receiving mental health support. In a recent survey 78 % frontline respondents who worked in England stated it was difficult or very difficult to access mental health support for service users (Marshall 2022). When looking at people rough sleeping, only 26% of professionals surveyed across England felt that people who were homeless could access mental health support as and when required (St Mungo's 2016b). However, along with this possible bias due to St Mungo's being a prominent homelessness charity, a weakness in this study is that there is little to explain why participants thought this occurred. According to Canavan et al (2012), barriers in accessing services arise for various reasons. The main barrier recognised by 23 expert participants, who worked in a variety of job roles within the homelessness sector, was that experiencing homelessness was due to the chaotic lifestyle of those individuals. Another barrier was that the lack of trust between health professionals meant that people experiencing homelessness did not engage with services. Further barriers included the lack of multidisciplinary working between health, social care, and social welfare, along with stigma by professionals towards the homeless populations. Barriers to services identified in the Homeless link study by frontline organisations were long waiting lists, high eligibility thresholds, geographical location, and the support needed not available in the local area (Homeless link 2022).

Participants felt that more joined-up working between different agencies was needed, including having specialist mental health workers to work specifically with those that are homeless (Canavan et al 2012). Similarly, Marshall (2022) found frontline homeless workers reported it being a struggle to work in a multidisciplinary way with other organisations and agencies, particularly mental health services and the DWP. These struggles were attributed to a variety of factors including, lack of capacity in the other organisation and lack of understanding about homelessness issues. Barriers to services identified in the Homeless link study by frontline organisations were long waiting lists, high eligibility thresholds, geographical location, and the support needed not available in the local area (Homeless link 2022).

2.8 Digital Exclusion

The welfare benefit of Universal Credit is generally administered online; many people who claim do so online and most contact with the DWP, regarding this benefit, is through the recipient's online account (Gov.uk 2021a). People experiencing rough sleeping may have difficulties navigating the Universal Credit System (Barton et al 2019). Many people experiencing homelessness often have no resources left, yet when claiming Universal Credit, the DWP assumes that people *"have social, material, economic and psychological resources"* (Thompson et al 2020:7). In a small qualitative study by Thomson et al (2020), to explore the impact on health of homeless people claiming Universal Credit, it was found that *"assumed capacity"* of the person experiencing homelessness was central to the *"root cause of unsuccessful and distressing interactions with the UC system"*. Assumed capacity places any difficulties in navigating the system as the claimants' personal responsibility. Staff participants in this study reported that supporting people to deal with Universal Credit and its administration systems resulted in extra work pressure (Thomson et al 2020:7). This was similar to findings by Bond, Braverman and Evans (2019) in which mental health professionals stated they were using clinical time to assist their patient access benefits if the patient was unable to do this themselves. Using digital technology, by default, disadvantages people experience homelessness however, defining the whole homeless population as digitally excluded fails to account for the *"complexities and variations"* of being homeless and how they may use technology (Harris 2019:157). Similarly, Veasey and Parker (2021:12) claim that Universal Credit's *"digital by default"* position has created a *"digital divide for claimants with no knowledge of or limited access to IT resources"*, which means that people are excluded from accessing benefits. Digital exclusion may also negatively impact homelessness rates. Voluntary, statutory, and social housing frontline workers, who worked in homelessness services within Newcastle, noted that, due to library closures and reduced opening times because of austerity cuts, people on low incomes were not able to access technology and this was thought to be detrimentally affecting homeless prevention work (Watts et al 2019).

Because many services did not offer face-to-face consultation during the COVID-19 pandemic and various lockdowns, Groundswell (2020a) and Boobis and Albenese (2020) found that digital exclusion was a major issue for people experiencing homelessness due to

not being able to access and/or pay for information technology and have access to the internet. Libraries and welfare advice agencies also closed, which deepened the barriers faced, as people were not able to get assistance in accessing services (Groundswell 2020b). A significant number of applications to The Vicar's Relief Fund during the COVID-19 pandemic, which homeless frontline staff across the United Kingdom can apply to on behalf of their clients, were for *“overcoming barriers to support”*. Funds for IT equipment was identified as a common need to allow people experiencing homelessness continued access to services (Frontline Network 2020:17).

2.9 The Coronavirus Pandemic and ‘Everyone In’ initiative

COVID-19 created challenges to the delivery of all frontline services across all sectors, including homelessness and mental health services, which meant services had to adapt and alter their ways of operating (Groundswell 2020c, Johnson et al 2020). Homelessness services dealt with increased demand throughout the pandemic, and the people presenting for assistance had more complex needs such as mental illness, loneliness and isolation (Boobis and Albenese 2020).

To limit face-to-face interaction, due to the public health response to COVID-19, many services became accessible online. This was seen as a positive outcome to some organisations and their service users (Local Government Association 2022). However, communicating with people was seen to be difficult by health and social care workers when working through the COVID-19 pandemic (Aughterson et al 2021). It was seen as particularly challenging to mental health community services (Rains et al 2020) and a huge issue to people working within the homelessness sector (Boobis and Albenese 2020).

Literature demonstrates that workers involved with the ‘Everyone In’ initiative had conflicting views on the success of the scheme (Watts et al 2022, Groundswell 2020d Fitzpatrick et al 2021). Some frontline workers reported that accommodation that was offered wasn’t suitable for women and those that had complex needs, with some areas placing people in poor accommodation with poor support (Watts et al 2022). Some people experiencing rough sleeping were asked to leave their accommodation due to anti-social behaviour, with a significant proportion having substance misuse, mental health and

criminal justice needs (Kaur et al 2021). In the early days of the Groundswell briefings, which examined the effect of COVID-19 on people experiencing homelessness in England, it was reported that, within some areas, support was poor, and when accommodated people were not given access to necessities to survive, such as food and medication (Groundswell 2020d). However, this service delivery improved over time (Groundswell 2020d). There were seen to be several benefits to the policy response of 'Everyone In', for example, people who had been rough sleeping for a long period of time agreed to be accommodated (Kaur et al 2021). Frontline workers noted that people experiencing homelessness were working well and engaging with services whilst accommodated, enabling successful support to be delivered (Groundswell 2020e, 2020f). Other studies found that local services had better partnership working, which improved outcomes for the person accommodated (Boobis and Albense 2020, Kaur et al 2021). Those working within local authorities were also upbeat when evaluating the work carried out during lockdown to support people experiencing homelessness, with multidisciplinary working alongside the Ministry of Housing, Communities and Local Government and third sectors seen to be an advantage in the support offered (Fitzpartick et al 2021).

There are conflicting results regarding the effects of working during the COVID-19 pandemic on frontline workers. One study surveyed social work and social care staff within the UK and found that respondents mental wellbeing had deteriorated during the pandemic (Ravalier et al 2022). A Canadian national survey found that nearly 80% of workers who supported people experiencing homelessness during the pandemic experienced worsening mental health and over 31% reported a considerable deterioration, with frontline workers being at a greater risk (Kerman et al 2022). Another study on frontline workers working across health and social care, found participants had increased workloads, however an advantage of working within the COVID-19 pandemic was that staff felt more bonded with their colleagues (Aughterson et al 2021). This positive was also noted by Carver et al (2022:14), who explored stress and wellbeing in frontline staff working within the homeless sector during COVID-19. The study used mixed methods and interviewed, on the telephone or online, 18 participants who worked in a variety of job roles within the six organisations. Eleven of the participants then completed the Maslach burnout inventory which measures occupational burnout. Findings were split into themes and participants spoke of working

within stressful and challenging situations pre and post pandemic, yet the burnout tool findings were that staff had “*low to moderate level of emotional exhaustion, low depersonalisation and moderate levels of personal accomplishment*”. The paper has its limitations, most markedly it was a small sample size and the results may not be transferable, as the staff participants were based in Scotland, and due to the devolved nature of homelessness law their experiences may not be transferable to frontline staff based in England (Crisis 2022c), none less it is a rare study that explores how working within COVID-19 specifically affects frontline homelessness workers within the UK.

The Frontline Network surveyed 930 frontline workers throughout the UK during November 2020, asking about experiences of working during the COVID-19 pandemic (Marshall 2021). A high proportion of the respondents (96%) stated that they normally supported people who also have mental ill health. It was found that 69% of respondents in England found accessing accommodation for the people they were supporting harder during the pandemic, due to affordability and appropriateness of accommodation available. Accessing a range of services for their service users was reported to have been more difficult for frontline workers across the UK during the pandemic, 63% of respondents found it difficult accessing welfare benefits with over 90% stating that digital access to Universal Credit was problematic (Marshall 2021). In previous years, surveys of frontline staff were critical of Universal Credit, particularly due to the length of time it took for the initial payment to be made (Loney-Evans 2020a). One of the hardest services to access during COVID-19 was mental health services with 82% of respondents reporting this, which is similar to the 2019 annual survey results (Marshall 2021, Loney-Evans 2020a). Workloads increased for frontline workers during the pandemic and the wellbeing of frontline workers was poor, 68% of respondents felt that their work was detrimental to their wellbeing and 86% felt that COVID-19 had a negative effect on their wellbeing (Marshall 2021). As this was a quantitative survey the results fail to give enough depth into why these difficulties had occurred. The survey was across the UK and there is little in the results that break down each devolved area. Other studies exploring frontline workers experiences during COVID-19 found challenges during the pandemic (Fitzpartick et al 2021, Watts et al 2022). These studies included frontline worker participants from a variety of job roles (Fitzpartick et al 2021, Watts et al 2022).

Watts et al (2022: xxi) reports that the homelessness sector has faced challenges since the beginning of 2020 which has resulted in “*low morale and high absence rates*”, and people working within the homeless sector were seen to have had their “*resilience...tested*” when working within COVID-19 (Fitzpatrick et al 2021: xvii).

Fitzpatrick, Watts, and Sims (2020) analysed policy development and information from senior key informants, along with interviews from 15 workers from the voluntary and statutory sector, to explore success and failures within the homeless sector during COVID-19. Participants reported a sense of pride in their work during the pandemic and were positive about the lack of barriers that they faced accommodating someone. There were also challenges working during this time, participants reported that people with complex needs were placed in unsuitable accommodation with unsuitable support which resulted in evictions. Another important point to note is that participants felt that due to the emphasis on the ‘Everyone In’ scheme, people were not getting the support they should have under the Homeless Reduction Act (2017). This is relevant, as the Homeless Reduction Act (2017) was introduced to support people who were previously not eligible for assistance under previous housing legislation people (Garvie 2017) and therefore single homeless people may not have been getting adequate housing support whilst the pandemic was ongoing.

The studies identified used different measurements of wellbeing and tools to decipher wellbeing, so they are difficult to compare, however they are useful as they gave an indication of how working within COVID-19 affected frontline homeless workers.

2.10 Workplace Violence

Globally, people who work in frontline roles are at risk of workplace violence, with health care workers (Yassi et al 1998), social workers (Radley Langenderfer-Magruder and Schelbe 2020, Davidovitz and Cohen 2021), psychiatric nurses (Zeng et al 2013, Ettorre and Pellicani 2017), mental health professionals (Anderson and West 2011), and housing staff (Simpson 2019) all found to be at risk. Research tends to focus on workplace violence experienced by health care workers and this type of research has grown in output since 1992 (Cebrino and Portero de la Cruz 2020).

The Health and Safety Executive (2022) for England and Wales define work-related violence as “...any incident in which a person is abused threatened or assaulted in circumstances relating to their work” and people who work in frontline roles across health and social care within England and Wales are at high risk of workplace violence (Health and Safety Executive 2020). Due to the increasing number of attacks on frontline workers, the Assaults on Emergency Workers (Offences) Act (2018) was introduced for England and Wales, however this act only covers emergency frontline staff such as the police and paramedics.

Figures differ on the prevalence of workplace violence in the workplace and frontline workers; however, it appears to be widespread. The World Health Organisation (2022b) estimates that between 8-38% of healthcare workers, such as doctors and nurses have experienced physical abuse and a higher percentage have dealt with verbal abuse and threats of violence. In a meta-analysis of 253 world-wide studies on workplace violence towards health care workers, a large proportion (61.9%) of workers had been exposed to workplace violence. Verbal abuse was a common experience (57.6%), which was followed by 33.2% of health care workers experiencing threats (Liu et al 2019). A survey of frontline housing workers, along with information from freedom of information requests to 28 housing associations and 139 local authorities, found that frontline housing workers commonly experienced verbal abuse, threats, and harassment, followed by physical abuse, with rates across all types of abuse increasing since 2017 (Simpson 2019). Fifty-six percent of housing workers surveyed attributed welfare reform and cuts to wider community services to the increase of workplace violence towards them, with Universal Credit and its administration being seen as a particular concern (Simpson 2019). Thirteen thousand social care staff were surveyed and over 50% reported that they had been verbally abused during the past year, with a quarter of respondents stating that they experience verbal abuse weekly or daily; 25% of respondents had experienced physical abuse within their work (Caincross and Gardner 2014).

Using the crime survey statistics for England and Wales, the Health and Safety Executive (2020) found that in 40% of cases the frontline worker knew the person responsible for the violence towards them. Several studies have categorised the profile of perpetrators of

abuse to frontline staff and shown that working with people with certain characteristics increases the risk of experiencing workplace violence. These include people under the influence of alcohol and illegal substances (Health and Safety Executive 2020), having a mental illness, a history of violence and a being young age (Ettorre and Pellicani 2017). Within homelessness and mental health day settings the risk of violence was seen to increase if the perpetrator was young, had substance misuse issues and or had a history of violence, contrary to other studies mental illness was not associated with violence experienced within these settings (Gilders 1997). Social care staff have reported higher levels of abuse from people with mental illness, learning disabilities and dementia, and nearly a fifth of abuse and violence experienced was from friends and family of the people the workers were caring for (Caincross and Gardner 2014). The Home Office (2022) found a high cohort of perpetrators were male and aged under 29.

Davidovitz and Cohen (2021) found that social workers and teachers had two responses when experiencing violence which is to accept the behaviour or not working any further with the perpetrator. Underreporting of abuse, across all sectors, is common. Some studies found that abuse and violence towards staff was culturally accepted in the workplace, was as an occupational hazard, and reported variously. Child social workers reported that, after experiencing violence, it was *"business as usual"* (Radley, Langenderfer-Magruder and Schelbe 2020:2116); housing workers *"it's just part of the job"* (Simpson 2019); and nurses *"just get on with it"* (McIlroy 2019). One in three housing workers who experienced violence in the workplace did not report the incident which was attributed to the worker's perceived lack of response from their employer and not having enough time to deal with these incidents due to the regular occurrence of them (Simpson 2019). Other research found that frontline workers empathised with the perpetrator's situation and did not report abuse due to this (McIlroy 2019). This was like a finding in a study that examined motivation of working within the care sector and found that workers had an *"affiliation with clients"* (Bjerregaard et al 2017: 122). According to Skills for Care (2013,) violence and abuse is underreported for five reasons: 1) violence being viewed as an occupational hazard; 2) uncertainty about what equates to violence; 3) what procedures to follow after experiencing an incident; 4) anxiety that the abuse was evidence of the worker being incompetent in their work; and 5) not wanting to complete incident paperwork.

Experiencing workplace violence detrimentally affects the wellbeing of health care staff (Cheung, Lee, and Yip 2018) and a systematic review by Lanctot and Guay (2014) found several consequences of workplace violence to health care workers. These included suffering physical injuries, mental distress including PTSD, burnout and anxiety, and becoming fearful towards the people they were caring for. Similarly, housing workers reported that after a distressing incident their mental wellbeing was detrimentally affected, and they felt unsafe whilst at work (Simpson 2019).

The literature demonstrates that homeless frontline workers may be at higher risk of experiencing workplace violence compared with other comparable frontline services. The risk is increased due to supporting people in distressing situations who have higher risks of becoming violent.

2.11 Compassion

There is an expectation that workers who support vulnerable people are compassionate, yet there has been little research within this area. Compassion is seen as a core value with health care (NHS England 2013) and historically there has been a dearth of research on this topic (Ropes and De Boer 2021). Research is now growing, particularly within health care in the UK following greater interest in the subject due to the publication of the Francis Report during 2013 (Limebury and Shea 2015). However, there is little focus on compassion within social care literature (Tanner 2020) and even less literature available about the role of compassion in frontline homelessness work.

Definitions of compassion vary. NHS England (2013:04) state that compassion may be described as *“intelligence kindness”* and Chochinov (2007: 186) defines it as *“a deep awareness of the suffering of the suffering of another coupled with the wish to relieve it”*. Five essential components of compassion are *“recognising suffering, understanding the universality of human suffering, feeling for the person suffering, tolerating uncomfortable feelings and motivation to act/acting to alleviate suffering”* (Strauss et al 2016:15). Sinclair et al (2018:1) conceptualised a model of compassion within health care from health care providers who worked within palliative care and concluded it was *“a virtuous and*

intentional response to know a person, to discern their needs and ameliorate their suffering through rational understanding and action”’. Recognising and responding to suffering is the common theme that threads through all the above.

Compassionate care is seen to improve patient outcomes (Lelorain et al 2012) and organisations within which frontline workers work can promote or hinder compassionate care (Ace, Farr-Wharton and Reddy 2020, Dutton, Workman and Hardin 2014). A literature review by Dutton, Workman and Hardin (2014:14-16) identified six elements that are relevant to the methods and subsequent effects of compassion for workers within an organisation. These were “*shared values*”, where workers in an organisation decide what is crucial, “*shared beliefs and values*”, what workers consider correct, “*norms*”, how workers react when faced with distress, “*organisational practices*” such as practical and emotional support, “*structure and quality of relationships*”, the bond between workers in the organisation, and “*leader’s behaviour*”, where leaders demonstrate the correct way to deal with distress.

Using content analysis to analyse 15 semi-structured interviews an Iranian study by Valizadeh et al (2018) found barriers to compassionate care in nursing were working in a culture that did not support nurses, organisations not placing importance on compassion, and a high workload. Subthemes were around workplace stresses such as, bureaucratic paperwork, low pay, and lack of training (Valizadeh et al 2018). Workers job roles can influence the barriers faced to delivering compassion, with health care staff lower in hierarchy facing more barriers due to workplace stresses (Dev et al 2019). Other studies looked at what hinders and encourages compassionate care; using mixed methods by qualitative interviews and open text questionnaires a larger study by Christiansen et al (2015) had 312 health care workers and students across a range of disciplines who were registered at a university in Northeast England as participants. The researchers found that individual and organisational factors affect compassion in health care delivery. Personal values such as having an emotional connection and being empathetic with their patients, along with working in a supportive environment enhanced being able to deliver compassionate care. The research identified situations that hinder giving passionate care and these were experiencing difficult behaviours from patient and their families and

working in a pressurised and goal focused environment (Christiansen et al 2015). Other situations found to hinder compassionate care included the impact of COVID-19 (Hochwarter et al 2022).

There are seen to be positive and negative implications for frontline workers demonstrating compassionate care. Street level bureaucrats are not seen to be compassionate; they “*mentally discount*” their clients, as a coping mechanism to deal with the tension between delivering ideal support versus the reality (Lipsky 2010: 141). Ropes and De Boer (2021) concluded that being compassionate may lead to emotional burnout due to the workers actions in demonstrating compassion such as working overtime and working out of their job remit. In direct contrast to nursing, in some professions such as social work being compassionate to services users is discouraged to reduce the risk of crossing professional boundaries and caring too much. This expectation of emotional distance may cause moral distress as social workers are conflicted in their response when faced with a service user in emotional distress (Tanner 2020). Another compassion tension identified in social work practice is social workers can be positioned between their service users and bureaucracy which can create feelings of powerlessness when working with austere resources (Symonds et al 2018).

In other studies compassion is concluded to have positive aspects in frontline work. An early American study examining the motivation of people who worked with public services using a measurement scale reported that, along with a desire to uphold social justice, policy creation and altruism, compassion was found to be a motivational factor in why someone works within the public sector (Perry 1996). Frontline workers, working in the Welsh homeless sector, cared for the people they were supporting regardless of the constraints of the system they were working within (England 2022). Tanner (2020) found that compassion was used to resist austerity and that having an emotional connection to others may increase resilience.

Welfare administration systems are seen as heartless (England 2022), and homelessness frontline workers are working within the brunt end of these systems. Due to the complex needs of people experiencing homelessness, compassionate care can also be relevant to this

sector to this setting (Limebury and Shea 2015). There is an argument that compassion is vital within homelessness social policy, to address the stigma about people experiencing homelessness and policy that surrounds this area (Horsell 2017).

2.12 Distress of Frontline workers

People who work in frontline roles are known to encounter occupational stress in their working environments, for example nursing (Waddill-Goad 2016, McCarthy 2013), social work (Jones, Fletcher and Ibbeston 1991, Manttari-van der Kulp 2016, Wirth et al 2019) and teaching (McCarthy 2019). The risk of occupational stress is increased when working with people who are traumatised (Scanlon and Adlam 2012). Zacka (2017: 11) explored moral agency amongst street level bureaucrats and argued that frontline workers are *“condemned to being front row witnesses to some of society’s most pressing problems without being equipped with the resources or authority necessary to tackle these problems in any definitive way”*.

In a study exploring the everyday realities of working within austerity with nine doctors and seven nurses who worked in Accident and Emergency departments in NHS hospitals in Central England, Kerasidiou and Kingori (2019:7) found that, due to wider cuts to social care (including mental health services), staff were working in services that had an increasing demand, with a participant renaming A and E *“Anything and Everything”*, due to the issues patients were presenting with. Departments lacked the resources to cope, and participants felt that they were not valued as workers; they felt powerless and had a sense of detachment in their work and reported increasing levels of stress and burnout. Morley, Ives and Bradbury Jones (2019) argue that austerity is causing ethical dilemmas in healthcare, that could be avoided. Twenty-one nurses from two critical care units were interviewed about ethical situations they had experienced, and data analysis was completed using feminist leaning phenomenology. Dilemmas reported included low staff numbers, lack of abilities within the staff group due to the turnover of staff, and bed shortages. The consequence of these dilemmas was that patient care was perceived to be unsafe, due to not being able to spend time with the patients, not feeling confident in the capabilities of their colleagues, and participants felt unsafe themselves. Scanlon and Adlam (2012:74,75) argue that it is inevitable in the current socio-economic environment that frontline

homeless workers become “...(dis)tressed dis-organised and potentially traumatised” due to being “stuck in the middle between the dis-organisation of the systems they work in and the distressing nature of working with the clients that they serve, between the ‘rock’ of increasing demand and dependant need and the ‘hard place’ of apparently decreasing resources”.

There is burgeoning global research on stress in frontline homeless workers, with this type of research rare within England. All studies found used differing terminology when defining occupational stress such as burnout, anxiety, depression, secondary stress, and vicarious trauma. The quantitative studies included in this review used different statistical tools when measuring stress amongst homeless workers. Some of the studies supported that frontline worker experienced occupational stress, others did not.

In a survey of homelessness frontline workers in the England 63% of respondents stated that their role was affecting their own wellbeing in a very negative or negative way, and also reported having a high workload (Marshall 2022). A Scottish study by Lemieux-Cumberlege and Taylor (2019) explored the rates of burnout, secondary traumatic stress, depression, anxiety, and stress, by surveying 112 frontline homelessness workers online. They used version five of the Professional Quality of Life Scale and the Depression, Anxiety and Stress Scale-21. Respondents mainly worked in Scotland, a quarter from the rest of the UK and 1.8% from outside the UK, the authors did not specify if this was Europe or the rest of the world. The researchers found that frontline homeless workers are at high risk of traumatic stresses due to witnessing and hearing about distressing incidents whilst at work, there were high levels of depression and stress, however levels of burnout and secondary traumatic stress were not as expected, and respondents scored low to average. In contrast a qualitative study by Wirth et al (2019) found that German social worker participants, who supported people experiencing homelessness and refugees, had symptoms of burnout and depression, due to vicarious and first-hand trauma, high workloads, and bureaucratic stresses. Using focus groups and interviews the experiences of stress and burnout of ten frontline workers who supported people experiencing long term homelessness in Lincolnshire was explored and analysed thematically. This study concluded that staff had stress from a high workload, yet burnout was negligible (Rogers, Thomas and Roberts

2020). According to research by Mette et al (2020a), social workers supporting people experiencing homelessness and refugees, did have burnout, but this did not impact on their ability to work. An American study surveying female frontline homelessness workers concluded that burnout was not a prominent feature amongst respondents, however the risk of being emotionally exhausted was increased if the workers dealt with bureaucracy, had little time to complete tasks and did not feel in control of their work (Baker, O'Brien and Salahuddin 2007).

Stress within frontline homeless services may be underreported due to workers being fearful that they will be perceived as too weak to work in the sector (Waegemakers Schiff and Lane 2019). Waegemakers Schiff and Lane (2019) found high rates of PTSD amongst Canadian frontline homeless workers. The researchers surveyed 472 participants using statistical instruments PROQoL and PCL-C which measure compassion satisfaction and fatigue, burnout, and PTSD. Results show that levels of compassion satisfaction, burnout and vicarious trauma were like other frontline professions, however nearly a quarter of respondents met the threshold that indicated that they should remove themselves from work. Thirty-three percent of participants reported PTSD which was a lot higher than other similar professions. Part of the statistics collected was about the educational attainments of the participants and the researchers argue that due to lack of trauma training frontline workers may not understand they have PTSD. Lipsky's (2010) street level bureaucrat framework avers that to cope with demands of the job, street level bureaucrats amend their output.

Another study by Mette et al (2020b:12) found the participants used "*problem orientated, and emotion orientated*" coping mechanisms and one specific coping mechanism identified was focusing on the positive aspects of their work. Similarly, an English study by Rogers, Thomas and Roberts (2020) found that frontline homeless workers, who specifically supported entrenched rough sleepers, rationalised the stresses of work balanced against the positive aspects of their work. Baker, O'Brien and Salahuddin (2007) found that female homelessness workers used optimism and planned their work as a coping mechanism. Using mixed methods an Australian study by Ferris et al (2016) explored how homeless workers dealt with working with people in distress and found that that homeless worker had higher

rates of job satisfaction with lower rates of burnout when working with people with high distress levels which the researchers deemed the “*Florence Nightingale effect*”. Arguably, this reaction could be due to how the homeless person presents, as levels of frustration were found in frontline workers who were working with people who demonstrated anger, yet they had compassion for people presenting with high levels of anxiety, with a risk of workers becoming desensitised to trauma the longer they had worked in the sector (Theodorou et al 2021). The authors concluded that supporting people who are traumatised and displaying difficult behaviour “*generates a high emotional burden for staff...leading to burnout vicarious traumatisation and/or diminished feelings of accomplishment*” (Theodorou et al 2021:8).

Research world-wide has found increased levels of mental health disorders for health care workers during the COVID-19 pandemic including, PTSD, secondary traumatic stress, depression, burnout, anxiety, and moral distress (Johnson, Ebrahimi and Hoffart 2020, Bassi et al 2021, Norman et al 2021). Within the UK the mental health of health and social care workers deteriorated during the pandemic (Thomas and Quilter-Pinner 2020) with rates of PTSD, anxiety, and depression high in people working in a variety of job roles across health and social care settings (Greene et al 2021).

2.13 Moral distress

Moral distress has been researched increasingly since the 1980s (Ramos et al 2016), terminology, such as moral distress, ethical stress and constrained moral response, is used interchangeably within research (Mares 2016). The term moral distress was created by Jameton after writing about ethics within nursing. He described moral distress as “*when one knows the right thing to do but institutional constraints make it nearly impossible to pursue the right course of action*” (Jameton 1984:6). Another definition is “*the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behaviour indicated by that decision*” (Wilkinson 1987:16). The term covers “*psychological, emotional, and physiological suffering... when we act in ways which are inconsistent with deeply held ethical values, principles, or moral commitments*” (McCarthy 2013:1). Moral distress may also occur when observing unethical acts carried out by others (British Medical Association 2021).

Much of the research that concerns moral distress is within the nursing discipline. This may be because nurses place high value on helping patients and regularly face moral and ethical decision making (Wilkinson 1987). There is a recognition that moral distress can be applied to other workplaces where moral behaviour and management occur (Crane, Bayl-Smith and Cartmill 2013). There is burgeoning literature about moral distress in professions other than nursing, such as such as disaster workers (Gustavasson et al 2020), psychological and occupational therapists (Goddard 2021), and family social workers (Stahlschmidt, He and Lizano 2022) yet there appears to be little research about moral distress and supporting mentally ill rough sleepers.

There is an increasing amount of literature on how to define moral distress, however, critics claim that the term is ambiguous with no clarity on its conceptualisation (Musto and Rodney 2016, Dudzinski 2016, Mares 2016, Morley et al 2019). Nathaniel (2006) is critical that the concept fails to acknowledge the prolonged effect on nurses who experience it. Some view it as an “*umbrella concept*” to highlight various incidents of people who are morally restricted in their actions (McCarthy and Deady 2008:254, Morley, Bradbury -Jones and Ives 2021). Fourie (2017) finds a restricted view of moral distress is contentious as there may be a wide range of situations that cause distress, not just where a worker is constrained in their actions. Likewise, Brake and Nauta (2022) were critical of the general model of moral distress and developed a moral dissonance model which takes into account social and collective factors that affect the individual experiencing distress. Moral distress can also be understood via an individual and organisational lens (Corley 2002). Some researchers recommend further research to expand on conceptual frameworks and theoretical models of moral distress which will aid understanding its causes (Ramos et al 2016, Brake and Nauta 2022).

To facilitate a greater understanding of what constitutes moral distress, researchers undertook a systematic literature review and narrative synthesis and concluded that there was a link between a “*moral event*” and “*psychological distress*” in defining moral distress and concluded that moral distress occurs when “(1) *the experience of the moral event*, (2) *the experience of ‘psychological distress’* (3) *a direct casual relation between (1) and (2)*

together are necessary and sufficient conditions for moral distress” (Morley et al 2019:660). Rushton, Kasznaik and Halifax (2013:1074) developed a moral distress framework that had four key connected parts ‘empathy’, ‘perspective taking’ ‘memory’ and ‘moral sensitivity’. Depending on how each dimension is aligned this will influence the response of the worker, which could be positive, such as increased resilience, or negative, such as moral distress. Other views are that moral distress is a process where at certain points the individual deals with issues such as moral sensitivity and deliberation (Ramos et al 2016) or there is an interplay between the worker and the situation they are dealing with (Gustavsson et al 2020).

In contrast Parley (2021) suggests that Jameton did not see moral distress as an emotional response but rather a predicament nurses face and is critical of the increasing psychological terms applied to it, Moral distress is rarely discussed as a positive experience; however, Tigard’s (2018) views of moral distress experienced by a frontline worker is that it demonstrates that the person has the right values to be in a caring role and the worker can learn about their moral values from this experience. Ramos et al (2016) sees moral distress as part of professional development, as they are dealing with new situations that they are not comfortable with. Musto, Rodney and Vanderheide (2015) view moral distress as a relational trauma between the individual and the organisation, caused by organisational practices impacting negatively on personal values.

Some studies have examined what causes moral distress. An early study by Wilkinson (1987:24), which developed a model on how moral distress affects nurses, concluded that moral distress was greater than experiencing challenging emotions, it also included “*situational, cognitive and action*” elements. Moral distress was found not to occur automatically if the nurse was dealing with a distressing incident, but that the nurse’s principles, conflicting with the incident, caused the moral distress to occur. Other causes of moral distress include external situational constraints, such as unsupportive organisations, the law, along with internal constraints such as self-doubt, past experiences, and anxiety about losing their jobs (Wilkinson 1987). Likewise, a conflict in values with other members of staff involved in a patient’s care was found to cause moral distress in palliative care nurses due to the feelings of powerless this provoked (Young, Froggatt and Brearley 2017).

The hierarchical structure within health services can impact negatively on nurses experiencing moral distress due to nurses having less influence in patient care than other professions (Ando and Kawano 2018) and being incongruous with anticipated care (Spenceley et al 2015). Institutional constraints can be caused by individual and organisational constraints whilst at work, and frequent distressing experiences increase the likelihood of moral distress occurring (British Medical Association 2021). A literature review of quantitative research articles about moral distress in nursing by Oh and Gastmans (2015) concluded that nurses experienced a greater amount of moral distress as a result of circumstances, such as being part of ineffective care team or receiving unacceptable behaviour from patient and family members. Several of the studies reviewed demonstrated moral distress as having several factors for it to occur. Another literature review by Burston and Tuckett (2012), examining moral distress whilst caring for elderly people, conceded that there are three elements that influence moral distress; 1) *“individual”*, such as personal character, value system and knowledge, 2) *“site specific”*, such as resources (normally a lack of) and the workforce, and 3) *“broader external influences”*, such as organisational/ general policies and the law (Burston and Tuckett 2012: 314). Likewise, using feminist phenomenology as a methodology, Morley, Bradbury-Jones and Ives (2021:1316) concluded that there were five dimensions that increased moral distress occurring in critical care these were; 1) not having their professional expertise recognised, 2) *“the roster lottery”* the variable decision making by different consultants, 3) tension between the nurses personal and professional ethics, 4) advocating for patients, and 5) relationships between members of the organisation the nurses were working for. Such a variety of research findings, as discussed above, may be due to the time and working context in which the research took place (Corley 2002).

Research demonstrates that globally frontline workers experienced moral distress across healthcare services during the COVID-19 (Lake et al 2021, Guttormson et al 2022). There is little research examining how COVID-19 affected moral distress on frontline homelessness workers. A Canadian study by Hodwitz et al (2022) used telephone interviews with homeless participants and staff who supported them during the pandemic (including nine health care workers, four health care leaders and two homeless shelter managers) and concluded that the participants experienced moral distress due to working in the pandemic. This was due to

three main factors firstly, working in an unfamiliar environment due lack of comprehension of the virus, the constantly changing public health guidance and applying these policies to their workplace. Secondly, having other support organisations close and/or restricted access to their clients, and thirdly feeling ineffective whilst working as they were unable to give support as they desired. The researchers noted that the managers of the homeless shelters felt this particularly whilst supporting people experiencing homelessness with a mental illness. The healthcare workers participants spoke of being distressed in watching their patient's helplessness through the pandemic (Hodwitz et al 2022).

Other research explores how moral distress affects people experiencing it. One point of view is that to be able to understand moral distress requires understanding the person experiencing it and realise that it effects the "*mind, brain, body and emotions*" (Musto, Rodney and Vanderheide 2015:94). Furthermore, there is recognition that personal demographics can affect how moral distress is experienced (Dyo, Kalowes and Devries 2016, British Medical Association 2021). Wilkinson (1987) concluded that experiencing moral distress caused strong emotions including anger, frustration, and guilt, with participants also reporting poor mental health and experiencing depression and anxiety. This is supported by Nemati et al (2021) who suggests that an increase of moral distress can lead to mental illnesses in nurses. The literature review by Oh and Gastmans (2015) concluded that, whilst moral distress occurred occasionally with nurses, when it did happen, nurses experienced moderate moral distress and that more experienced nurses were, the more likely to experience moral distress.

Nurses may direct anger at themselves, others, or the wider system after experiencing moral distress. It may affect the nurse for a longer period of time after the incident occurs (Nathaniel 2006). A coping mechanism was focusing on what others had done wrong; however, coping mechanisms began to fail with increased frequency of experiencing moral distress (Burston and Tuckett 2012). There was no consensus on whether patient care was damaged due to experiencing moral distress, with participants reporting either improved care, the same care or worse care (Wilkinson 1987). Morley, Bradbury-Jones and Ives (2021) found four occurrences when nurses experienced moral distress which were; 1) to

retract from the situation, 2) reluctantly accept the situation, 3) to contest the situation, and 4) find a suitable resolution to the situation.

There are wide ranging consequences to the individual, organisation and service systems if a nurse experiences moral distress (Caram et al 2022). Experiencing moral distress frequently means that the distress is intensified each time the worker experiences the phenomenon (Caram et al 2022). It can negatively impact on job satisfaction (Ando and Kawano 2018) and increases the risk of workers intending to leave their occupation (Trautmann et al 2015).

2.14 System change

Research has found that people who are experiencing mental illness and homelessness should be classed as having “*complex or multiple needs or as a population facing multiple exclusion homelessness*” (Reeve et al 2018: 52). People experiencing multiple disadvantage experience two or more of the following, homelessness, mental illness, substance misuse, current or historic contact with the criminal justice system (Fulfilling Lives 2019, CFE Research and the University of Sheffield 2020). Poverty is another common factor that affects most of this population (Bramley et al 2015). National data sets indicate that a significant number of working age adults are classed as experiencing multiple or complex needs, it is estimated that 250,000 people yearly encounter an amalgamation of homelessness, criminal justice, and substance misuse services concerns (Bramley, Fitzpatrick and Sosenko 2020). People experiencing multiple disadvantage are more likely to be discriminated against, stigmatised, isolated and lonely (Meam coalition 2017).

Some academics, policy makers and practitioners acknowledge that people experiencing multiple or complex needs are being failed by the systems and services that are currently in place to support them (Cornes et al 2011, Bramley et al 2015, Reeve et al 2018, Fulfilling lives 2019, CFE Research and the University of Sheffield 2020, New System Alliance 2023). There is a burgeoning amount of literature that advocates for system change which is defined as “*changes to the people, organisations, policies, processes, cultures, beliefs and environment that make up the system*” (Fulfilling Lives 2019:4). The aim of system change is to influence policy at a local and national level to create better outcomes for people with

complex needs or experiencing multiple disadvantage, as usually outcomes can be poor for this population (McCarthy et al 2020, Meam coalition 2022).

For service users the system is seen as being extremely complicated to get through and rigid, with a one size fits all approach common (Moreton et al 2022, Pawson et al 2022). For people experiencing multiple disadvantage this complication is magnified due to the array of services needed to be accessed (CFE Research and the University of Sheffield 2020).

People experiencing multiple disadvantage are at risk of “*falling through the cracks*” of services and therefore not receiving any support at all (Dobson 2019:11, New System Alliance 2020). This results in extreme inequality and reduces the quality of life of the individual (Bramley et al 2015). The Meam coalition (2022) claim the power imbalance in systems is harmful to individuals accessing them and service users currently feel powerless when engaging service and systems for support (Single Homelessness Project 2020, New System Alliance 2020). Ultimately this is damaging to the relationships they have with people supporting them as there is evidence that this frustration is being taken out on the support workers (Moreton et al 2022, Reeve et al 2018). There is criticism that the current way of working with people experiencing multiple disadvantage is also extremely draining for public finances (New System Alliance 2020).

There is a burgeoning amount of grey and academic literature suggesting ways of changing these systems which are seen to be complicated ‘*inefficient, fragmented and inconsistent*’; consequentially people with multiple needs are stuck, or move in and out of services and systems, without success (Moreton, Welford and Milner 2022:8, Reeve et al 2018, New System Alliance 2020). Due to budget cuts, austerity is seen to have hindered any system changes (Moreton, Welford and Milner 2022, Sweeny et al 2018) and financial cuts have directly impacted on local homelessness services (Dobson 2019). After interviewing seventeen local authority commissioners Blood et al (2020:3) concluded that homelessness services are “*traumatised... by the direct or indirect effects [due to cuts to other services such as mental health and addiction] of funding cuts and national policy changes*”. In a study exploring the health needs of the homelessness population in Nottingham, service users and stakeholders spoke of cuts, closures and reductions across all services attributed to

austerity, which detrimentally affected people experiencing mental ill health and homelessness (Reeve et al 2018).

When homelessness services are commissioned, they are typically commissioned in silos for a short term (Blood et al 2020, McCarthy et al 2020, Moreton, Welford and Milner 2022). Working in silos causes difficulties to the person experiencing multiple or complex needs and the key person supporting them. Services and systems working in silos from each other are often rigid and offer inflexible support to individuals (Reeve et al 2018). Workers from teams can reduce their accountability for service users if there are various agencies supporting them (McCarthy et al 2020). Homelessness workers often become the key person in coordinating any services for someone experiencing multiple disadvantage (Lord, Tickle and Buckell 2021). They can be responsible for support in areas where they have had little or no training. This feeling of responsibility towards service users can be heightened if there are no other services or staff giving support (Moreton et al 2021). One study demonstrated that homelessness support workers were being relied on to give mental health support, even though they were untrained to do so (Reeve et al 2018).

One area identified as being difficult for people trying to access services was the assessment process. Assessments and meetings with service providers are seen as '*confusing, stressful, complicated and retraumatising*' due to past trauma and historical interactions with services (Single Homeless Project 2020). Participants with lived experience of homelessness, and support workers, found housing assessments too formal and advocate for a more relaxed approach to allow for conversations which allow the person being assessed to open up about their situation (Moreton and Welford 2022). Another study found that during a homelessness assessment individuals were asked up to 550 questions resulting in the need for people to constantly repeat themselves (and their trauma) at each individual assessment (Pawson et al 2022).

Research demonstrates that people experiencing homelessness have had past trauma (Buhrich, Hodder and Teesson 2000, Taylor and Sharpe 2008, Fitzpatrick, Bramley and Johnsen 2013) which means they may find communicating and working with services and staff difficult (Mental Health Foundation 2017). Consequentially, many services have begun

working in a ‘psychologically informed way’ which, at its core, allows for a positive relationship to be built between workers and service users (Keats et al 2012, Miles 2019). A review of literature by McCarthy et al (2020) found that delivering trauma informed care is seen as a desirable standard and there is a growing consensus that services need to work in a trauma informed way (Reeve et al 2018, CFE Research and the University of Sheffield 2020, Moreton et al 2021, Meam coalition 2022, Moreton, Welford and Milner 2022, Moreton and Welford 2022, Pawson et al 2022, New System Alliance 2023). Research demonstrates that services which delivered trauma informed care meant a better overall outcome for people experiencing homelessness (Hopper, Bassuk and Olivet 2010).

There have been a number of recommendations made following this body of research to improve the outcomes for people using and working in homelessness systems. Services and the support offered needs to be flexible with the needs of the service user at its core (CFE Research and the University of Sheffield 2020, Cooke et al 2022). The Meam Coalition (2020) advocate that all services and workers need have a good understanding about the cause and effects of experiencing multiple disadvantage. People with lived experience should be involved in service design (CFE Research and the University of Sheffield 2020), however this area is under researched as a recent literature review found little empirical evidence of co-producing services with people experiencing multiple disadvantage (Broadhurst 2022). Service users experiencing multiple disadvantage want joined up holistic support (Reeve et al 2018, New System Alliance 2020).

To make the assessment process easier and to avoid service users having to repeat information, it is recommended that there is a data sharing protocol between services, (CFE Research and the University of Sheffield 2020) or to have different services join to facilitate doing one single assessment (Reeve et al 2018). All services across sectors and provisions should be given equal power when supporting individuals (Cooke et al 2022). There should be specific frameworks of support which involve the individual and increase their feelings of control when engaging with services (Meam 2020). There is an increasing use of “navigators” who support and advocate those who are experiencing multiple disadvantage across all services and systems (CFE Research and the University of Sheffield 2020, McCarthy et al 2020, Moreton et al 2021), however others argue that the use of navigators

demonstrate that the system is too complicated if they are needed to support someone experiencing multiple disadvantage (New System Alliance 2020). Using peer advocates for support has been successful for people experiencing homelessness, with evidence of increased engagement with health and care services (Finlayson et al 2018). There is evidence to suggest that are situations where it is crucial that people are offered support such as discharge from hospital and prison (Meam Coalition 2019). There is also growing endorsement of strength-based models of support which shifts the paradigm away from the perceived faults of the individual to questioning “*what happened to you*” (Sweeny et al 2018 :330). It empowers service users as there is an understanding that they are an expert about their own lives (Sweeney et al 2018, New System Alliance 2020).

For frontline workers there is an increasing understanding that receiving psychological support through clinical supervision is good practice as this promotes the workers well-being and helps in giving trauma informed support to service users (McCarthy et al 2020, Hough 2021, Moreton et al 2021). Workers need regular support and supervision within their work (Meam coalition 2022, Moreton et al 2021). They need small caseloads to be able to give an adequate amount of support to individuals (Moreton and Welford 2022, Moreton, Welford and Milner 2022). Other recommendations include, support for staff who are supporting people experiencing multiple disadvantage, flexible working conditions, having a specific job description and working within this, and regular training and development (Moreton et al 2021).

2.15 Chapter Summary

The literature has demonstrated issues that may be relevant to frontline homelessness workers who support rough sleepers with a mental illness in England. Research has demonstrated that destitution and homelessness rates (including rough sleeping) has increased in the Midlands and across England since the implementation of austerity and welfare reform. People who are experiencing homelessness and mental illness are disadvantaged when claiming welfare benefits, and frontline staff report a negative impact on their workload due to the administration processes of the DWP. Welfare reform and working within austerity measures have been detrimental to the relationship between the frontline worker and the people they are supporting. COVID-19 and the public health

response in England put considerable strain on frontline homeless workers during the pandemic. Frontline homeless workers are at risk of becoming distressed and experiencing moral distress within their work and are also at heightened risk of experiencing violence from the people they are supporting. There is a growing volume of literature that suggests that the services and systems that support people experiencing homelessness are failing people with complex needs. Trauma informed care and multidisciplinary working is seen as good practice within the sector. Considering the link between homelessness and mental health there was a lack of research about how welfare reform, austerity and COVID-19 affected the everyday work of frontline homeless workers who specifically support rough sleepers with a mental illness. Most research on welfare reform is concentrated in the north of England and there is little research in the Midlands geographical area. This chapter has highlighted gaps in the research literature.

Chapter three: Methodology

3.1 Introduction

In the previous chapter a literature review evidenced that there is a dearth of literature on how working within austerity, welfare reform and the COVID-19 pandemic had affected frontline workers who support mentally ill rough sleepers. This research project was therefore designed to build knowledge within this discipline. Within this chapter I will provide a detailed discussion on my chosen qualitative methodology of constructivist grounded theory and how this was used to answer the research question. The chapter begins by explaining my philosophical beliefs as a researcher. Different research methodologies are discussed along with the history and evolution of grounded theory. This is followed by rationalising the use of constructivist grounded theory in this study above other qualitative research methods.

3.2 Researcher Methodological Position

Within social sciences, methodology is concerned with how the research process is accomplished (Taylor, Bogdan and DeVault 2016) and the significance of the philosophy supporting the methodology. As a researcher, it is important for a researcher to be transparent regarding their epistemological and theoretical positioning and philosophical world view, as these views will ultimately affect the research process (Creswell and Creswell 2018, Meyrick 2006). My axiological position relates to how my own values have impacted the research project. The term axiology derives from the Greek language, “*axios*” translated as “*worth or value*” and “*logos*” translated as “*logic or theory*”, signifying “*a theory of value*” and how this affects the ‘*knowledge creation process*’ (Biedenbach and Jacobsson 2016:140). It is argued that the researcher’s own values affect the research process from conceptualisation through to its final presentation (Taylor, Bogdan and Devault 2016). Researchers have “*biographies and social privileges that affect their theoretical, philosophical, substantive and methodological choices*” with “*ideological decisions*” being “*research decisions*” (Lembert 2007: 261), therefore the axiological position within social science research refers to how the research was value bound. I have worked in frontline services for over 20 years, predominately with people who have a mental illness and are homeless, in a variety of job roles and settings for local authorities, adult social care and the NHS. Many of the service users I have worked with have a history of multiple

disadvantages, such as experiencing homelessness, mental illness, addiction, offending (Meam Coalition 2018b) along with childhood and adult trauma. The experience of advocating for and supporting vulnerable service users was undoubtedly the catalyst of this project and has significantly influenced my own working and political values.

Reviewing methods of research through epistemology and methodology will demonstrate an ontological stance (Scotland 2012). Ontology is the study of nature of reality (Guba and Lincoln 1994) and Crotty (1998: 10) surmises ontology is about '*what is*'. My ontological position is that that of a constructivist, the constructivist strand recognises the numerous positions and experiences of the researcher and participants (Powers and Knapp 2010). Constructionists deem "*meaning is constructed by human beings as they engage with the world, they are interpreting*" (Crotty 1998: 43). Constructionism refutes impartial experiences and asserts that experiences are socially constructed, and that it is not possible therefore for a researcher to be impartial, as they also "*construct the worlds they research*" (Ghezeljeh and Emami 2009:17). I believe that knowledge is based upon a person's understanding and experience, and therefore this fits well into the qualitative research paradigm.

Epistemology is the "*theory of knowledge*" (Brinkmann 2017:8). It is important for researchers to "*identify, explain, and justify*" their epistemological position as this informs their theoretical and methodological stance (Crotty 1998:8) There are a range of epistemological stances that researchers may take; Crotty (1998) highlighted objectivism, constructionism, and subjectivism. My epistemology position is an interpretivist one which has its origins in Max Weber's *verstehen* (Crotty 1998). This position is also known as social constructionism (Creswell and Creswell 2018) which sees the researcher as part of the research project (Antwi and Hamza 2015). This stance means the researcher "*stands within the research process rather than outside it*" (Charmaz 2014: 321) and data is built from the processes between participants and the researcher (Ghezeljeh and Emami 2009).

3.3 Research Methodologies

Within research paradigms there are four main belief systems, 1) positivism, 2) post positivism, 3) critical theory, and 4) constructionism, of which all have different ontological,

epistemological, and methodological positions (Guba and Lincoln 1994). Within social sciences the two main theoretical viewpoints are positivism where the researcher seeks *“the facts or causes of social phenomena apart from the subjective states of individual”*, and interpretivism where the aim is to understand the viewpoints and experiences of people (Taylor, Bogdan and Devault 2016:14). There are usually three main methods of collecting data: qualitative, quantitative, and mixed methods (Creswell and Creswell 2018)

Qualitative research is generally (but not exclusively) linked to smaller research projects (Denscombe 2016). The results are not generalised to whole populations (Austin and Sutton 2014). This type of research gained popularity within American sociology in the early 1900s, with a resurgence in use from the 1960s onwards (Taylor, Bogdan and DeVault 2016) and is now a common research method with British Sociologists (Bryne 2012). It is an accomplished discipline with researchers using an extensive *“interconnected interpretative practise, hoping to always get a better understanding of the subject matter at hand”* (Denzin and Lincoln 2011: 4). It is an inductive process with researchers collecting *“data to build concepts, hypothesis or theories”* the aim being to *“understand and make sense of phenomena from the participants perspective”* (Merriam 2002:5-6). The researcher aim is to understand the *“meaning people attach to things in their life”* (Taylor, Bogdan and DeVault 2016:18). It answers the questions *“how and what and why”* (Kotecha 2022). Qualitative research understands that life and therefore human experiences are constantly evolving (Roller and Lavrakas 2015). It is diverse in its application, and it is understood to embody a broad range of theoretical and methodological approaches (Denny and Weckesser 2018, Ragin 1994, Austin and Sutton 2014). Words or observations are used as data (Taylor, Bogdan and DeVault 2016) along with images and items (Dey 1993, Denscombe 2016). Data is collected and analysed in a variety of ways such as interviews, focus groups, case studies, and observation (Jackson, Drummond and Camara 2007, Pope and Mays 1995).

In qualitative research, the researcher is acknowledged as an integral part of the research process (Ragin 1994). The researcher *“is the primary instrument”* when analysing and collecting data, with the researcher concerned with *“process, meaning and understanding through words and pictures”* (Atieno 2009:14). The method is appropriate when exploring a research area that is not well known (Fossey et al 2002). The researcher listens to

participants stories and experiences (Campbell 2014, Pope and Mays 1995) and these experiences add depth to research findings (Leung 2015). When justifying the validity of qualitative research Guba and Lincoln (1994) argue that experiences can be classed as knowledge if there is a general agreement between participants about the knowledge being built, if participants repeat similar experiences that this should be classed as '*theoretically plausible*' and therefore the results should be credible (Charmaz 2014:89).

There is much debate about the quality of qualitative research, with criticism that the methodology is weak, with the researcher fitting pieces of a puzzle together to fit a specific problem (Denzin and Lincoln 2011), others argue that the methodology is "*subjective, unscientific and consequently unreliable*" (Austin and Sutton 2014:439). Lincoln and Guba (1985) stated that qualitative research should have credibility, transferability, dependability, and confirmability to be trustful. Another point of view is that there should be a clear link between the research paradigm and the research design to ensure the interpretation of the data is sound and reliably demonstrate the participants perspectives (Fossey et al 2002) and to enable trustfulness in this thesis the rest of chapter three and chapter four aims to demonstrate this.

In contrast, quantitative research is known as the "*scientific paradigm*" (Atieno 2009: 13) and holds a positivist philosophical viewpoint. The goal of positivism is to "*gain predictive and explanatory knowledge of the external world*" (Keat and Urry 2010: 3); its aim is to have impartial, reliable, and measurable data (McNeil and Chapman 2005). When data is analysed quantitatively it is reduced to give a broad overview of the research area (Ragin 1994.) Quantitative research is hypothesis testing or deductive. Data is collected and analysed using numbers and statistical techniques and data collection methods such as questionnaires and surveys (Taylor, Bogdan and DeVault 2016; Pope and Mays 1995, Denscombe 2016). It uses a "*reductionist, logical and strictly objective paradigm*" where feelings from the participant and the researcher are viewed as detrimental to the research process (Leung 2015:324). It therefore loses the human 'voice' (Austin and Sutton 2014) as the human experience is lost due people, settings and groups being reduced to variables (Taylor, Bogdan and DeVault 2016).

Mixed methods use both quantitative and qualitative data (Bowen 2009; Creswell, and Creswell 2018) and the research design will have “*distinct designs that may involve philosophical assumptions and theoretical frameworks*” (Creswell and Creswell 2018:4). Supporters of using a mixed methods argue that it allows for a greater insight into the research question (Pope and Mays 1995).

3.4. Chosen Research Methodology

A qualitative design was deemed an appropriate way to answer the research question and it also corresponded with the research aims and objectives, the study was exploratory in nature, and it fitted my ontological and epistemological beliefs. Qualitative research is being increasing used within homeless research projects (Martin and Kunnen 2008) and health care (Denny and Weckesser 2018). I wanted to explore how frontline workers who support mentally ill rough sleepers experienced working within austerity, welfare reform and COVID-19 and this choice of methodology allowed me to do this, as one of the aims of qualitative research is to allow people who are not usually heard a “*voice*” (Ragin 1994: 83) It allows participants to convey their viewpoints and knowledge (Carter, Shaw and Thomas 1999) and in context (Guba and Lincoln 1994). Qualitative research may be initiated by public and political occurrences (Tracy 2010, Ragin 1994), which was applicable to my research due to the huge rise in people experiencing rough sleeping since 2010 and the government emphasis end rough sleeping (Department for Levelling Up, Housing and Communities 2022d).

3.4.1 Qualitative Research Designs

Along with a research methodology the researcher must choose a research design which stipulates how the research is conducted (Creswell and Creswell 2018). Atieno (2009:15) refers to “*methodological congruence*” and recognises that although qualitative research has an underlying paradigm, researchers using different methodologies will understand data in a different way. Several qualitative research designs were considered for this project including, ethnography, phenomenology, and grounded theory. Ethnography was discounted for practical and theoretical reasoning. I felt I was too close to the research area and participants to be subjective in my interpretation and avoid any bias. Both grounded theory and phenomenology are inductive and the early stages of conducting research are

similar (Reiter, Stewart and Bruce 2011). In the early stages of planning this study an obvious choice was phenomenology, as the focus of phenomenology is to examine the lived experience of participants. However, it is argued that when using phenomenology, the researcher needs to '*put aside personal attitudes and beliefs*' about the research area (Merriam 2002:7) and due to my past and current working history I was unsure of how successfully I could manage this without detrimentally affecting the research validity.

3.5 Grounded Theory

Grounded theory was chosen as my research methodology as it is seen as a suitable methodology for research into '*practical activity and routine situations*' and the '*participants point of view*' (Denscombe 2016:113). Grounded theory aligned with one of my main research aims, to develop a theoretical framework on how welfare reform, austerity measures and the COVID-19 pandemic were affecting frontline staff who were supporting mentally ill rough sleepers. Constructivist grounded theory was chosen as my methodology due to it aligning with my philosophical beliefs and as a novice researcher the structure and organisation of this research methodology appealed.

Grounded theory creates theory from data (Glaser and Strauss 1967, Charmaz 2014). It "*is an exploration/discovery process*" (Charmaz and Keller 2016:19) using "*rigorous procedures for researchers to check, refine and develop their ideas and intuition about the data*" (Charmaz 1996:28). Glaser (2005) concluded that many types of data be used across qualitative and quantitative sources. The premise is to shape categories from codes and by constantly comparing "*data, codes and the emerging categories*" create theory (Kelle 2007:193) The data collected and analysed is seen to be "*explicit and orderly*" (Kumar 1999:17). Grounded theory offers a freedom to enter the empirical social world to discover societal concerns and '*social processes*' (Jones and Alony 2011, Ligita et al 2020:117). Clarke (2007) viewpoint is that grounded theory allows for an intense empirical exploration of social life. It is an appropriate method when little is known about the research area (Chun Tie, Birks and Francis 2019). Researchers collect and analyse data with an open mind and as minimised preconceptions as possible, to generate theory naturally from the data without forcing or corruption (Glaser, 2013). It is not the participants that are analysed during grounded theory methodology but the beliefs which are given through the data collection

process (Corbin 2017) so researchers who have different ontological and epistemological beliefs will interpret the data differently. Strauss and Corbin (1994:278) emphasise that *'patterns' and 'processes are analysed which 'signifies a conceptualization of what occurs under certain conditions.'*

The main processes of conducting grounded theory are:

- **Comparative analysis:** Which is where data is collected and analysed in a concurrent and methodical way (Harris 2015). Birks and Mills (2015) demonstrate the analytical way this is completed, Incident is compared with Incident to create a code; Future incidents are compared with existing codes. Codes are then compared with codes and then folded into a category. Categories are then compared with categories which informs theoretical sampling.
- **Theoretical sampling:** When to do this is contested by grounded theorists. Broadly speaking this is where researchers recognise and follow clues when analysing data to magnify, explain and strengthen the data collected (Birks and Mills 2015). Researchers can alter their information sources, or the data being collected to enable advancement of the developing theory (Birks and Mills 2015).
- **Theoretical Saturation:** There is no new emerging data that can continue to advance a category. Dey (2007) compares this with a sponge that cannot absorb any further water.

3.5.1 History and Different Schools of Grounded Theory Methodology

Grounded theory is referred synonymously in different texts as either a method or methodology. In this study it will be referred to as a methodology. The methodology of grounded theory was originally developed by Glaser and Strauss (1967) when positivism was the preferred paradigm in the scientific community, due to its perceived impartiality which was seen to improve research rigour in empirical research (Newman 2008). Glaser and Struass (1967) therefore developed grounded theory to bridge the gap within social and empirical research (Kelle 2007). Positivism is entrenched in traditional grounded theory (Newman 2008). When developing grounded theory Glaser and Strauss criticised the lack of social research that was created by empirical means disapproving of the emphasis that researchers were placing on justifying theories, arguing it was harmful to the actual creation

of theories (Glaser and Strauss 1967, Kenny and Fourie 2014). As with a positivist approach the researcher is thought to be a detached entity when conducting a traditionalist ground theory study. Within social research Glaser and Strauss believed that theory generation and verification should be given equal importance (Kenny and Fourie 2014). The aim, when using grounded theory is to generate an inductive theory by using theoretical sampling (Glaser and Strauss 1967). The researcher should start with a question instead of a “*preconceived conceptual framework*” with the understanding that the truth will be found in the data collected (Glaser 1978:44). Common criticisms of grounded theory include it is not positivist enough in its approach, it’s too complicated to learn as a methodology and can be easily mixed up with other methods (Clarke 2007).

3.5.2 Classic or Traditional Grounded Theory

Classic or traditional grounded theory is also sometimes referred to as ‘Glaserian grounded theory’ (Artnian 2009, Van Niekerk and Roode 2009, Alexander and Bakir 2010, Age 2011). Both Glaser and Strauss had been taught from different philosophical viewpoints prior to working together, Glaser at Columbia University where positivist methodologies were preferred, and Strauss studied at Chicago’s school of sociology which championed qualitative methodologies and whose research methods were heavily influenced by pragmatism (Bryant 2009, Charmaz 2014). Together they undertook research on peoples experience of dying in hospitals in the USA during the 1960s and wrote the “*Awareness of Dying*” (Glaser and Strauss 1965), now a seminal text in the field of death and dying. From this work they created grounded theory methodology (Glaser and Strauss 1967; Chamberlin-Salaun, Mills and Usher 2013); “*The Discovery of Grounded Theory*” (Glaser and Strauss 1967), also now a seminal text, has become the foundation for what is known as traditional or classical grounded theory (Chun Tie, Birks and Francis 2019). Positivism is entrenched in traditional grounded theory (Newman 2008). In this version of grounded theory basic social process are enunciated through actions words and at an abstract level (Clarke 2007). It was intended to be used by social scientist with a range of different theoretical backgrounds and working disciplines (Clarke 2007). Glaser and Strauss’s original book did not provide a firm explanation of how to undertake a grounded theory study (Taylor 2013), with criticism about theoretical sensitivity and how this worked. Glaser and Strauss stated that researchers needed to be ‘*theoretically sensitive*’ to enable

conceptualisation of theory from the emerging data (Glaser and Strauss 1967). Glaser and Strauss disagreed when they attempted to clarify the term, which ultimately resulted in a division between the two (Kelle 2007). Strauss and Glaser went on to develop their own separate approaches to grounded theory with Glaser unswerving from his original version and who continued to contend traditional grounded theory is the methodology in its most authentic form (Charmaz 2014, Rieger 2018). Glaser and Strauss did not originally explicitly discuss philosophical foundations for this methodology (Chamberlain-Salaun, Mills and Usher 2013, Age 2011, Bryant 2009). It has been classed as both a positivist and hermeneutic methodology (Age 2011). As the theory has evolved, the philosophical basis of it is frequently debated and contested by scholars. Strauss in his work with Corbin concluded that the roots of grounded theory originated from the philosophical viewpoint of pragmatism, where ideas and concepts are assessed on how practical they are (James 2014), along with the sociological concept of symbolic interactionism (Corbin 2017, Crotty 1998). Symbolic Interactionism derives from social psychology and sociology and is seen to be about human behaviour and a method of investigating about how a human and groups of people behave (Annells 1996). It is informed by pragmatism (Charmaz 2014). Symbolic interactionists believe that interaction with '*society, reality and self*' is how people understand their environment (Charmaz 2006: 7). Glaser (2005) disliked the perceived dominance that social interactionism seen to have on grounded theory and stated any number of other sociological theoretical frameworks may influence grounded theory e.g., social organisation theory, social structural theory. Grounded theory has now evolved into a methodology with different methods (Rieger 2018).

3.5.3 Strauss and Corbin

Strauss and Corbin moved towards claiming grounded theory as a '*method of verification which Glaser disagreed with*' (Charmaz 2014: 11). Glaser was critical of Strauss and Corbin when they developed the stage of axial coding which assists the researcher to reveal the '*properties of categories*' within grounded theory (Harris 2015:38). Glaser thought that this stage was too inflexible and didn't allow for true emergence of the data (Seidel and Urquhart 2013). When developing their own version of grounded theory Strauss and Corbin were heavily influenced by the works of symbolic interactionists such as George Mead and Herbert Blumer, consequently symbolic interactionism is core in their evolved version and

application of grounded theory methodology (Chamberlin-Salaun, Mills and Usher 2013). Strauss ultimately believed that people are not docile when dealing with wider societal forces and are dynamic beings in their own right (Charmaz 2014) and therefore saw social processes are at the core of this version of grounded theory (Clarke 2007). Clarke (2007) believes the major difference between Glaser and Strauss work was that Strauss developed tools to aid reflexivity when conducting grounded theory research.

3.5.4 Second Evolution of Grounded Theory

The second evolution of grounded theory was promoted by Strauss (1987) with Juliet Corbin (Strauss and Corbin 1990, 1998) and Adele Clarke (Chamberlin-Salaun, Mills and Usher 2013). Adele Clarke's work was influenced by situational analysis (Clarke 2007) which focuses on "*discourses, narratives and historical analyses*" (Reiger 2018 and Age 2011:1601). Clarke (2007:433) avers that "*we and the people and things we choose to study are all routinely both producing and awash in seas of discourses, analysing only individual and collective human actors no longer suffices for many qualitative projects*". She has also collaborated with Charmaz (Charmaz and Keller 2016). It is thought that she moved grounded theory from a postpositivist to postmodern position (Mills et al 2007). Grounded theory is now seen to have its philosophical underpinnings amongst objectivist and constructivist viewpoints depending on the type used (Taylor 2013, Chun Tie, Birks and Francis 2019). Along with the theorist's mentioned above there are now many different philosophical positions to grounded theory, with pragmatic (Bryant 2019), hermeneuticist and realist viewpoints (Haig 2007). All the applications of grounded theory have similar methodological steps including concurrent data collection and theoretical sampling (Rieger 2018). What differentiates between them is '*the philosophical approach of the researcher, the use of literature, and the approach to coding, analysis and theory development*' (ChunTie, Birks and Francis 2019, Denscombe 2016: 111) however, most grounded theorists would agree that each version allows for generating theory in the '*real world*'.

3.5.5 Charmaz and Constructivist Grounded Theory

The third major evolution of grounded theory was the constructivist approach developed by Cathy Charmaz (2006, 2014). Charmaz was a student of Glaser and Strauss and learnt about grounded theory methodology from them in person. Charmaz was a medical sociologist,

heavily influenced by Meads symbolic interactionism and whose main research area was about living with chronic illness and disability (Low and Hyslop-Margison 2021).

Constructivist grounded theory comes from pragmatism and has many philosophical similarities, such as viewing *“reality as fundamentally social and processual”* (Charmaz 2017a:38). Symbolic interactionism has also continued to influence the constructivist approach to grounded theory with Charmaz commenting it’s a *“one theory-methods package”* (Charmaz and Keller 2016:18).

Due to its origins Charmaz asserts that it is a suitable method of enquiry for social justice research (Charmaz 2017b). Charmaz developed the constructivist approach when early grounded theory was being criticised due to the condemnation of qualitative types of research in the postmodern research era, and she deemed the application of Strauss and Corbin’s method was inflexible in its approach (Charmaz and Keller 2016). She disagreed with the epistemological positioning of traditional grounded theory however she adopted the practical steps from traditional grounded theory in her methods, such as coding and memo writing (Charmaz and Keller 2016). In her early qualitative research work she was particularly critical about the principle of a theory being discovered when analysing data with grounded theory methodology (Kenny and Fourie 2014). Charmaz was also critical that subjectivity was disregarded within epistemological trends during the 1960’s onwards yet social constructivists in the 1980’s failed to critique themselves (Charmaz and Keller 2016). Therefore, she emphasised the importance of the researcher in the research process. She argues that as researchers *“we are part of the world we study and the data we collect. We construct our grounded theories through our past and present involvements and interactions with people, perspectives, and research practices”* (Charmaz 2006: 10). The researcher and the research process are examined along with the data (Charmaz 2017a). Theory is not therefore waiting to be discovered but constructed through our interactions with the world. Reality is *“fundamentally social and processual”* (Charmaz 2017a:38).

The *“worldview”* of the researcher affects the research project, it must be decided what the researcher believes the notions of reality is, the connection between *“the knower and the known”* and how to determine what is real (Annells 1996:379). As I have a constructivist ontological world view, a constructivist grounded theory methodology, which was

developed by Charmaz (2006, 2014) was used. As discussed above, Charmaz (2006) is critical about theory being discovered by the researcher. The constructivist grounded theory approach therefore acknowledges the researcher during the research process and the association between the researcher and research participants (Mills, Bonner and Francis 2006a, Powers and Knapp 2010). Charmaz (2017a:39) asserts that the “*viewer and the viewed are joined in the research experience*” with the neutral observer being omitted (Charmaz 2014). It is important to note that ‘*analysis is contextually situated in time, place, culture and situation*’ (Ghezelijeh and Emami 2009) so if research results will never be transferable. Charmaz (2014: 13) adds that constructivist grounded theory “*highlights the flexibility of the method and resists mechanical applications of it*”. The researcher “*must examine rather than erase*” their own beliefs, as these will shape the research, however at the same time these beliefs will affect what data is identified (Charmaz 2014: 13). Consequentially, as I have been working within frontline mental health and homeless services for 21+ years, my working history, personal values, and biases needed to be acknowledged and be transparent during the research process, as these would undoubtedly affect the research process. How I applied the method will be discussed in further detail below.

3.6 Chapter Summary

Within this chapter I have explained the rationale of using a qualitative research design for my study. I explained my ontological, epistemological, and axiological positioning. I have explored the different methodologies of qualitative, quantitative, and mixed methods research. I then move on to discuss grounded theory, its history, and its different ontological and epistemological positioning. Finally, I have discussed the development of constructivist grounded theory and how and why I decided to use this methodology to explore how frontline workers who support rough sleepers with a mental illness have experienced working within austerity, welfare reform and the COVID-19 pandemic. The next chapter discusses the methods I used to undertake the study.

Chapter Four: Methods

4.1 Introduction

In the previous chapter it was explained why a qualitative research design and the methodology of constructivist grounded theory was chosen to explore how austerity, welfare reform and the COVID-19 pandemic has affected frontline workers who support rough sleepers with a mental illness. This chapter begins by discussing how the outbreak of the COVID-19 pandemic affected the research design. Following this it is explained how people experiencing homelessness were consulted on the initial research questions, dealing with gatekeepers and problems faced when recruiting participants. The amended research aims and objectives, because of the COVID-19 pandemic, are confirmed. The chapter moves on to discuss how reflexivity was used throughout the research project and how tools were used to aid this such as a research diary. Undertaking research as an 'insider' is then discussed, along with the issues that arose from completing emotionally demanding research and how this was dealt with. The chapter then moves on to sampling decisions and the participant demographics. The last sections in the chapter cover data analysis and collection. How and why data was collected using semi-structured interviews either face-to-face or by telephone is explained. The interview schedule, and how and when it was modified, is explained, along with how documentary analysis informed the interview schedule after the outbreak of COVID-19. The chapter then reveals how data was analysed using a constructivist grounded theory approach and how an exploratory theory of moral distress was subsequently created between myself and the participants. Finally, the chapter addresses core ethical issues that were considered and occurred during the overall research process. The principles of credibility and trustworthiness within qualitative research are threaded throughout the chapter.

4.2 Methods Pre and Post COVID-19 Pandemic

The COVID-19 pandemic disrupted my research project immensely. I was in the early stages of recruiting and interviewing staff and patient participants, when the first lockdown began. Due to the public health guidance and the government aim to protect the NHS access to both these groups of participants were withdrawn by the NHS trust I was recruiting from. Below I outline my pre-COVID-19 plans and then discuss in detail the study as it was

conducted. My rationale for providing some detail about my pre-COVID-19 research is because I used data in my findings that had been collected prior to lockdown.

The original research design, prior to the COVID-19 lockdown, was to interview homeless mental health patients who were being treated on an acute mental health inpatient unit or in the community and the staff who supported them, to explore how they experienced austerity and welfare reform.

For staff and patient participants there was a rigid inclusion criterion that had to be met before they could be interviewed. Patient participants had to be aged 18-65, be classed as single homeless, were receiving or in the process of claiming sickness/and or disability benefits. They needed to have mental capacity as per the Mental Capacity Act (2005) and be able to speak a reasonable level of English and live within the Midlands geographical area. They needed to have been receiving treatment for mental illness in an acute inpatient unit or in the community whilst they were experiencing homelessness. Staff participants needed to be supporting and working with patients who met the above criteria either in an acute mental health inpatient unit or the community.

4.2.1 Recruitment Issues

Along with the major issue of the COVID-19 pandemic there were issues that arose recruiting participants. Three staff participants were recruited and were interviewed prior to the COVID-19 pandemic, however as soon as the national lockdown began my access to further staff participants was withdrawn and two participants recruited immediately prior to lockdown was not able to be interviewed. Two community patient participants were recruited. However, one did not attend the pre-arranged interview; the other was heavily under the influence of substances when they arrived to be interviewed, so I did not proceed and rearranged the interview at another date convenient for the participant, however the participant did then not attend.

4.2.2 Participation and Public Involvement

Patient and public involvement is often abbreviated to PPI. It refers to Involving people in the research design, who have lived experience of the research area which is believed to

create better research results (Shimmin et al 2017). PPI involvement in research and services within health is more prominent since it became a statutory duty under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) to (NHS England 2017). NHS England, for example, have a strategy until 2026 to ensure that the public are involved in research and new ideas within their services (NHS England 2023). Examples of the public who may be involved in research and commission service can include patients, carers, and community groups (NHS England 2023). PPI is now considered best research practice by many research bodies in the UK, including the National Institute for Health and Care Research (2019) and the Health Research Authority (2022). For research, it is about involving people in the public with the appropriate lived experience to assist in designing, conducting, and disseminating the research findings (Health Research Authority 2023), and the public being involved in governance, designing information for patients about treatments and education and training (NHS England 2023). Critics claim that some researchers use this process in a tokenistic way, and do not engage with the public in a meaningful way when actioning PPI (Ocloo and Matthews 2016), making any research on the impact of PPI ineffective (Staley 2015). A systematic review found that within the NHS, PPI is administered in various ways (Mockford et al 2012), and a systematic review by Brett et al (2014a) found little academic literature which addressed the challenges of PPI.

However, most research suggests that PPI is beneficial to both service users and researchers, it gives service users power, and the researcher gains more awareness of the research area (Brett et al 2014b). There are benefits of using PPI to design research tools such as finding the correct way to word questions, and highlighting research areas that may have not been considered (Brett et al 2014a). For example, Gillard et al (2012) described how having people involved in PPI for a qualitative mental health study produced intricate findings that wouldn't have been captured otherwise.

There is little expectation of doctoral students to involve the public in their research (Tomlinson et al 2019), however, doing so may enhance the doctoral research experience in a variety of ways, including improving research quality and confidence of the doctoral researcher (Coupe and Mathieson 2020, Tomlinson et al 2019, Dawson et al 2020).

I was keen to involve people experiencing homelessness with my research, however there were difficulties in this. Dawson et al (2020) suggests building prolonged relationships with PPI contributors, however, with the often-transient lifestyle of people experiencing homelessness and the time restraints of completing a PhD this was not possible. I therefore decided to request involvement with shaping the initial research questions for the staff and patient participants. People who were experiencing homelessness were approached to discuss the initial research proposal and the initial research questions. The informants were accessing a homeless day centre and were rough sleeping at the time. Permission was granted from the centre manager to speak to the service users and ten people assisted with commenting on the relevance of the research proposal and shaping the research questions. I met with the informants on the same day.

All informants individually agreed that the proposed research project was valuable and would benefit the homeless population. In keeping with my constructivist philosophical positioning, I would have liked to have had more in-depth involvement from people experiencing homeless to ensure my research was ‘with’ this population rather than ‘about’ (Hayes, Buckland and Tarpey 2012: 6) however, the modest inclusion which occurred added significantly to the research questions and supports findings by Brett et al (2014a) that the informants involved in my PPI identified issues to question that I had not considered.

4.2.3 Gatekeepers

Negotiating with gatekeepers in healthcare research can be a major issue and, due to increasing barriers in gaining access to sites, this is a widespread concern for researchers (Widing 2012). Gatekeepers are an “*under theorised and abstract figure*” (Collyer, Willis and Lewis 2017: 97), and within this research project I negotiated with gatekeepers who held a wide range of job roles within an organisation. This occurred at several stages throughout the research process. Prior to applying for ethical approval, I met with a representative on behalf of the organisation I wanted to gain access to, to discuss the project and to see if project could be facilitated. After ethical approval was granted, the research was discussed with a senior manager at the proposed inpatient setting. This manager approached staff participants to recruit as participants, and also put me in contact with the staff members who were tasked with attempting to recruit inpatients participants. This process was

duplicated in the community setting to recruit staff and patient participants. I met with all the frontline staff who were attempting to recruit patient participants on my behalf to discuss the research project and alleviate any concerns that they may have had. Widing (2012) emphasises a researcher is responsible for maintaining good communication with gatekeepers to gain and keep access to research sites. Due to my position as an insider researcher, although there were some issues which is discussed further below, it was easier to build relationships with most gatekeepers who I had worked with historically. This supports the notion that insider positioning relationships are easier to build due to shared understandings (McAreavey and Das 2013).

However, dealing with the gatekeepers was not wholly straightforward and upon reflection I felt that some of this was due to my past working history of advocating for patient's rights, which was known to some in the gatekeeping organisation. Staff members, tasked with patient recruitment, were concerned that the research would only highlight staff failings. I attempted to reassure staff members that the research was about wider policy, however this perception incumbered recruitment of patients overall, confirming the perception that, if the research is felt to jeopardise the gatekeeper's position or work, they may become noncooperative (Dempsey et al 2016). Some of the staff assumed that the research was based on failings of the DWP only. Due to this misunderstanding, potential patient participants refused to participate, as they felt that the research did not apply to them. This issue was addressed and resolved prior to the COVID-19 pandemic by reiterating the research aims to recruiting staff members. Some of the patient participants in the community setting were also reluctant to take part due to their lack of trust with people and services. The outcome was, that due to the COVID-19 pandemic and the withdrawal of access to patients, no patients were interviewed for this study.

I was very disappointed that I was unable to interview patients as one of the key reasons that the study was undertaken was to demonstrate how austerity and welfare reform was affecting this population. I questioned the value of the research moving forward and if I would be able to add to knowledge within the area. CohenMiller, Schnackenberg and Demers (2020) discuss failure within qualitative research, they argued that within social sciences failure should be expected and embraced, as it allows for new understandings.

Although the overall failure of the original research design was out of my control, due to the COVID-19 pandemic, with hindsight it allowed me to concentrate the research solely on frontline workers, which allowed for a deeper comprehension of the pressures that they face whilst at work.

4.3 Amended Research Aim and Objectives due to the COVID-19 Pandemic

As stated above, due to the public health response of the COVID-19 pandemic, access to NHS staff and patients was withdrawn. Similar to many other research projects in the UK and worldwide, the original research design required adaptations (National Centre for research methods 2022, Nind, Coverdale and Meckin 2022). It was very unclear, at the outbreak of COVID-19, as to how long the public health guidelines would last, consequentially I did not initially change the research design and concentrated on other areas of the PhD. As the lockdown progressed it became clear that I would have to either pause my research for an indefinite period or alter the research design to progress with my PhD. Due to my personal circumstances, I was very reluctant to pause the research, but I was also conflicted, as I felt changing the research would lessen its value, both to me personally and to the wider academic community. I had interviewed three participants before lockdown and did not want to alter my research design completely and lose this data. I was very conscious that any new ethical approval process would be time-consuming as I would need approval from two organisations, the Health Research Authority, and the university. Furthermore, due to continuing to work within a homeless service myself, during the initial lockdown, I was mindful of the stresses and pressure frontline staff were under. Like Garthwaite (2020), I felt it was unethical to add to this pressure. I had been involved in the 'Everyone In' scheme in my local area and I felt it was significant to explore how staff, service users and patients were experiencing this policy, so I continued with qualitative research. Many homelessness services in the research locality had shut down and many statutory services staff were working from home, so a further major dilemma was how to have contact with frontline workers whilst minimising the risk of transmitting COVID-19.

I spent time with my supervisors discussing all these dilemmas and ultimately decided to add a new group of participants, referred to as key informants, to the research. The key informant participants were frontline workers who worked for a wide range of

organisations across statutory and voluntary organisations in various professions. These participants had insight and knowledge of working within national and local government policies and responses to the COVID-19 pandemic and homelessness in the Midlands geographical area and were purposefully sampled. During this period, I also began to analyse documents about COVID-19, homelessness and mental health, to inform the modified interview schedule (discussed below) that reflected the inclusion of the COVID-19 pandemic. Along with many other researchers I also needed to adapt my data collection method to comply with social distancing guidelines (Nind, Coverdale and Meckin 2022) and chose to interview people over the telephone which is discussed in more detail below.

Due to the COVID-19 pandemic the aim of the research was also altered; to explore how the welfare reform agenda and austerity measures, along with the recent Covid-19 outbreak, affected frontline workers who supported mentally ill rough sleepers. The objectives were:

- To explore how frontline workers, who were supporting mentally ill rough sleepers, experienced working within and delivering services under the welfare reform agenda austerity and the COVID-19 Pandemic.
- To explore frontline workers experiences of the local and government response in assisting homeless people during the COVID-19 outbreak.
- To understand how a range of government policies and strategies, implemented since the welfare reform agenda, austerity measures and COVID-19 pandemic began, have impacted upon frontline workers whilst they are supporting mentally ill rough sleepers.

4.4 Reflexivity

I was very conscious that my previous and past working experiences could prejudice this study and therefore I saw it as essential that my own positionality and any potential biases within the research area were transparent. To address concerns about research validity and wanting to improve my research skills, reflexivity was used throughout this study. Reflexivity has been used in two ways, methodological and epistemic (Johnson and Duberley 2000) and throughout the project, my own values and principles have been examined, to check how these may impact on the research (Brannick and Coghlan 2007).

Qualitative research findings are often criticised as invalid, due to not acknowledging how researchers themselves affect the study process (Patnaik 2013), as it is recognised that the researcher, as a *“human instrument has shortcomings and biases that might impact the study”* (Merriam 2002: 5). Reflexivity is needed to *“self-reflect on one’s personal bias, preconceived notions, assumptions, theoretical predispositions, and ideological commitments”* (Powers and Knapp 2010:155) and is deemed to be crucial within research to demonstrate that the researcher has a grasp of the *“phenomenon under study and the research process itself”* (Watts 2007:82). If an insider researcher (this positioning is discussed below) analyses data using a traditional qualitative structure, it may affect research findings and therefore reflexivity is an important process (Dodgson 2019). It is also argued that using reflexivity improves researcher skills and allows the researcher to have a better comprehension of the *“self-while creating knowledge”* (Berger 2013:2) and that *“learning to reflect on your behaviour and thoughts as well as the phenomenon under study creates a means for continually becoming a better researcher”* (Glesne and Peshkin 1992: xiii). According to Charmaz (2017a:36), constructivist grounded theorists need to use reflexivity, as the method requires *“developing and maintain methodological self-consciousness...to enable detecting and dissecting our worldviews, language and meaning”*. There is no specific way to be reflexive (Nadin and Cassell 2006), and I used reflexivity in a variety of ways, such as speaking regularly to my supervisors, keeping a researcher diary, and writing memo’s, all of which is discussed in more detail below.

4.4.1 Researcher Diary

Many researchers suggest using a research diary as this allows a researcher to document their actions and mindset during the whole of the research process (Bloor and Wood 2006, Walker, Read and Priest 2013). Clarke (2009:69) suggests using a research diary to keep a clear record of the research process and used a research diary when she had finished interviewing participants to be able to recall specific elements of the interview and to *“enhance insight and develop understanding”*. Personally, I wanted the steps I had taken, and decisions I had made during the research process, to be as transparent as possible, consequentially a research diary was kept throughout the research process. It ranged from my experiences of liaising with gatekeepers, to writing about my thoughts and feelings after an interview had taken place and after contacting participants about emerging themes. I

wrote in my diary as soon as possible after an interview had occurred, for most participants this was as soon as the interview had concluded. Whilst writing the diary I was conflicted with an ethical dilemma about how much information I should reveal about the participants and their area of work. I was conscious that, although my diary was private and kept in a locked cabinet whilst not in use, that if it was ever lost or stolen it was important that the participants details would not be comprised by any information kept in it.

Box 1: Example of diary excerpt after an interview

Interview number 4 was completed today, over the telephone. As I could not see any body language the interview felt very formal more than the previous interviews that had taken place, however I may have also felt this as the participant works at a very senior level and the power dynamic felt different compared to my other interviews. This participant was also very nervous that they would be kept anonymous, and I spent some time prior to the interview reassuring them about this. I was also aware during the interview that the participant was aware of my ethos/values/skills. Key thing I picked up during the interview was the frustration that was felt towards other services. Before the interview had begun, they stated *“how does adult social care staff sleep at night?”*

I also wrote about some of the situations/incidents I experienced at work which I felt may bias my feelings, thoughts and/or actions during the research process, I felt that it was important to recognise these incidents so I could reflect on them and discuss these issues with my supervisors if needed.

Box 2: Example of diary excerpt about an event at work

Whilst at work today I dealt with a person that had been placed in an unfurnished flat, due to “everyone in”, that they cannot afford to heat. They were moved from catered temporary accommodation into somewhere where they need to cater for themselves. They were given very little warning about the move (the night before) and had no access to cooking equipment and utensils. They had spent all their benefit money and was not due another payment for over a week. They were very cold and starving hungry as they had not eaten properly for days, and I fed and gave them a hot drink. I gave them food to take away. I felt so angry that a person could be left like this, and no thought had been given to other practicalities that needed to be taken care of when moving someone into their own accommodation when they have complex needs. People are being treated as numbers when they are being moved around with no thought on how the individual may be affected. The irony is that due to this, they (the person experiencing homelessness) are being forced to break lockdown rules to survive and are being put at risk at catching COVID-19. I feel very tired of working within such a broken system. I am so worn out with it all and I am worried these feelings I am having will be of detriment to my PhD.

I also recorded conversations that I had at work with people who were not research participants yet knew about my area of research and discussed relevant areas with me whilst working and/or volunteering. I named these people research “sources”. I felt it was important to keep a record of such conversations when I felt they related directly to the research area, and to be transparent about these conversations in case they created any bias within my work.

Box 3: Example of diary excerpt regarding information from a “source”

The accommodation being provided to people experiencing homelessness during ‘Everyone In’ is not always suitable. People who all have complex needs are being placed into shared houses and there are issues with people selling the shared furniture and damaging the property.

At times I wrote in my diary after data analysis and coding. This helped me articulate my feelings about emerging themes and I would discuss these with my supervisors if I needed to. I spoke to my supervisors regularly and sent over my data analysis to review and we discussed emerging codes. For example, I spoke with them about an emerging code I felt uncomfortable with, which was about violence from homeless people toward frontline workers, as I did not want to add stigma to an already stigmatised population.

Box 4: Example diary excerpt after coding

I have been completing coding and an area that is dominating is the physical and verbal aggression staff face. I feel very conflicted as I do not want my research to add to the stigma that service users face but at the same time that's what's coming from the data!! and staff face abuse regularly.

Along with writing in my research diary I wrote memos (discussed in more detail below) which also encouraged reflexivity and caused me to question my thought processes and preconceptions. I also had separate books that I wrote in regarding other matters that would have affected the PhD such as theories, interesting articles that may relate to the PhD and supervisory issues and kept a monthly log of the activities I had completed throughout my PhD which I used as an audit trail.

4.5 Insider Research

Insider research is *“conducted within a social group, organisation and culture of which the researcher is also a member”* (Greene 2014:1). An insider researcher maintains that they cannot erase their past knowledge as *“one cannot unknow what one knows”* (Stern 2007: 117) which is controversial to some, as historically researchers are detached observers from their research area (Williamson et al 2020). Accordingly, throughout the whole research process I was very conscious of being an insider researcher and how my own personal biases, due to past and current working experiences, could influence the research project and ultimately how the data was interpreted.

Hou and Feng (2019:1) argue that the strain of being an insider/outsider researcher blends *“key concepts of ontology, epistemology, reflexivity, positionality, serendipity and intersectionality”* and that this *“messy”* changeability should be acknowledged as an integral part of research process; however, as a novice researcher I felt uncomfortable at times with this. I knew most of the participants through my working history and some participants were colleagues and friends of varying intensities. This made me an *“intimate”* insider, due to the pre-existing relationships I had with some of the participants (Taylor 2011). As an intimate insider I was mindful of my changing role with the participants, between researcher, friend, and colleague. Dickson-Swift et al (2006) explored how healthcare researchers experienced having boundaries with participants in data collection within sensitive research and an identified theme was researchers were anxious about professional

boundaries and keeping an emotional distance with participants. I related to this, as at times I was saddened by some of the information I was gathering, and I was anxious that, due to my positioning as an insider researcher, I was too close to the research area and or/most of the participants. I was concerned that my research would be criticised due to this.

To some participants I held a shared identity as a frontline worker, yet at times I was also seen to be an expert due my status as a PHD student and researcher. A researcher's position can alter throughout the research process (Greene 2014), and I moved back and forth between the identities as a student, friend, colleague, and frontline worker, which was personally challenging. I was confident in my role as a frontline worker but less so as a PhD student. My working background meant that I did not usually disclose personal information about myself to people I am supporting, yet due to the nature of my relationships with some of the participants some personal information was known about me and vice-versa. As a novice researcher I found this testing due to not wanting to cross any researcher/participant boundaries. The literature referring to research boundaries commonly mentions "*boundary blurring*" (Dickson-Swift et al 2006: 854) and due to the blurring of my status to participants I was frequently concerned that this would negatively affect the research project and had discussions with my supervisors about this. Due to my proximity to some of the participants, that "*where the research-self is part of the other narrative, the narrative of the researched and researcher become entwined*" (Taylor 2011:9). whilst doing any frontline work, if another worker was speaking about something related to my research area, I would not add to the conversation in attempt to be neutral and not influence it in anyway. I was mindful that, if any of these workers became a participant in the research, they may already have an idea of my own viewpoint and answer accordingly. There were also ethical dilemmas that I had to contend with, for example, I avoided recruiting potential participants who I believed to be emotionally fragile. This belief was based on incidents and conversations I had whilst working and I did not want to add to their emotional stress. A researcher who was not an insider may have recruited these people and possibly have had different data as a result.

There are other disadvantages with being an insider researcher. The researcher's impartiality and personal prejudice are questionable (Greene 2014) which therefore effects the validity of the research. My own values could affect the research results and several steps were taken to minimise this risk including the research diary and creating memos and having regular discussions with my supervisors about the research, however there were positives to this positioning, Bonner and Tolhurst (2002: 3) concur that benefits include being "*theoretically sensitive*" and being able to rapidly build a relationship with participants. Interestingly, interviews with the participants I knew prior to the interviews were relaxed and felt like more of a conversation. The research process felt more formal to me with participants that I did not know. Some participants were very candid, and I felt that my insider positioning had encouraged this.

4.6 Emotionally Demanding Research

Apart from the anti-reductionist perspective, where the researcher's emotions are acknowledged as effecting the research process, most reflexivity is concerned with how data is interpreted and not the emotional stresses of the researcher (Komaromy 2020). Due to the overriding assumption that the researcher must be impartial during the research process, the emotional difficulties on the researcher are not readily acknowledged in the field (Martin and Kunnen 2008), and there is scant focus on the risk of trauma to researchers (Loyle and Simoni 2017). However, conducting qualitative research can place emotional demands on the researcher (Dickson-Swift et al 2007, Dickson-Swift et al 2008, Mcgarrol 2017, Orr et al 2021). As my research progressed, I was aware that I had naively not considered the emotional difficulties that I subsequently encountered during this research project.

Emotionally demanding research is defined as "*research that demands a tremendous amount of mental, emotional, or physical energy and potentially affects or depletes the researcher's health or wellbeing*" (Kumar and Cavellaro 2018:648). They proposed a conceptual model for researcher self-care within emotionally demanding research with four domains which they class as being emotionally demanding to the researcher 1) "*researching sensitive issues*", 2) "*researching prior life trauma*", 3) "*experiencing traumatic life events during research*", and 4) "*unexpected events that arise during study of non-sensitive areas of*

research" (Kumar and Cavellaro 2018: 649-651). After reflecting on my research experience all the domains were applicable to myself.

4.6.1 Researching Sensitive Issues

There are a multitude of definitions of what constitutes sensitive research (Johnson and Clarke 2003). Sensitive research may contain topics that are "*socially taboo*" (Hayter 2010: 2079), such as "*abuse, death and violence*" (Dickson-Swift, James and Liamputtong 2008: 5), and research areas such as substance misuse and homelessness (Dickson-Swift et al 2006). Research which is sensitive may also involve "*ethical and moral issues*" (Johnson and Clarke 2003:423). It is also recognised that the research may also be classed as sensitive due to how the topic makes the participants feel when talking about it or the effect of the research on the participant or researcher (Dickson-Swift et al 2007, James and Liamputtong 2008). My research topic would be therefore classed as sensitive. Some participants were worried about an adverse reaction from their employer when discussing issues, and prior to agreeing to be interviewed clarified that their interviews be confidential and that their details would be kept anonymous, and I took the responsibility of keeping them anonymous very seriously. Participants frequently talked of distressing situations and events that they were faced with or had dealt with and at times, as mentioned above, I felt saddened and distressed at what I was being told. This personal response was unexpected and surprised me as I believed that I was normally an emotionally resilient person. However, it is acknowledged that the researcher's emotions, such as anger, distress and identifying with participants, should be recognised, to improve comprehension of the research area (Hubbard, Backett-Milburn and Kemmer 2001). Johnson (2009) reflected on her phenomenological PhD research about breast cancer and concluded that, although there were challenges, overall, the emotional response she felt benefited the research project in its entirety, from liaising with participants to data analysis.

However, there is growing awareness that there are difficulties for researchers themselves who are researching a sensitive issue (Dickson-Swift et al 2007, Dickson-Swift et al 2009, Johnson and Clarke 2003). This may include anxiety (an area of concern was ethical concerns regarding anonymity of participants), lack of confidence and isolation (Johnson and Clarke 2003). Other emotional negative effects found are desensitisation, researcher

vulnerability, and exhaustion (Dickson-Swift et al 2007 and Sherry 2013). Various researchers suggest peer support can help the researcher when researching sensitive issues (Dickson-Swift et al 2008, Dickson-Swift et al 2009, Kumar and Cavallaro 2018, Haugstvedt 2020), however as a PhD researcher, unfortunately, I felt very isolated from my peers. I did not know any other PhD researchers in my own faculty well enough to speak to about this and the COVID-19 pandemic stopped any peer relationship building as PhD events and training were cancelled.

My research journal was an essential tool (Johnson 2009), and I used mine regularly throughout my research with an emphasis on acknowledging how I felt after interviewing participants which is discussed in more depth later in this chapter. Having regular supervision is also suggested as a strategy when researching a sensitive research area (Dickson-Swift et al 2008) and I met with my supervisors at least monthly, as being able to talk to others to debrief supports the researcher and data quality (Ellsberg and Heiss 2002).

4.6.2 Researching Prior Life Trauma

Participants experiences *“may evoke strong reactions from the researcher because it reminds the researcher of their own personal experiences or they empathise with the participants story”* (Dickson- Swift et al 2009:65), yet, as also concluded by Kumar and Cavallaro (2018) I found hardly any literature within this area. The incentive for this research project was my prior working experiences and I can relate to the above statement by Dickson-Swift et al (2009). I had decided to carry on working in the sector whilst undertaking the PhD, to keep myself informed of changing policies. However, this was a double-edged sword; participants were informing me of events that were similar or were distressing me in my own working life. This made me feel despondent, cynical, and agitated about the sector overall. I questioned the point of this research project and whether there would ever be improvements in policies to support service users and the staff who support them. I procrastinated over analysis and writing up the research findings as the data I had collected made me feel anxious, this was like the experience of Kumar who had difficulties transcribing her data due to the negative emotional response she had whilst transcribing (Kumar and Cavallaro 2018). I was completely taken aback by my emotional response to the project. To protect myself and ensure I wasn’t reflecting my own experiences on the data I

had therapy sessions; there is a growing awareness amongst qualitative researchers that this support may be needed (Ellsberg and Heiss 2002, Dickson-Swift et al 2009). The therapy helped me understand my reactions and made me more comfortable in proceeding with the project.

4.6.3 Experiencing Traumatic Life Events During Research

Whilst at work I found the body of a service user who had died by suicide. The circumstances were very distressing. I had disturbed sleep for a period and found it hard to concentrate on the research project. I questioned myself deeply about whether I could have personally prevented the death, had I missed something etc. It felt too raw to be writing about frontline workers distress when I was distressed myself, and it took several weeks before I began research work again. I felt guilty and worried about missing deadlines, yet knew I needed to take a break from the work to process this experience. Similarly, using an autoethnographic approach Sherry (2013) reflected on her research study with participants who were experiencing homelessness, substance addictions and mental illness and recognised the pressures and challenges her research raised such as feeling vulnerable, being reflective and emotional exhaustion. For Sherry, this came to the forefront after a death of a participant and other participants' mental health crises, and she questioned her ability to continue with her research project.

Working in frontline services through most of the COVID-19 pandemic was worrying, particularly at the early outbreak of the disease, as early indications suggested the disease was deadly and extremely contagious. This was concerning due to the poor health of many service users, and the fear of infecting my own family if I contacted the virus through work.

4.6.4 Unexpected Events

I was unprepared for my emotional response to the participants experience and it was difficult to prepare for the emotionally unknown (Kumar and Cavallaro 2018). Throughout my working life I have worked with people in difficult and sensitive situations and believed my emotional resilience to be strong. When looking back at the ethics application, the section regarding researcher welfare mainly concentrated on physical protection and I had stated the *"risk of emotional distress to myself is low"*. However retrospectively, I believe a

combination of factors caused me to burnout. Dickson-Swift et al (2006) found that when researching stress in researchers, some participants explained that they felt stress due to being emotionally exhausted, similarly my work became more difficult during the pandemic due to service and system constraints. I frequently witnessed service users in severe distress which took its toll on me emotionally.

4.7 Sampling Decisions Pre and Post Covid-19

Sampling decisions are a fundamental part of the research process and can be complicated in qualitative research (Tuckett 2004). Within qualitative research the chosen methodological inquiry and the research area influences sampling decisions (Higginbottom 2004); the rationale behind sampling decisions is often missed in research studies (Meyrick 2006) and needs to be discussed to add to the research quality. Grounded theory methodology, and the use of interviews and documents as data, mean that sampling decisions are a critical element of this research design, yet most grounded theorists are ambivalent about this process (Gentles et al 2015). Sampling is “*where to go to obtain the data*” (Strauss and Corbin 1998: 201). To get the best possible data within a grounded theory study, the ideal participant is an expert within the research area (Morse 2000).

Although there are many professions that support people experiencing rough sleeping and mental illness, the participants in this study worked in roles which meant their job was wholly to give direct support to this demographic. They were chosen as participants as it was felt that they would be best able to answer the research question due to the job role criteria and the direct experiences they would have due to this. This allowed for intensive interviewing where participants perspectives are studied (Charmaz 2014). They worked for organisations such as the NHS, the local authority, charity and third sector organisations. All of the participants had worked in the sector for a number of years.

There needed to be a starting point to begin the study (Charmaz 2014), therefore participants were initially purposefully sampled to ensure expertise in the research area, with the option of snowball sampling if needed (Biernaki and Waldorf 1981). Purposeful sampling allows for locating “*information rich cases*” (Patton 1990:103); in grounded theory purposeful sampling is also known as theoretical sampling and is used to choose research participants according to the research and emerging theory needs (Tuckett 2004).

- Staff participants were approached by a senior member of their team about taking part and were given a Participant information Sheet (PIS) (Appendix one), if they were interested in taking part, for further detailed information and to contact myself if they had any questions or agreed to participate.
- Key informant participants were approached either in person or by email, and if they were interested in taking a part key informant participant information sheet (PIS) (Appendix 2) was sent to them by email or given in person providing further information. Potential participants then contacted me if they wanted more information and/or to arrange an interview.

As discussed above, three staff participants were interviewed prior to lockdown. After the outbreak of COVID 19 seven key informant participants were interviewed. Some of participants, who were interviewed both pre and post COVID-19, agreed to be reinterviewed and were consulted at a later stage about emerging codes and developing theory.

4.7.1 Participants Demographics

To protect the anonymity of the participants they were given a pseudonym (Table 15). Some of the participants only agreed to participate in the research on the basis they were anonymised, as they felt they may disclose information controversial to the organisations they worked for. Othman and Hamid (2018:737): concur that *“carelessness in qualitative research could result in disclosing the identity of the respondent may lead to mistrust”* and I took very seriously the trust the participants gave me in taking part in the interviews. I also kept their demographic brief for the same reason (Table 15). The aim was to interview thirty participants however, the outbreak of COVID-19 severely hampered this aim. Ten participants were recruited. To help construct the emerging theory four participants were interviewed twice and another was interviewed three times. I had informal chats with “sources” that worked in the sector. I shared components of the developing theory with these workers, along with those formally recruited. Although some, including Charmaz, may be critical that the sample size was small (Charmaz and Keller 2016). Cleary, Horsfall and Hayter (2014) argue that credible research results can be achieved if a study with a smaller number of participants have in-depth knowledge of the research subject. I was confident that this was the case as all but one of the participants had worked in frontline services for

15 years plus and were very experienced frontline workers. Morse (2007) supports that if data quality is good, less interviews and participants are needed during the research process. This is discussed later in more detail in regard to data saturation and theory generation.

4.8 Data Collection

Three main methods used for collecting qualitative data are focus groups, observations, and interviews (Kuada 2012) and interviews are the most used data in qualitative research (Edwards and Holland 2013). Grounded theory allows for a range of methods of data collection, including documentary and video data (Corbin 2017). Focus groups and observations for data collection were discounted for practical and ethical reasons. Focus groups were disregarded due to the sensitive subject matter to be explored as Naylor et al (2014) point out, the main disadvantages to focus groups are that participants may acquiesce to the conversation of the group and therefore not demonstrate a different point of view and conversations may be taken over by certain participants. Using observation as a way of collecting data was also rejected due to the practicalities of carrying this out in the field. Mulhall (2003) identified several problem areas with observation as an insider researcher, including questioning does an insider researcher observe things that are part of their work culture, is the insider researcher taking advantage of colleagues that work in the sector and how does becoming a researcher rather than a worker affect the relationship between colleagues and service users. Observational data may have a greater amount of subjectivity when interpreting it, compared to interview data (Mulhall 2003), and due to my current and past working history, despite using reflexivity, I was concerned about how my potential biases may have impacted interpreting observation data.

Semi-structured interviews were chosen as the primary data source for this research project. Three staff participant interviews were undertaken face-to-face in a private place that was familiar to the participant, however after ethical amendment, due to the national lockdown, one staff participant originally interviewed face-to-face agreed to a reinterview by telephone to discuss emerging codes and theory development. The rest of the interviews with key informant participants took place over the telephone.

Prior to beginning every interview, both face-to-face and on the telephone, I went through and reiterated every point on the consent form. For interviews that took place before lockdown participants staff participants signed their consent immediately before the interview began on (Appendix three) for telephone interviews key informant participants either had signed the consent form (Appendix four) and sent it back to me prior to interview or I signed the sheet on the participants behalf immediately before the interview began after I had re-explained the points on the form and they had consented to take part. The sheet was clearly marked with permission provided (PP) to indicate that this had occurred. Similar to findings in other research, the interviews that took place over the telephone were shorter than those that took place face-to-face (Irvine 2011). On average, the face-to-face interviews lasted an hour whereas telephone interviews and follow up interviews were shorter from 30 minutes to around 45 minutes.

4.8.1. Interviews

Interviews are a common method for data collection within qualitative research (Gill et al 2008). The aim of an interview is to “*explore, the views, experiences, beliefs and or motivations of individuals on specific matters*” which allows for greater insight into the phenomena being researched (Gill et al 2008: 292). It is an adaptable technique, and this data collection method allows the researcher to understand participants experiences (Galletta 2013, Foley et al 2021), and are a particularly appropriate method of data collection when discussing sensitive subjects with vulnerable participants (Hutchinson, Wilson and Wilson 1994). The nature of qualitative research allows for the researcher to recognise processes both overt and implied (Charmaz and Thornberg 2021) and due to the interview process, I was able to recognise the significance of what was being discussed by body language, voice tone and pauses in conversation. Interviews generate data that would not be possible from other data collection methods, and they allow the flexibility to be combined with other data sources (McIntosh and Morse 2015). They are also a common method of data collection when the researcher is undertaking research in areas they know well in a personal or professional capacity (Baumbusch 2010). Interviews allow for the researcher to become a collaborator and activist for the area being researched (Fontana and Frey 2008). As pointed out above, interviewing is frequently used as a method of data collection within grounded theory. However, different philosophical viewpoints, within

grounded theory, view interviewing differently; for traditional grounded theory the aim is to uncover meaning, whereas within constructivist grounded theory meaning is co-constructed with the participants in the study (Glaser and Strauss 1967, Charmaz 2014, Foley et al 2021). Interviewing is a valuable tool in collecting data for a constructivist grounded theory study, due to the researcher being able to see and comprehend the participants reactions to the questions (Charmaz 2014, Saarrijarvi and Bratt 2021). Conducting interviews over a length of time allows participants to completely reveal their viewpoints (Butterfield 2009), however critics of interviews claim that people do not demonstrate authenticity and do not truly reveal themselves within this process (Charmaz 2014). Participants may construct themselves in a variety of ways such as *“heroes, victims, survivors, successes or failures”* due to feeling exposed by the interview process and feeling the need to explain their behaviours (Whitaker and Atkinson 2019:623). I was conscious that at times some of the participants were in conflict of revealing too much due as they were fearful of reprisal from their employing organisations. Whitaker and Atkinson (2019) advice is not to overexaggerate the importance of findings from the interview process, yet to still understand that a conversation is an encounter with the social world. This was kept in mind when analysing data and using co-construction with participants throughout the research process ensured the importance of interview data was not overstated, which adds to the credibility and truthfulness of the research findings.

Along with theoretical justification, the research method needs to be viable for the researcher, with constraints including *“time, labour, power and money”* (McNeil and Chapman 2005:24) and all four of these constraints were considered when the data collection method was chosen. As a PHD researcher I did not have a large budget or a research team to realistically consider many other data collection techniques. The research had to be completed in the timescale of a typical PhD research project and therefore taking all of the above into account interviews were ultimately decided as the best method of data collection for this research project.

There are three main interview types, 1) Structured, 2) Semi-structured and 3) unstructured (Crano, Brewer and Lac 2015). In structured interviews each participant is asked the same questions and are fundamentally a vocal questionnaire, which means they are not

appropriate when detailed knowledge of the research area is required (Taylor, Bogdan and De Vault 2016, Gill et al 2008). In unstructured interviews there are no set questions the researcher asks and these often take a lot of time to conduct due to their unorganised nature (Gill et al 2008). Semi-structured interviews were chosen as they are flexible in their approach (Edwards and Holland 2013, Gill et al 2008) and they are theoretically appropriate for grounded theory (Salazar, Crosby and DiClemente 2015, Denscombe 2016). They are commonly used in healthcare research as they give participants direction when answering questions (Gill et al 2008). They can be used in an empathetic and political way to enhance people's lives (McIntosh and Morse 2015). A semi-structured interview allows for *"both open ended and more theoretically driven questions, eliciting data grounded in the experience of the participant"* (Galletta 2013:45). As a caveat, Adams (2015) states that for a semi-structured interview to be successful the researcher needs to be familiar with the subject matter and I felt comfortable with the subject matter due to my working history. Questions asked were open-ended which allowed for the participants to fully recount their experiences as they saw fit; they allowed participants to discuss information that may not have previously been seen as important to the researcher and they also enabled them to describe their own life experiences (Galletta 2013, Gill et al 2008, Creswell and Creswell 2018). This allows the researcher and participants to be receptive to developing themes (Jackson II, Drummond and Camara 2007). Charmaz (2014: 73) believes that, if the researcher is an *"interested learner"*, this allows the participants to convey their own expertise in their own life and as such I attempted to take this position throughout the interview process. Language is an important part of a grounded theory interview (Charmaz 2006) and due to my working history, I was aware of and could use the participants *"work"* language confidently.

I have interviewed patients and service users throughout my career for a range of purposes, to gain information from them to enable me to advocate on their behalf so I was comfortable with the interview process. However, I had only conducted interviews for research purposes during my undergraduate degree. To improve my interviewing skills as a researcher, I attended training by the Social Research Association on Interviewing for Qualitative Research. Attendance at this training was useful as it gave me confidence to interview people in the role of a researcher rather than a frontline worker.

4.8.2 Telephone Interviews

For qualitative researchers all over the world, there were specific challenges faced after the COVID-19 pandemic began, such as needing to respond to public health guidelines and collect data whilst socially distancing, and at the same time keeping research rigour (Lobe, Morgan and Hoffman 2020, Roberts, Pavlakis and Richards 2021, Renosa et al 2021). As mentioned above, my research design changed after the pandemic, to comply with the UK public health guidance of social distancing. Several ways of using remote tools were considered before applying for an ethical amendment. One choice was to use online video calling to interview participants. However, I was concerned about how data-secure some of these software programmes were and the ease in which some participants may be able to access a computer and have the software to take part. Anecdotally, I was aware of services being taken by surprise by lockdown and that staff working from home had little or no information technology to support them.

There is growing literature discussing telephone interviews for research purposes. Historically telephone interviews were regularly dismissed by researchers as a poor way to collect data (Crano, Brewer and Lac 2015) as it is harder to build understanding with the participant via telephone. Interviewers were also disadvantaged as they could not collect non-verbal forms of communication when interviewing this way (Naylor et al 2014), such as *“facial expressions, body language and other non-verbal signs are not observed”* (Saarrijarvi and Bratt 2021:393). Research demonstrates that telephone interviews are shorter in length than face-to-face, with the concerns that this negatively impacts on data collection quality (Irvine 2011). However, a literature review by Novick (2008), about using telephones as a tool within qualitative research, concluded that there is little data which suggests that telephone interviews create poorer findings. In examining participants experiences of being interviewed by telephone for a grounded theory study, Ward, Gott and Hoare (2015:2782) concluded the participants found this method of data collection positive, with the telephone being deemed as *“user-friendly”*. Telephone interviews are also viewed as suitable when discussing sensitive subjects, as they give the participants privacy (Block and Erskine 2012).

However, I found several disadvantages to this method of data collection. Practically, for me this meant I could not observe if someone was uncomfortable with my questioning, which would then have enabled me to try and put them at ease. I found it easier to build a rapport when I carried out the earlier face-to-face interviews. The telephone interviews felt more formal and as previous research has demonstrated, they were shorter than the face-to-face ones. All the participants who were interviewed by telephone used a mobile phone and for a couple of the interviews the phone signal was poor, I lost connection on the calls and had to call the participant back. This impacted on the flow of conversation. One participant was looking after children at the time of the interview and there were constant interruptions. I offered to rearrange the interview which was declined. This participant was very distracted throughout the interview process and ultimately this was the shortest interview that took place. I felt the interview was rushed and the data collected was poor, compared to the other interviews that had taken place. A study by Azad et al (2021) found that researchers using a mobile telephone to interview had concerns about the reliability of the technology being used and the researcher losing power to control the interview; particularly regarding the participant having autonomy about where they would like to be when interviewed and possibly having distractions in their surroundings.

4.8.3. The Interview Schedule

The use of interview schedule in constructivist grounded theory is flexible, however, Charmaz (2015) suggests using a schedule to prompt the researcher to use open-ended questions. McIntosh and Morse (2015) stress the importance of crafting the questions to allow the participants to answer freely. An interview schedule was initially crafted for staff and patients prior to Covid 19 (Appendix 5 and 9). As discussed above, people who had current lived experience of rough sleeping took part in a PPI exercise to develop the interview schedule for patient and staff participants. The informants read through the semi-structured research questions that I planned to use for staff and patient participants. Discussions took place with me and two small groups of five informants as to whether the questions were clear, did they need re-wording and did the informants feel that there were other areas in the context of the research that needed exploring. No informant felt that the questions needed to be reworded. Several informants felt that the issues of debt, whilst waiting for a benefit payment, should be explored, along with issues around "Priority Need"

and “Local Connection” which are terms used in part seven of the Housing Act (1996) and may affect what support homeless people receive. The initial interview schedule for patient participants (Appendix 9) was amended to add a question about managing financially when claiming benefits, however it was decided, after discussions with all informants, that the question about the experience of approaching the local authority for housing assistance would initially suffice to explore priority need and local connection.

The staff interview schedule was used for the first three interviews, pre COVID-19. During the initial lockdown of Covid-19 I undertook documentary analysis which is discussed in greater detail below and used the documents shown in (Appendix 6) to inform the questions for Key Informant participants who were added as a participant group after the pandemic. The modified interview schedule (Appendix 7) allowed for exploration of the emerging perceptions and understandings of participants experiences of working through the COVID-19 pandemic and the ‘Everyone In’ initiative (Foley et al 2021).

As the interviews were semi-structured the interview schedule was flexible, and questions were frequently modified which was in keeping with theoretical sampling.

For example, one of my participants spoke about how the public have taken on roles that traditionally would have been delivered by local government.

“So, you will get lots of the public now which I see, never used to see it before, you know I’m going on just a couple of years ago, I never used to see so many people in town or anything that are giving the homeless food or drinks, hot drinks, you know I feel like it’s... is the right word publicised? I don’t know is that the right word”?

I then questioned the next participant about this.

“One of the other things that has come up through previous interviews is that participants feel that the public have taken over things that some agencies have dealt with in the past, how do you feel about that”?

After every interview, and as suggested by Adams (2015), I spent time reviewing the interview and questions to see what was successful and what wasn’t. I also noted responses

and gaps in knowledge from the participants that I felt needed to be explored further (Charmaz 2014). As data analysis progressed and emerging codes developed another interview schedule (Appendix 8) was developed for re-interviewing participants. This schedule was used to clarify focused codes and the emerging theory. The schedule for further interviews, 12 to 16, was very open and informal, as the aim of these interviews was to confirm the constructed theory with participants.

Participants gave permission for the interviews to be recorded on an audio recording device and they were transcribed verbatim, which ensured that the transcription was accurate and “*thus increasing reliability of the data*” (Othman and Hamid 2018: 736). There were issues around general data protection regulations that needed to be considered due to recording participants; these are discussed in detail later within this chapter. Identifying information was removed from the data transcriptions. Data collection and storage was in line with general data protection regulation legislation. As soon as the interview was finished, I made notes in my research diary, typically this would explain how I felt, if something significant had occurred during the research process and/or participants interviews, and any emerging codes. This was very useful when coding data as it helped me to remember specific details that would not have been captured on my transcription sheets.

4.8.4 Documentary Analysis

Documents offer rich data source (Charmaz 2014). Different types of data can be analysed using grounded theory (Stern 2007), Glaser (1978:6) contends “*it transcends specific data collection*”. Harris (2015:36) supports that “*anything goes*” when deciding what to use and different methods can be chosen as the research progresses. They have traditionally not been used within qualitative research (Merriam 2009); however, their usage is increasing (Bowen 2009). Documentary analysis can be implemented in various ways during the research project, from the research design to answering the research question (Dalglish, Khalid and McMahon 2020). I used documentary analysis in two different ways, extant documents (in which I had no part in their construction) that were in the public domain for the first public lockdown due to COVID-19, were analysed as a supplementary form of data (Charmaz 2014). These included newspaper articles, grey literature, and government reports. All documents were found online. Documentary analysis needs to be an “*iterative*

process of selection, reading and capture” (Gorsky and Mold 2020: 90). There were 73 documents initially collected and these were split into themes (Table 4.1). At this stage, 59 articles were discounted as they were no longer relevant and/or were not pertinent to the research question. Policy was changing rapidly during this time due to the continually developing pandemic situation with existing policies becoming quickly obsolete and new policy put in place (Bragazzi 2020). At the time of collecting the documents, due to the uncertainty around the COVID-19 pandemic, it was unclear if the documents would be useful as part of the overall research findings and after receiving ethical amendment for the new participant group of key informants, it was decided that the documents analysed would mainly inform the initial interview questions that would be asked of this participant group (Appendix 7). However, after interview data analysis the document analysis was used to support research findings and complement the theory development. There are limitations to using documentary evidence such as the document being incompatible and being written in a way that is not useful for research purposes, however as the research began in an inductive way the document analysis was useable (Merriam 2009).

Fourteen documents shown in Appendix 6, were used to inform the key informant participants initial questions about the impact of COVID-19 on homeless service provision (Appendix 7). Two of the documents shown in Appendix 6 were also used as discussion in the research findings which were referenced in the usual manner.

Table 4.1: Documentary Analysis: Initial Documents

number of documents initially chosen	73
homelessness and COVID-19	29
mental health and COVID-19	28
DWP and COVID-19	16
Total number of articles chosen and analysed	14

4.8.5 Research credibility and trustworthiness

Credibility can be sought in a variety of ways, including the credibility of the researcher (Patton 1999). I have been explicit about my working history and knowledge in the area. I

have also noted my own background and how this may have affected my positionality as a researcher. Byrne (2001) suggests that researchers can be credible by highlighting their own connection between the research area and the participants, throughout this thesis I have been explicit about this. Interviewing the same person more than once and involving the participants for longer periods of time, is another way to aid credibility (Erlandson 1993, Connelly 2016). The nature of constructivist grounded theory meant that participants were involved in constructing the findings, and several participants were interviewed more than once to co-create the final explanatory theory. Erlandson (1993) suggests that credibility should be sought from the research participants, and this was done by involving them to co-create the explanatory theory. I also received feedback from “sources” in the sector on the emerging and final explanatory theory.

Another method to aid credibility is confirmability in which Byrne (2001) suggests the use of an audit trail. Throughout the research process I used a research diary and used memos to capture my thoughts and feelings about the research project and I had regular meetings with my PhD supervisors. Constructivist grounded theory allows researchers to be explicit and methodical about their learning (Charmaz and Thornberg 2021). Data sheets were kept which demonstrated how the data was coded and analysed. Charmaz (2014) suggests that reflexivity is paramount in a constructivist grounded theory study, and my reflexivity is discussed at length and threaded throughout the thesis.

Building trust within qualitative research is crucial (Stahl and King 2020). Trustworthiness or rigour of research are terms often used interchangeably (Connelly 2016). Lincoln and Guba (1985) believe that credibility, transferability, dependability and confirmability are used to assess trustworthiness of research; the most important part of trustworthiness is transparency in the methodology and methods used (Adler 2022). Another example of trustworthiness is being able to demonstrate that you have carried out research in keeping with your chosen methodology (Connelly 2016). Throughout this thesis I have attempted to be transparent with my methods and draw attention to my thoughts, feelings, philosophical positioning and decision-making processes.

PPI in research is an established process within the UK (Biddle, Gibson and Evans 2016). Its purpose is to ensure research is “with” participants rather than ‘about’ them and can be used throughout different stages of the research process (Hayes, Buckland and Tarpey 2012:6). As stated previously, people who were experiencing rough sleeping were involved in developing the semi structured interview questions. This supported the value of the research purpose as it ensured that the questions asked were of importance to the people experiencing rough sleeping and that their voices contributed to this research project (Hayes, Buckland and Tarpey 2012).

To aid trustworthiness in grounded theory research it is important to show how data saturation was achieved (Aldiabat and Le Navenec 2018). The researcher judges when data saturation has been achieved (Wiener 2007), however, a literature review by Francis et al (2010) found that researchers did not explain in enough detail how data saturation had been achieved. There are several factors that Aldiabat and Le Navenec (2018: 249-251) found to facilitate data saturation in grounded theory. These are:

- *“Simple versus complex research question.”*

Although my overall research question was broad, my participants were all extremely experienced and the concept of austerity and welfare reform affecting their working practices was not new to them which aided confidence in data saturation as smaller research projects with moderate claims may be able to saturate early (Charmaz 2014).

- *“The Researchers Experience with Qualitative Methods”.*

I am a novice researcher but had used qualitative research methods in my undergraduate degree and for work. I also had regular guidance from my PhD supervisors who are experts in using qualitative methods, including grounded theory. As the research project progressed, I became more confident in the methods and was confident that the study had saturated.

- *“Using Triangulation of Data collection Methods”.*

Along with semi-structured interviews, this research was informed by documentary analysis that was carried out during the first lockdown in the COVID-19 pandemic. The themes found in this analysis assisted in developing the initial semi-structured interview

schedule for the key informant participants. Two articles supported data findings and the development of the explanatory theory co-constructed with participants.

- *“Understanding the philosophical underpinnings of the Research Method”.*

As a PhD student I spent a lot of time researching ontological and epistemological positioning and on the philosophical underpinnings of constructivist grounded theory. My supervisor was an expert in grounded theory methodologies, and we discussed a range of issues as they arose concerning the philosophical underpinnings of the research.

- *“Researchers familiarity with using a guiding theoretical framework”.*

There are criticisms that grounded theorists do not follow specific frameworks and within this study I read and re read Charmaz framework for constructivist grounded study prior, during and after data collection.

- *“Use of sensitizing concepts in grounded theory research”*

Charmaz (2014) claims that sensitising concepts are researchers’ ideas that can be liberally applied when looking at a research study and are ideas to begin the study and not finish it. Due to my working history, I had various concepts that I wanted to explore during data collection, however similarly to Charmaz (2014) these concepts allowed the research to develop which assisted in saturating the data.

4.9. Data Analysis

To aid credibility in grounded theory research it is important to demonstrate how methodical and complete the research is (Charmaz and Thornberg 2021). In the next few sections of this chapter how data was analysed and coded is discussed. As demonstrated above, typically within grounded theory, data collection and analysis occur simultaneously, so interview questions can be altered as concepts and theory begin to appear (Foley et al 2021).

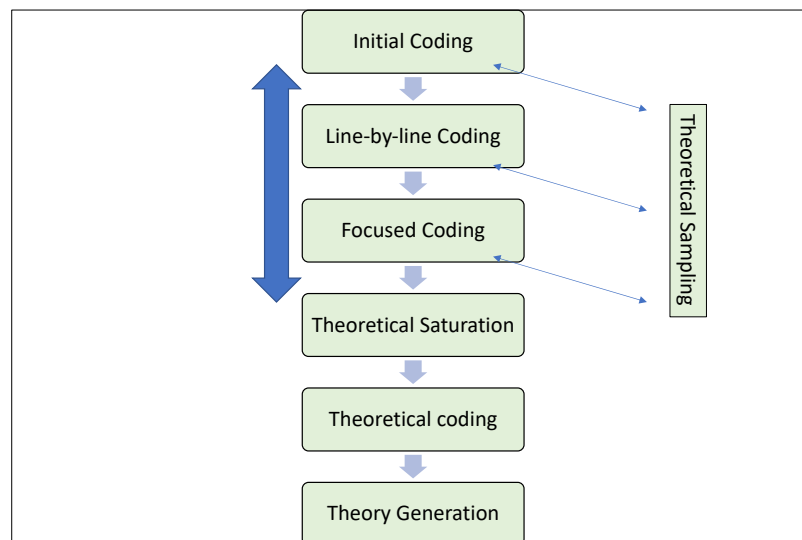
As discussed above, I began to think about and provisionally analyse the data as the interviews were taking place and took notes to highlight where I felt the participant had

discussed something I felt was important. Immediately after the interview (or as soon as possible) I made notes in my research diary about the interview and used this information to assist whilst analysing. This was in keeping with the principle that within qualitative research early analysis of data begins concurrently at the time of data collection (Weckesser and Denny 2022). Continually analysing data is common amongst qualitative researchers as *“it is impossible to not start thinking about what is seen and overheard”* (Pope, Ziebland and Mays 2000:114).

The interviews were transcribed by me for two main reasons, firstly to ensure immersion in the data collected in keeping with Charmaz’s (2014: 120) advice, to *“stay close to the data”*. Secondly, for ethical reasons Othman and Hamid (2018) describe how they did not use a transcription service when conducting a sensitive research project, to prevent another person handling the data. They deleted audio recordings as soon as the interview was transcribed to ensure confidentiality of the data and I repeated this action in my own research. For most interviews transcription was undertaken immediately, whilst the interview was fresh in my mind. However, it was not always possible to do this throughout the process due to time constraints. Transcribing was a time-consuming process, particularly when trying to ensure that recordings had been transcribed perfectly. The recordings were listened to at least three times during transcribing to ensure nothing was missed and at the same time early analysis, which had started during the interviews, continued. Re-listening to the interview several times whilst transcribing helped my analysis and I became aware of potential themes that I hadn’t considered during the interviews.

After provisional analysis of the data, during and immediately after the interview had taken place, data was further analysed using techniques that are typical in a constructivist grounded theory study (Charmaz 2014). This is demonstrated in Figure 1 below, and each area is discussed in further detail.

Figure 1: Data analysis of this research project



4.9.1 Initial and Line-by-Line Coding

The primary analytic strategy with grounded theory is coding, which is an exploratory research method to view and define data (Charmaz 2017b). The term coding originated from quantitative social research, where each code is data that is established in advance (Kelle 2007), however, within grounded theory, codes come from the data (Glaser and Strauss 1967) and the codes are comparatively analysed. Throughout the coding process, within constructivist grounded theory, the role of the researcher is acknowledged and the relationship between participants and researcher affects what the researcher understands when the data is analysed (Mulugeta et al 2017). To aid reflexivity, and also due to my insider positioning, codes were discussed with my supervisors to ensure that any biases in interpreting results were minimised to aid the trustworthiness and research credibility.

There is various literature on how to code when using grounded theory methodology, often with different styles (Holton 2007). However, the main stages of coding within constructivist grounded theory are initial and focused coding (Regier 2018). As a novice researcher, and new to grounded theory, my aim was to be methodical when coding. This involved repeatedly reading through interview transcripts looking for similar codes (Denscombe 2016). In the earlier interviews (interviews 1-3) the data was split into the main codes discussed during interview, which were homelessness, mental health, the DWP, housing. These codes were split into two further sections, issues affecting the patient, and issues

affecting staff. I used a system of splitting the page into three to enable points raised about each theme in the interviews to be side by side (Table 4.2). This gave me a visual way of looking at the data and to begin to understand potential codes and a way to compare them easily. Coding was not a linear process (Charmaz 2014) and at times initial coding was taking place alongside developing focused codes, due to collecting and analysing data simultaneously.

Table 4.2: Early coding on experiences of staff supporting their service users with the DWP

The DWP	No 1 Mary	No 2 Lei	No 3 Keira
Issues for Patients	Hounding and pressuring people, suffering in silence, ESA OK, PIP difficult turbulence from experience	Low Amount of benefit No issues with UC, Harder to get PIP with MH illness, PIP process inducing anxiety	Getting Sanctioned, All S/U have UC or PIP issues, needs to be an easier way to challenge

I attempted to follow Charmaz (2014) advice and use ‘action’ words, whilst developing codes, however I was not always successful with this approach. I found initial coding difficult to begin with, but it became easier as the research progressed, and I began to recognise similar codes in the data. Below is an example (Table 4.3) of initial coding from an early interview about how a participant viewed the Department of Work and Pensions’ approaches to mentally ill rough sleepers.

Table 4.3 Example of initial coding

Initial code	Excerpt of Interview Transcription.
Being pressurised and pestered relentlessly.	Participant: You know because it starts with like, now it’s the opposite, the job centres are hounding people and pressurising people and they have actually made it more difficult for some people with mental health problems, they’ve actually stopped people because they are saying unemployment has come down and benefits because yeah but some of these people are suffering in silence and they are probably not claiming the benefits they are entitled too, because there’s a kind of, because there are too many obstacles put
Obstacles/detriment for people with a mental illness	
Mental health patients bearing the brunt/false figures.	
Oppression	

Social excluded from benefit system	up against them, They can't challenge, they've got no one to support them yeah and thing like that. Do you know what I mean?
Insufficient system	
Isolation, Oppression	

After I had completed initial coding, I was left with many codes (Table 4.4).

Table 4.4: Initial codes after data transcription

Diagnosis	Past trauma
Schooling	Benefit trap
Harassment	Uncaring DWP Staff
Receiving Payment	Poverty
Suffering	Sanctions
Struggle to be awarded disability benefit	Too many obstacles
Waiting	Detrimental effect on mental health
Loss of autonomy	Lack of resources
Harder now	Squeezed services
Poor service capacity	Third sector costs
Justifying	Need for preventative services
False persona	Don't want to know
Lack of Mental Health Awareness	Protecting budgets
Hidden services	Location
Set up to fail	Navigating a rigid system/service
Effort	Oppression
Workplace trauma	Language used: "push and dump"

Comparative analysis began after initial coding of the first interview transcription and compared to codes generated from subsequent interviews, therefore data was being collected from further interviews and analysed concurrently. I spent time immersing myself in the data and a table was created after the third interview (discussed in more detail below) that assisted in capturing initial and focused codes.

After the initial coding stage, I used line-by-line coding. This should involve “*attributing words or sentences of data to a heading or code that represents what the data grouped under that code have in common*” (Harris 2015:37); the initial codes may be descriptive words (Denscombe 2016). Initial/line-by-line coding assists the researcher to progress their research analytically (Charmaz and Keller 2016). The process is to view “*actions in each segment of the data rather than applying pre-existed categories*” and use action words to code, whilst keeping the codes open-ended (Charmaz 2014: 116). Ultimately the point of line-by-line coding is to assist the researcher to understand the participants worldview (Charmaz and Thornberg 2021).

4.9.2 Focused Coding

Once codes have come together and important codes have been identified line-by-line coding can cease, and focused coding can begin (Charmaz and Thornberg 2021). Focused codes therefore build upon initial codes. Within constructivist grounded theory focused codes are the ones that appear the most and are important to theoretically coding forthcoming data (Reiger 2018). Ultimately these codes are ‘*key components*’ and ‘*the most significant categories*’ revealed during the initial coding phase (Denscombe 2016:117), I used these codes to begin forming categories. This stage is an important part of grounded theory as it allows the researcher to develop the research analytically and begin to answer the research question yet keeping a grip on the data (Charmaz and Thornberg 2021). Charmaz (2014) is clear that during focused coding the researcher should be concentrating on the initial codes, their meaning and how they are compared. At the time of focused coding, I was analysing large amounts of data, however I continued using a table to capture the codes in order to be methodical in analysis. Focused coding assisted with theoretical saturation where, if gaps in knowledge were identified, interview questions could be modified as appropriate. Theoretical saturation is discussed in more detail later within this chapter.

Box 5 below is an example of how focused codes were generated using data with a participant discussing a high demand for service provision.

Box 5: Example of focused codes

Focused Codes	Excerpt of interview transcription
Workplace trauma Rose tinted glasses Stretched service Doing what you can	Participant: You get, you just get a little bit stressed, I think, so you know and there is such a high turnover of people that you don't feel like you are doing quality of work, like I used to do a lot more work previously when, before covid, I think there is a big turnover of people now so erm you don't get to do quality work with them like that you used to be able to.

After all the interviews were completed and analysed (Table 4.5) below captures all the focused codes generated.

Table 4.5: Focused codes

Invisible services	Impossible systems
Who is difficult to engage with?	Caught between systems
Passing the buck	Fractured services
Access denied	Squeezed and stretched services,
Doing more for less	The Law
Post code lottery	Turning people away
No options	Doing what you can
Rose tinted glasses	Survival game
Digitally excluded	A long process
Hounded	Pooping it
Suffering in silence	No Chance
Everyone in	Taking it out on us
Get on and deal with it	Fighting
Future fear	Knocking head against a brick wall

The focused codes were crucial to developing a core category and establishing connections between the categories (Chun Tie, Birks and Francis 2019). Some of the initial and focused codes were discounted if they were random or did not fit into the emerging core category.

4.9.3 Theoretical Sampling

The term theoretical sampling emerged with the creation of grounded theory and is a core component of this methodology (Coyne 1997, Higgonbottom 2004). This sampling style, and how it is used, is commonly depicted poorly amongst grounded theorists (Gentles et al 2015). Within constructivist grounded theory theoretical sampling “*guides you where you go*” and encompasses “*starting with data, constructing tentative ideas about the data and then examining these ideas through empirical inquiry*” (Charmaz 2014: 197-199). The objective of this sampling style is to link categories with the burgeoning theory (Gentles et al: 2015) with an “*increased depth of focus*”, which means there will be reduced themes for the researcher to focus on whilst analysing data (Denscombe 2016: 115). Data sources were not changed during theoretical sampling for three main reasons, COVID-19, ethical approvals and getting permission from organisational gatekeepers. For example, I would have liked to have interviewed a social worker about assessing someone who is experiencing homelessness under the Care Act, however due to COVID-19 there was increasing pressures on adult social care and most workers were home based, so my access to this data source was limited.

Theoretical sampling was used in this study to modify interview questions to enable a deeper understanding of emerging codes and categories and was used from the initial interview to the final interview. When taking consent participants were asked if they agreed to be reinterviewed at a later stage in the research process to answer further questions, this allowed the core category and subsequent categories to be narrowed down allowing a deeper understanding of the developing theory.

4.9.4 Theoretical Saturation

To assist with theoretical saturation a table (Table 4.6) was developed which was split into four parts. The sections were 1) categories, 2) initial codes, 3) focused codes 4) data extracts (Table 13). This table was used as a visual tool that allowed me to conceptualise the data, focus on specific data and link it to theory. It was also useful in determining data saturation where there was no more emerging data to advance a category. Interviews one to five were used to construct the table initially. As stated, above data collection and analysis was concurrent and therefore subsequent interviews were added after the data was transcribed

and initial and focused coding had been completed. The table was also a useful tool to assist in theoretical sampling and modifying interview questions around developing theory.

Table 4.6 Example of a section of a data table used to conceptualise and link data

Categories	Initial code	Focused Code	Data extract
Austerity	Lack of resources	Squeezed services	<p>...hostel beds have been cut dramatically due to government cutbacks and funding, so it's the system being squeezed both ends you've got a person who is homeless and mentally ill, you know it's difficult, it's a battle to get them into hotels a lot of the time and also into mental health services. (3, line 134-136).</p> <p>...what's getting harder for our services, is all the cutting down, they are closing down all these hostels, they are closing down you know sort of places where the homeless can go, they are closing them down so in a way it's harder for us to try and support the homeless because of the resources are being cut (2, line 207-210)</p>

4.9.5 Core Category

When using grounded theory methodology, a core category is generally established. The core category is described as a social-psychological process that allows for understanding of how the different categories connect within the grounded theory model (Harris 2015). Holton (2007: 266) suggests that the researcher trusts their *"intuitive sense of the conceptualization process"* when working on the core category. A core category began to emerge in the earlier face-to-face interviews; however, the COVID-19 lockdown began, and I was not able to carry on interviewing staff and patient participants to be certain.

4.9.6 Theory Generation

Theories are used in different ways during research projects, a positivist may use theory to test a hypothesis whereas in grounded theory the theory is positioned at the conclusion of the research (Creswell and Creswell 2018). Theories can be applied at both an *"abstract and concrete level"*, to explain events or processes (Quinn-Griffin and Landers 2014:15). A theoretical concept is unlike an *"everyday concept because it is a mental image of an aspect of reality that is put into words to describe and explain the meaning of a phenomenon"*

(Smith and Lier 2008:19), however it is acknowledged that there is no firm consensus in explaining different theory types (Higgins and Moore 2000). Within social sciences there are several theories that can explain incidents. Meta theory is seen to be at the most conceptual level, as it is a theory about inquiry and its main difference to other theory types is that it is *“knowledge about knowledge”* instead of explaining *“the empirical world”* (Higgins and Moore 2000:180). Grand theory is used to explain predominant actions across social and political sciences (Wiarda 2010). This theory type is extremely abstract and conceptual (Smith and Lier 2008, Higgins, and Moore 2000) and attempts to connect *“macro and micro levels of reality”* (Turner and Boyns 2002:353).

Middle range theories were developed by Robert Merton in the 1940s to analysis *“logically derived and empirically tested”* hypotheses which then can be applied to different areas of study (Lee 2021: 515, Kaidesoja 2019). Middle range theories are thought to have a strong connection between professional practice and academic research (Smith 2008) and are a *“usable structure of ideas”* (Smith and Lier 2008:20) which may possibly have implied rather than obvious *“philosophic underpinning and assumptions”* (Higgins and Moore 2000: 181).

Grounded theory differentiates from other methodologies as the researcher starts the study *“without a rigid set of ideas”* (Denscombe 2016:112). It is an essential requirement that the theory generated is from the data collected instead of being fitted into other theoretical frameworks (Stern 2007). The theory is created during the *“research process itself”* (Harris 2015: 33). Glaser and Strauss (1967:32) saw *“theory as process”*, therefore a theory is ever evolving. Compared to other qualitative research methodologies, the main aim of grounded theory is to develop theory, particularly about process (Strauss and Corbin 1994). Grounded theory is generally used to build substantive theories which are *“localised to dealing with particular world situations”* (Merriam 2002: 7), conceptualised by Glaser and Strauss (1967) as a theory that is applied to a specific situation. However, the theory generated in this research is an explanatory theory which are *“multivariable constructs used to make sense of complex events and situations”* (Davidoff 2019:1). They allow for a credible explanation for events and are not descriptive or a typology (Hedstrom 2005).

Across most grounded theory disciplines, when theory starts to materialise from the data, literature can be utilised (Heath 2006). As soon as data was collected, I began to read around a range of topics, theories and theoretical frameworks. It is thought that researchers using grounded theory should not impose theory on data, however Kelle (2007) recognises that Glaser and Strauss were aware that researchers would use prior theoretical knowledge to comprehend empirical findings. Reading literature throughout the research process helped with my understanding of the research results, coding and developed the ultimate theory identified in this study. Table 4.7 below demonstrates some of the theoretical frameworks that were explored whilst undertaking the research.

Table 4.7: Some examples of theoretical frameworks explored during the research project

Disenfranchised grief (Doker)	Asylums (Goffman)
Iron cage (Weber)	Power theory (Foucault)
Moral distress (Jameton and Wilkinson)	Moral conflict at work (Zacka)
Street level bureaucrats (Lipsky)	Street level bureaucrats (Lipsky)

4.10 Memo Writing

Memos are a feature of using grounded theory and are seen as a vital process when using this methodology (Harris 2015, Lempert 2007). Memos articulate the researcher's views on data, along with codes and comparisons noted (Charmaz 2014) and are used to *"record the researchers' thoughts, develop ideas, and compare findings"* (Harris 2015: 37). I frequently questioned if I was completing this process correctly, especially as memos are frequently described as *"messy and incomplete, with undigested theories and nascent opinions"* (Lempert 2007: 249). However, I wrote what I felt was important. Charmaz (2014) supports there is no set method in completing a memo and advises only to be analytical. Although I did not write memos after every interview session and relied mainly on my research diary. I found the process was useful when I needed to clarify my thoughts on what had been discussed by a participant, and when I needed to be analytical and/or conceptual about emerging codes (see Box 6).

Box 6: Example of a memo about "blame"

Memo on Blame
Blame is to say someone else is accountable for a wrongdoing. I can totally relate due to my own past experiences its totally frustrating when other services put so many obstacles

in the way and point-blank refuse to help “it’s just a housing issue” when it’s so much more complicated than that. Why do people blame? is this to protect their own psyche due to the distress of the job, do we blame to feel in control when we are dealing with other services, show others are inept and therefore it’s not our fault.

4.11 Theoretical Coding

The next coding phase was that of theoretical coding where codes that have importance or have emerged signal that theoretical sampling can begin (Charmaz 2014). Within qualitative research there are typical sampling styles such as convenience where the researcher chooses samples that are easily obtained and purposeful where samples are chosen that will answer the research question and theoretical sampling (Marshall 1996). Theoretical sampling allows the researcher to look for and follow “*clues*” when analysing data (Birks and Mills 2015: 181). This permits the researcher to “*create an analytic definition*”, and later helps reveal category connections until theoretical saturation is achieved and theories begin to develop (Charmaz 2014:205). Theoretical saturation happens when all concepts within the theory are well developed, and no new data is appearing when sampling and analysing the data (Charmaz 2014, Birks and Mills 2015). Being sensitive to theory enriches coding (Glaser 1978), which comes from the researchers “*disciplinary and professional knowledge as well as both research and personal experience*” (Strauss, and Corbin 1994: 280). I believe that I was theoretically sensitive as I was able to identify data that was important to the emerging theory (Birks and Mills 2015). At this point, along with analysing the data for this study, I had read extensively around the research area and had past and current working history in the sector. During this stage I also began to re interview participants to discuss the theoretical codes and emerging categories. I also had informal chats with “sources” in the sector, to check if these were relatable to their own experiences.

4.12 Theory Generation

Data were saturated to enable theoretical generation. The term saturation originated from grounded theory (Glaser and Strauss 1967). However, the notion of data saturation is problematic to qualitative researchers (Fusch and Ness 2015, Favourate 2020). There is no census on how saturation is done (Hennink, Kaiser and Macroni 2017) and there is not one approach that is suitable for all methodologies (Fusch and Ness 2015). Its bearing on the

research process therefore varies according to the different methodologies used by researchers (Saunders et al 2018).

Saunders et al (2018:1897) critically reflected on this issue and identified four data saturation models, 1) *Theoretical saturation*: which is linked with grounded theory. 2) *Inductive thematic saturation*: which relates to codes or themes becoming visible. 3) *A priori thematic saturation*: where codes and categories show that they are typical within the data collected. 4) *Data saturation*: how fresh data replicates previously collected data.

As noted in the model above, grounded theory has its own conceptualisation of when data is saturated. Grounded theory researchers stop gathering data when theoretical saturation is reached (Harris 2015); “*Saturation is reached when the learner hears nothing new*” (Stern 2007:117); “*stop when the ideas run out*” (Dey 2007: 185), and therefore there is no “*new concepts or ideas emerging*” (Harris 2015: 37). This ambiguous way of ceasing research can be problematic for researchers (Denscombe 2016). As in my own research, it is common for the need to address sample size when apply for ethical approval (O’Reilly and Parker 2012, Hennink, Kaiser and Macroni 2017). In my original ethics application, I had applied to interview up to 30 participants, however, as discussed earlier, this was not possible due to the COVID-19 pandemic.

Furthermore, researcher skills can influence data saturation, “*...how theoretically smart, how well these data are theoretically sampled and verified, how well funded, how much time allotted and how patients she is and how hard he thinks*” (Morse 2015:137) and the researchers own perspective can influence when data is saturated (Fusch and Ness 2015). I felt my working history and knowledge of the research area aided my “*theoretical sensitivity*” when data was saturated, and as the researcher needs to be clear on how they measured saturation (Favourate 2020), I found the suggestions from Morse (2000:3-4) and Fusch and Ness (2015), set out below, useful when explaining sample size and the subsequent impact on data saturation.

Grounded theory is commonly criticised for small sample sizes (Clarke 2007) as within qualitative research the focus with data saturation is quantifying interviews or participant

sample sizes (Favourate 2020) with researchers frequently questioning “*what is an adequate sample size?*” (Hennink, Kaiser and Marconi 2017). The following aspects were considered when deciding on a sample size:

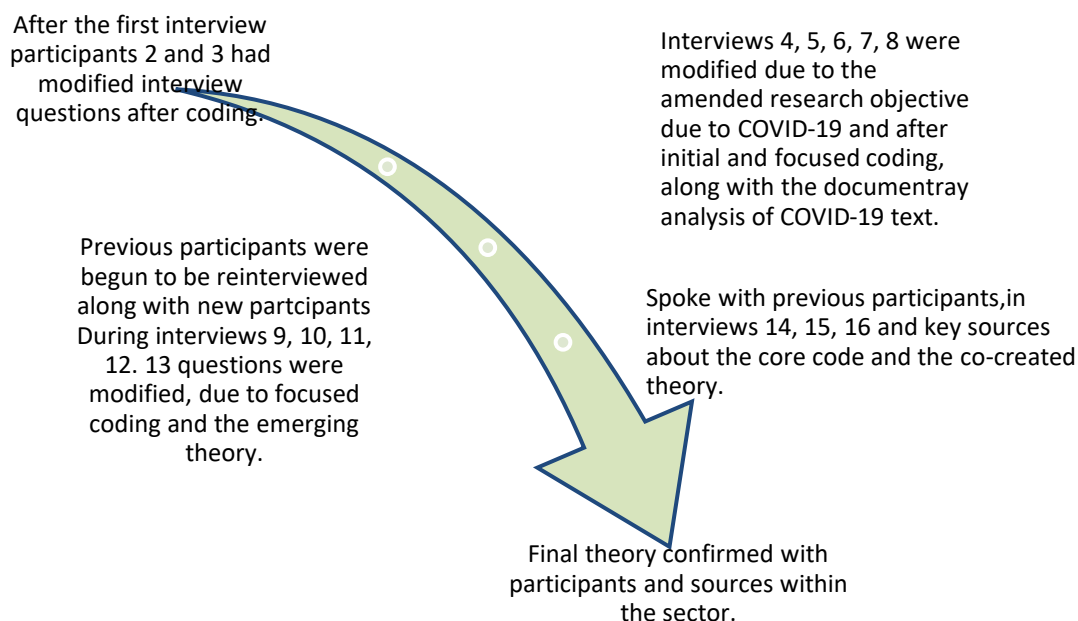
- “*The scope of the study*”; the normal consensus is, that if a study has a wide research aim, data will take longer to saturate (Morse 2000:3). Fusch and Ness (2015) support that smaller studies are more likely to saturate quicker than larger ones. My own project was focused on a particular issue that affected a small population which suggest that data saturation may be quick.
- “*The nature of the project*”, less participants will be required if the research area is apparent, and data is being collected easily (Morse 2000:3). Due to the working history and background of my participants, I felt that they understood the research question and therefore the data I was obtaining was rich enough when deciding that data was saturated.
- “*Quality of data*”; as above, I felt that the data collected in the interviews was rich in nature. ‘*If data are on target, contain less dross, and are rich and experimental, then fewer participants will be required to reach saturation*’ (Morse 2000:4). Fusch and Ness (2015) support that good data is crucial for saturation purposes. My participants were very knowledgeable about the research area as most had worked in the sector and supported people experiencing rough sleeping with a mental illness for at least fifteen years.
- “*Study design*”; as I used constructivist grounded theory, I was able to go back to participants to discuss emerging codes, and theories which helped achieve saturation.
- “*The use of shadowed data*”; Morse (2000:4) classes this as participants speaking about other people experiences in hearsay. However, in my research I would argue shadowed data is where I had discussed and received confirmation of my theory from ‘sources’ in the sector about my theory, as during later interviews similar codes and categories were identified.

With constructivist grounded theory Charmaz (2006) avoids making claims of generalisation of results.

4.12 Co-constructing Theory and Data Saturation

The theory generated was co-constructed with my participants, which was an important part of the constructivist grounded theory approach. I began coding incidents at my first interview and comparing these codes with subsequent interview data. The codes developed into focused codes and the focused codes were compared with other focused codes and initial codes. Around the time of developing focused codes, I began theoretical sampling which is *'the process of collecting further data in the light of categories that have emerged from earlier stages of data analysis'* "to reinterview participants about the codes to obtain more information and fill in knowledge gaps (Khanal 2018: 9). This builds on and illuminates the categories (Charmaz 2014). From this data I continued to code and interview new and earlier participants about the developing core code and emerging theory. As per constructivist grounded theory the theory is not found it is equally built between the participants and researcher (Charmaz 2006). Charmaz (2014) recommends reinterviewing participants as a relationship has already been built and it is therefore easier to ask difficult questions. I reinterviewed participants to obtain further data as the coding and theory generation progressed. It is acknowledged that data saturation within grounded theory is an unclear process and data saturation can be used interchangeably with the term theoretical saturation (Aldiabat and Le Navenec 2018). As a researcher with a working background and knowledge of the research area I was satisfied *"where the grounding theories"* stopped (Khanal 2018:3). I acknowledge my own role and how this may have influenced when I believed data and theoretical saturation was reached. However, to promote trustworthiness in the research findings and in keeping with constructivist grounded theory, the participants were *"partners"* in the research process (Mills, Bonner and Francis 2006b: 12). Their opinion on whether data saturation had been reached was crucial. Final interviews were to confirm the theory with participants and *"sources"* within the sector. Data was only classed as saturated when the participants agreed with the explanatory theory created. Co-constructing was not always a linear process as demonstrated in Figure 2 below.

Figure 2: Main processes when co-constructing the grounded theory model



When I spoke to participants about the final theory, they related to all aspects of it. One participant exclaimed “*exactly*” when the theory was explained, another said they “*totally relate to it*”. A source who worked in the sector, on hearing the theory, disclosed that they had previously left a job in a statutory service due to the issues raised in the theory; another source informed me they were going to leave their job due to the detrimental affect the issues presented within the theory was having on their mental health.

4.13 Ethical Considerations

Ethics within qualitative research are continually challenged and discussed, and as a researcher I accept that I had influence on the research process and the research process on myself (Goodwin, Mays and Pope 2020). The research was conducted within transparent ethical guidelines, and I worked within clear legislative and regulatory structures. This research was given ethical approval from the Health Research Authority (IRAS Project Identification :264586) and De Montfort University (Ref: 3374). Similar to the stance of DeJonckheere and Vaughn (2019), an ethical attitude was taken throughout the research process, and protecting the participants was at the forefront of this project.

4.13.1 Informed consent

I used reflexivity within my own ethical practice and took this practise seriously. One of the unique issues within qualitative research is the perception of the connection and control and exploitation between the participants and the researcher (Orb, Eisenhauer and Wynaden 2001, DeJonkheere and Vaugn 2019). As an insider researcher I was very conscious of this power and took time to ensure that all the frontline workers participated in this research voluntarily. If potential participants considered taken part in the research, they were given a participant information sheet (Appendix 1 and 2) and given time to decide to proceed (at least 48 hours). All participants were made aware of their right to refuse to take part. Written consent was taken (Appendix 3 and 4) prior to the interview taking place, and for key informant participants, their options were to email me a signed consent form or as discussed above used permission provided (PP) to sign on their behalf. For all participants the points on the consent form were verbally reiterated prior to information to ensure they were happy to continue to take part before progressing to initial interview. Goodwin, Mays and Pope (2020) highlight that consent can be an ongoing process and for participants who agreed to be re-interviewed I offered to go back through the consent form again once they were reinterviewed, all declined however I took the time to ensure that they were still agreeable to continue to take part in the research.

For most interviews there was no concerns regarding consent and interviews proceeded as expected however an ethical issue rose with one key informant participant. I began the telephone interview and within a few minutes of the interview the call cut out. I immediately received an email and text message from the participant to ask if my questions could be sent by email as their phone signal was weak and they would prefer to have the interview questions emailed to them so they could consider their answer. I explained that this was not possible due to my ethical approval. Although using my professional judgement I did not feel the participant was distressed, I did not want the participant to feel uncomfortable in anyway, so I did not attempt to rebook the interview. I reassured the participant via email (as I was unable to connect to their telephone) that it was fine to discontinue, and I would dispose of the data collected (as per ethical approval) and thanked them for their time. I discussed this unusual situation with my supervisor.

4.13.2 Confidentiality and Anonymity

Great importance was placed on the issues of confidentiality and anonymity within this research. Some of the participants only took part in the research on the understanding that they would not be identifiable. This was due to fear of repercussions from their employees due to the sensitive nature of interview discussions. For research transparency the boundaries of confidentiality were explained to the participants prior to or during taking consent (Goodwin, May and Pope 2020). Crano, Brewer and Lac (2015) state that research has demonstrated participants will talk about personal issues if they are confident that the information will be anonymised and be kept in confidence. Therefore, anonymity and confidentiality empowered participants to give open and honest answers. I discussed the issue of confidentiality further with participants who wanted further information on the matter. It is important that researchers uphold the participants personal integrity of participants (Thunberg 2022). Goodwin, Mays and Pope (2020) acknowledge that at the beginning of a research project keeping a participant anonymous might appear easy, however similar to Richards and Schwartz (2002) there was a multitude of things that needed to be taken into consideration, including removing language or phrases used by participants in quotes that might have identified them to other people in the sector.

The issue of confidentiality is a problem for researchers, as they must decide to either suppress data to protect participants identities and then risk being criticised for the research truthfulness of the findings (Baez 2002), and this was a balance that I had to find when reporting the research results. My initial face-to-face interviews were held in a private room that the participant was familiar with. Lobe, Morgan and Hoffman (2020) argue that there is no difference in ethical issues with telephone interviews compared to face-to-face, including the issue of anonymity. To control my own environment when undertaking a telephone interview, I was always at home in a room alone with shut doors and windows with a sign on the door asking no one to enter.

With permission from the participants, the interviews were recorded on a Dictaphone were transferred immediately onto a computer with encryption and security software. Once transcribed the audio recording was immediately deleted. Any information on paper was kept in a locked cabinet.

I had brought a mobile phone sim from a high street mobile phone company to enable patient participants, who may not have internet access, to be able to contact me by phone/text. I put the contact telephone number of this sim in my own mobile telephone contacts and after ten days noticed this number was showing up as a WhatsApp contact, even though I had not set this up. I sent a message to this number and received a reply. As soon as I was aware that the number was being used on WhatsApp, I managed to gain control of the account and close it. I was subsequently informed when complaining to the mobile telephone provider that the number I was given was a recycled telephone number, which is common practice, and the previous owner was continuing to use this telephone number for WhatsApp. Although I had not asked participants for contact via WhatsApp, I was concerned that this would be viewed as a potential data breach. I reported this issue to the university ethics board and the data protection team, and the NHS trust I was working with who reported it to their data officer. No further action was taken as it was thought the risk was negligible and was seen as a potential rather than actual data breach. I complained about the situation to the mobile phone provider and WhatsApp via email however received no reply. There is little peer reviewed literature about using recycled telephone numbers in research however a study in the United States found that, out of a sample of 259 recycled mobile telephone numbers, 171 were affiliated with other online services which posed a high security and privacy risk (Lee and Narayanan 2021).

4.14 Chapter Summary

In this chapter it was explained how research methods were used in a constructivist grounded theory study of how frontline workers have experienced working with mentally ill rough sleepers during welfare reform, austerity, and the COVID-19 pandemic. Discussion is provided on how the research design and subsequent research questions were altered to adhere to and complied with the public health response to COVID-19. Reflexivity was an important part of the research process due to the study being emotionally demanding to myself as an insider researcher. It was explained and demonstrated how a theory was co-created with my participants and how data was saturated. It has been clarified how strong ethical procedures have been upheld during this study and the reasoning for this, such as the participants being confident in their anonymity. Finally, the chapter demonstrated how

constructivist grounded theory was used to construct an explanatory theory of frontline workers moral distress, which is discussed in more detail within the next chapter.

Chapter Five: Findings and Discussion

5.1 Introduction

This chapter begins by presenting and a brief explanation of the core category of “moral distress” and categories of “too many obstacles” and “lack of resources”. A table highlighting the pseudonyms and expertise of the participants follows. The chapter moves on to a composite story which exemplified a typical scenario described by the participants. This is followed by the presentation of an explanatory theory of moral distress of frontline workers working within austerity, welfare reform and the COVID-19 pandemic.

The moral distress experienced by the participants was complex and two main categories, “*too many obstacles*” and “*lack of resources*” are integrated into and perpetuate the core category of “*moral distress*”. Participants began their work with the intention to help and support vulnerable people. They were compassionate to the situation and needs of the mentally ill rough sleeper yet were systematically not able to support their service users as they saw fit, due to failings across all services, policy, and legislation in housing, health, care and the DWP. Frontline workers had a lack of agency and power across all organisations and services when attempting to supporting their service users. Witnessing the service failings and the effects of these failings on people experiencing rough sleeping was distressing to the frontline worker and damaging to the relationship they had with their service users, with the service users often taking out their frustrations on the frontline worker.

Six themes supported the core category of “*moral distress*”. These were: “*caught in the middle*”, where frontline workers were caught between disjointed organisations and systems across housing, health, social care and the DWP; “*facing violence and trauma*”, which demonstrated how the mentally ill rough sleepers took out their frustrations on the frontline workers; “*get on and deal with it*”, depicts how frontline workers were left to deal with any issue, whether it was their responsibility or not; “*lack of trust*”, reveals how, due to system constraints and of being failed by services, building a trusting relationship with the person experiencing rough sleeping was difficult, and finally “*doing their best*”, which depicts how frontline workers used what resources they had to abate the feelings of moral distress they experienced.

The category of *“too many obstacles”* depicts the numerous systematic barriers and continued difficulties the frontline workers faced when they were attempting to access and navigate services and systems. Four themes supporting this were: *“falling through the gaps”*, which demonstrated how people experiencing rough sleeping were systematically denied access to services; *“law gets in the way”*, shows how the policies and legislation surrounding people experiencing homelessness and mental ill health was not suitable for their needs and hindered the frontline worker; *“forgotten entities”* highlights the problems faced by the frontline worker in supporting their service user’s access services; and finally, *“an ideological stance”* demonstrated how participants felt about the political positioning of the government ideology towards the needs of people experiencing rough sleeping with a mental illness in accessing and dealing with the DWP’s administration system.

The category, *“lack of resources”* is supported by three themes: *“squeezed and stretched services”*, which illustrated the pressures of working within and accessing services on behalf of their service users; *“a fractured system”*, depicts the siloed nature of the services; and the last theme, *“withdrawal of services”*, demonstrated how rough sleepers were either barred from a service, or specific services were withdrawn (see figure 3 below).

All participants were frontline workers supporting rough sleepers with a mental illness, working for a broad range of services across statutory, voluntary and the third sector organisations. Pseudonyms are used to protect their anonymity.

Table 5.1 Participant pseudonyms

Pseudonym	Specialism	Pseudonym	Specialism
Mary	Mental Health and Homelessness	Val	Multiple Exclusion Homelessness
Lei	Mental Health and Homelessness	Alex (Interviewed twice)	Multiple Exclusion Homelessness
Keira (interviewed twice)	Mental Health and Homelessness	Ade (Interviewed three times)	Multiple Exclusion Homelessness
Jenny	Multiple Exclusion Homelessness	Sam (Interviewed twice)	Multiple Exclusion Homelessness
Abdul	Multiple Exclusion Homelessness	Leo (Interviewed twice)	Multiple Exclusion Homelessness

5.2 Composite story

Jordy worked with a rough sleeper named Albert who misused substances and has had a previous diagnosis of drug induced psychosis. Albert was rough sleeping due to being evicted from his last tenancy due to rent arrears. He was unable to access social housing, as due to the rent arrears he was ineligible to go on the housing waiting list. Albert had missed several appointments with the Department of Work and Pensions for Universal Credit which resulted in a benefit sanction. He could not recall his password to look at his claim online and after an hour of waiting to get through to the DWP on the telephone, with Jordy supporting him during the call, he became frustrated and hung up. He walked out of the office swearing and shouting that Jordy was useless. Albert was very mistrustful of support services, and it was difficult for Jordy to engage with Albert. Jordy was concerned as Albert had not been looking after himself, he was not eating and drinking regularly, he had sores on his body and was not dealing with his personal hygiene. Albert was not registered with a GP and refused to register with one.

Jordy spoke to Adult Social Care about a Care Act assessment for Albert, however the triage team stated they believe Albert's issues stemmed from mental health and substance misuse so those need to be addressed first and that he would also need to have a place to live before they could assess. Jordy was told to call back when this was in place. Jordy arranged a mental health act assessment which took several attempts before it was arranged. When the assessment took place some mental health needs were acknowledged, however Albert was thought to have capacity and was not found to be detainable under mental health act legislation. Jordy was advised by the mental health assessors to encourage Albert to address his substance misuse needs and to register for a GP.

5.3 Moral Distress

The central issue, and core category of the theory of how frontline workers were affected when working with mentally ill rough sleepers during welfare reform, austerity, and because of the COVID-19 pandemic, was 'moral distress'. They were unable to support mentally ill

rough sleepers in ways they wanted to, due to structural constraints of the organisations along with the wider systems they worked within:

*...you are asking us to put **a sticking plaster over a burst artery** really, but we can see them, we can listen to them, they can offload, cry and be distressed and then talk to us and feel a bit better for doing that but they are still going out to the street (Keira first interview).*

The metaphor of “a sticking plaster over a burst artery” epitomises the enormity of the experiences of the participants as they were working within broken services and systems with an increasing number of people with complex needs needing their support, yet they lacked the resources and faced multiple obstacles to do so effectively.

This caused a type of moral distress that accorded with Jameton’s (1984) conceptualisation, where people know what action to take but these actions are not viable due to institutional limitations. All participants expressed their distress in different ways; from discussing their own distress:

...it’s not very nice because you [a frontline worker] want to help people and it becomes frustrating for you, because you know you can’t help them and when you get home you think about it, you know when someone has spoken to you like that, you know it upsets you (Ade second interview).

acknowledging the distress, they witnessed in their colleagues:

I just think there must be cases where people [frontline worker’s] struggle to the point when they wake up and it impacts on their life because it’s always on their mind from a previous incident (Jenny).

to realising that their only way of getting out of the cycle of moral distress was to actually leave their job:

...you think to yourself what’s the point in me keep going on about it ‘cause nothing is changing (Jenny).

Although it is difficult to compare studies on how homelessness frontline workers mental health is affected by their work, due to the different parameters used in measurement, there are studies which suggest negative effects (Loney- Evans 2020a, Marshall 2021, Marshall 2022, Lemieux-Cumberlege and Taylor 2019, Wagemakers Schiff and Lane 2019). Research has demonstrated that experiencing moral distress

can cause mental illness (Wilkinson 1987, Nemati et al 2021) and negatively impact on job satisfaction (Ando and Kawano 2018) and staff retention (Trautmann et al 2015).

When discussing moral distress in nursing, Jameton (1984) asserts, that to stop nurses reaching burnout the work they do needs to meet their own ideals and ensure this is reflected in the care they provide. The frontline workers reported that they went into the job to help people yet were continuously constrained by systematic and structural limitations across all statutory and voluntary services, so were never able to meet their ideal standard of care and support:

I sort of I suppose I came in with the expectations that oh great we can solve peoples homelessness and you know, see them and get them accommodated and into mental health services and that's it you know and very quickly sort of the realisation was different that actually you are up against a lot more than just... you know it's not as easy as that, with the revolving door of homelessness and the problems (Keira second interview).

This left them feeling cynical, powerless, overwhelmed, disillusioned, and frustrated, similar to Wilkinson's (1987) findings of moral distress. They witnessed the distress that the service and system failures had on the rough sleepers they were supporting, and as a result were left emotionally and morally exhausted:

Well I got into this because obviously I wanted to help people cause I was in a similar situation and I still do feel like that, the [sighs] frustrations of the job and the changes that have you know have occurred over the years, have kind of diluted that kind of, that feeling but I still, I am still there to help people, I know that, it does, it does make you quite cynical in terms of how what, what is expected of us (Alex second interview).

Experiencing constraints has been shown to increase the odds of moral distress occurring (British Medical Association 2021), and participants spoke of their concern for their colleagues when they were not able to support people experiencing rough sleeping:

I do take the view that actually I worry that people are doing this work for too long and are working with the same client group and it invariably it is, it can be very disempowering and frustrating, the outcomes are very often not great and often you can feel, as an individual, as a worker, you can feel disempowered because of actually what changes (Val).

This was in keeping with research by Carver et al (2022:6) who found that people ultimately go into the sector to “*make a difference*”, and then experience “*role conflict*” when they confront challenges in their attempts to make that difference. The participants in this study doubted their own abilities and questioned “*whether we are doing enough?*” and “*I feel like we could do a lot more*”. These experiences concur with research by Wilkinson (1987) who showed that self-doubt can cause moral distress.

There is a dearth of literature on why homeless frontline workers are motivated to work in the sector, however other studies, regarding the motivations of workers in the caring professions, found that most went into the profession to help people. For example, Watson (2007:130) argues that the nursing profession has an “*ethical covenant with society as sustaining human caring*”.

Scanlon and Adlam (2012: 74-75) on the probable traumatising nature of working within homeless services, upholds the experiences expressed by participants in this study. They argue that all establishments involved with housing, care and support will progressively be:

...dis-stressed as they find themselves stuck in the middle between the dis-organisation and the systems they work in and the distressing nature of working with the clients they serve between the “rock” of increasing demand and the dependant need and the “hard place” of apparently decreasing resources (Scanlon and Adlam 2012: 74-75).

The metaphor, ‘between a rock and hard place’, resonated with experiences of frontline workers in this study; they were caught in the middle.

5.3.1 Caught in the Middle

The frontline workers were caught between disconnected organisations and systems across all services (DWP, housing, health, and social care) which systematically denied them, and the rough sleepers they were supporting, access to:

*....we are **caught in the middle**, battling between these two systems because the pressure on beds, and meanwhile we’ve got this very unwell person that we are trying to manage and keep safe* (Keira first interview).

This was due to a variety of practical and structural reasons. Many services would not acknowledge any duty (i.e., support) owed towards people experiencing rough sleeping. This left enormous pressure on the frontline workers who were very aware of the continued dire circumstances of the many rough sleepers they were supporting. For example, Keira had attempted to refer a rough sleeper into secondary mental health services as the rough sleeper was acutely mentally unwell. However, the rough sleeper was not admitted into hospital and was offered home treatment instead. Keira felt that this treatment option was not suitable for the rough sleeper because of the difficulty of facilitating home treatment. As people experiencing rough sleeping lifestyles are often transient, locating the rough sleeper would have been a major barrier to treatment taking place. Keira had attempted to mitigate this issue by asking for emergency temporary accommodation for the rough sleeper, to enable the home treatment to take place at an address. However, this request was refused by the local housing department. This left the rough sleeper untreated and Keira feeling an overwhelming responsibility for managing this risk and supporting the rough sleeper through a serious mental health crisis:

Meanwhile we've got this very unwell person that we are trying to manage and keep safe...so the problem hasn't been resolved, so they are still going to be distressed, still vulnerable, still potentially at risk (Keira first interview)

The front-line workers supported rough sleepers with a dual diagnosis of mental illness and substance misuse, however, they felt that this group of patients were rarely helped by the system:

Dual diagnosis, which again, as we both know, is horrendous because people fall right in the middle where one drugs services won't support them and then mental health services won't support them (Jenny).

Research by Groundswell (2022) attributed the difficulties to accessing dual diagnosis services was partly due to conflicting policies and practice within the mental health and substance misuse area. Maryon-Davies (2016) found that rough sleepers, who had a dual diagnosis of mental illness and substance misuse, were particularly difficult to support, as other services across health, social care and housing frequently excluded people with this diagnosis.

Accessing adult social care services was extremely problematic to the participants. They described the interactions between the departments as a “ding dong” and a “constant struggle...to even understand their processes”. They were exasperated that often adult social care judged that the rough sleepers referred to them had housing related support needs only; “...it’s a housing this, it’s a housing, you know so usually that’s checkmate”, and that other vulnerabilities were not taken into consideration. These experiences were consistent with research by Mason, Cornes and Dobson (2017) and Armstrong et al (2021). This left the onus on the services the participants worked for to provide support for people with complex needs:

We are finding at the moment, is that we have got a cluster of high support needs people that we can’t place elsewhere because of the you know the potential risk to where they will be going, to others to where they will be going (Alex).

When referring their service users to adult social care for a Care Act assessment, in keeping with Armstrong et al (2021) participants found barriers to rough sleepers accessing services who they believed had medium to high support needs. One participant explained how they had referred a rough sleeper to adult social care multiple times, but they kept refusing the referral. He became exasperated and stated the case would result in a serious case review, which occurs when there is a suspicion that a person has been harmed due to the failings of services (Social Care Institute for Excellence 2015):

We had a [rough sleeper] who needed social care...a physical care package and we kept on ringing social services saying that we don’t have the capacity to look after [the rough sleeper] anymore and then it was like a tennis match a lot of to-ing and fro-ing, this [rough sleeper] had carers coming in it was clear his, their physical health was deteriorating, they needed care, so although social services acknowledged that, they did not acknowledge that this was not a suitable environment for them and it warranted for me to say well if this goes to a serious case review and I’ve mentioned to you that we can’t look after him, only then did the manager ring and you don’t want to be using words like serious case review for a manager then to pick stuff up and then in the next few days afterwards they placed [the rough sleeper] in residential care” (Leo).

Of relevance is the study by Hastings and Gannon (2021: 8-9) which demonstrates that workers have “resist mechanisms” to ‘modify rather than resist austerity’. Leo was caught between the care needs of the rough sleeper and adult social care who disregarded Leo’s assessment of the rough sleepers needs. By stating that he felt the case could become a

serious case review (and resisting austerity) he could be seen as non-cooperative and difficult to other organisations, however due to adult social care response this was a strategy he used in desperation to get the rough sleeper the help he needed.

Care Act assessments were requested by frontline workers when there were concerns that the rough sleeper would not be able to live independently. Participants were frustrated by the eligibility criteria under the Care Act (2014) and were angry that adult social care and the legislation that supported this area often did not deem rough sleepers as eligible to meet the Care Act threshold, despite the frontline worker believing the rough sleepers had complex and or high support needs and requiring social care support:

In particular the Care Act, don't fit, don't fit into a box, they [the rough sleeper] don't have sufficient needs and therefore fall through the gaps effectively although their cumulative needs are probably greater than many people social care does pick up (Val).

...their duties and the legislation that surrounds that is also quite narrow so unless you do hit all the criteria the support is lacking (Abdul).

During the COVID-19 pandemic local authorities were relieved of some of their duties under the Care Act (2014) to ease the pressure from Adult Social Care. However, the flipside of this meant there was a lack of urgency to assess rough sleepers unless they were thought as being at high risk of harm due to unmet care needs (Reyes 2020).

They became infuriated that adult social care frequently accepted no responsibility towards people who were referred to the department and that the opinions of the frontline workers, about the needs of the rough sleeper, were disregarded:

We just find it so frustrating that their decision-making [Adult Social Care] process soon effectively deems that the person has some community care needs but not sufficient to offer any kind of provision whatsoever [voice raises sounds outraged]. It's difficult to deal with I will be honest with you, there's real disparity there (Jenny).

This left the frontline worker exasperated with other services, feeling powerless and ultimately having the responsibility of supporting the rough sleeper alone, which contributed to the moral distress they experienced. Their experiences were also mirrored in work by Halton (1994:14), who explored the '*unconscious aspects of organisational life*' and

coined the term '*paranoid schizoid position*'. He found, that rather than getting angry at the people they support, care workers divert this anger at other organisations. Anger at other organisations is also argued to be a coping mechanism after experiencing moral distress. (Burston and Tuckett 2012) and a disagreement in values with others involved in someone's care can cause moral distress occurring (Spenceley et al 2015, Young, Froggatt and Brearley 2017):

You get frustrated by the pettiness of people closing the door and saying, "oh it's not my problem" (Jenny second interview).

It was reported by frontline workers that the rough sleepers they were supporting had often approached the local authority for assistance when they had been threatened with homelessness, prior to rough sleeping. Contrary to homelessness legislation, where local authorities can offer advice and assistance if a person is likely to be made homeless within 56 days (Homelessness Reduction Act 2017), frontline workers were aware of people being turned away until they were at crisis point and rough sleeping.

Witnessing the wrongdoing of other services may also cause moral distress (British Medical Association 2021). Keira described how a person with a severe mental illness, who was sofa surfing, was told to come back (to the local authority) on the actual day they had exhausted their accommodation options. This was frustrating to Keira, as she understood the advice was incorrect and limited how she could immediately support the person whom she felt was vulnerable. She also became upset at the considerable anxiety and stress that this caused to the person who had approached the council:

He's been to the council. He went the other day cause his friends to have said they can't keep having him there and he was told no go away and come back when you are on the streets, tell us when you've got nowhere to go. He said, "well they've told me I've got a week to go, they said Well, come back on Friday when you've got nowhere to go (Keira first interview).

Rough sleepers, who had conditions such as mental illness, physical illnesses and learning disabilities, were often placed into emergency accommodation that the frontline worker felt was unsuitable for their needs. The lack of suitable accommodation was compounded by closures of temporary accommodation within the local area:

...a service user that has got, paranoid schizophrenia, wouldn't necessarily be deemed suitable from a safety aspect towards other service users, for a hostel environment, but also for their mental health needs it wouldn't, it isn't deemed as suitable for them, but there isn't any other option (Abdul).

It was acknowledged that the local authority housing department was under resourced, and this may have contributed to this response. However, it was questioned, if the response was to keep the figures down regarding how many people were approaching the local authority for help and at the time of the interview (pre COVID-19) some participants experienced an increase of referrals from people who were sofa surfing which supported national trends that emphasised that 'sofa surfing' was the largest category of people experiencing homelessness in England (Fitzpatrick et al 2021).

They were constantly stressed by the experience of being caught in the middle and being required to have a wealth of knowledge and experience to successfully carry out their work. This was alongside their other job role responsibilities and across a wide range of legislation and services, such as mental and physical health care, substance misuse, immigration, and welfare. However, there is not a specific training pathway to become a homeless worker (Lemieux-Cumberlege and Taylor 2019) and participants felt aggrieved that, on one hand they were not treated as professionals with expertise, yet needed to be able to work with people with complex needs, often in difficult situations:

We are not professionals, we are not care professional, we are not drug and alcohol professional, we are not mental health professional, but you are asking us to deal with perhaps some of the most excluded and vulnerable people in our society.... and there's still no formal qualification to work with people in homelessness (Val)

Numerous nursing studies on moral distress found that feeling powerless in the profession can cause moral distress (Young, Froggatt and Brearley 2017, Ando and Kawano 2018) and due to other services not viewing homelessness frontline workers as professionals and the powerlessness this creates in interactions arguably leaves this group at a higher risk of moral distress.

People with professional status can have their work inspected (Jameton 1984) yet Keira explains that homelessness service provision differentiates across England, which would make it difficult for homelessness workers to justify their actions:

It's all very much left to each local authority, or local health authority to decide what they provide for their population so it's a post code lottery really (Keira, first interview).

This lack of acknowledgement of expertise was also felt by one participant who *was* a 'professional', with a mental health qualification. She reported how one rough sleeper, that she was supporting, was vulnerable due to a mental illness. Under housing law in England this meant the local authority had more statutory duties towards the rough sleeper (Shelter 2021b). However, her assessment on the mental health of the rough sleeper was disregarded by a housing department. This was seen as an unjust decision and left her feeling powerless and lacking agency:

When you've got this specialist advice of the mental health team and you know consultant psychiatrist saying someone is vulnerable, but you still ignore that advice and then that's...well I guess it's down to them but still, still it's frustrating (Keira, first interview).

Public sector workers, who work directly with the public, have been described as having “*substantial discretion in the execution of their work*” when applying policy, and referred to as “*street level bureaucrats*” (Lipsky 2010:3). Lipsky (2010:19) also acknowledged that, although some street level bureaucrats have “*professional status*”, they are also restricted by working within a system which means that they also need to conform to management and organisational expectations. Frontline workers therefore have a responsibility towards their own organisations (Jameton 1984). There are disparities between different frontline organisational aims which can cause tension and conflict between frontline workers, with one worker working towards one aim and the other worker another. In the situation above both Keira and the housing officer are assessing “*vulnerability*” under different legislative frameworks and reached different conclusions and a conflict in values is seen to cause moral distress (Young, Froggatt and Brearley 2017). Crozier (2017) asserts that a bureaucrat has power when using their discretion within their work and as the housing officer has the power in this situation (access to housing for the rough sleepers), the interaction

left Keira feeling powerless and frustrated that her own expertise had been disregarded. Similar research has demonstrated nurses not being able to influence the outcome of care due to having less seniority than doctors was found to be a cause of moral distress (Ando and Kawano 2018).

The frontline workers were working within a local area that had had many cuts to homeless services over the years. This was attributed to austerity by Alex in his first interview *"...everyone's services have been reduced, that's, that's clear and evident over the years"*. This included loss of temporary accommodation, loss of day services for the homeless and cuts to local mental health inpatient beds. The loss of support services affected the frontline workers in various ways. Lack of services for rough sleepers to access, equated to a higher caseload for the frontline workers and cases were open for a longer period due to lack of opportunity to move people on to other services:

There is only limited day centres left, there is different, limited advice places where service users go and get some advice and help, there's not much places left at all (Sam).

So, austerity is the last ten years of this government and austerity has had a real detrimental effect on how we're running a service now from a practical point of view from lack of resources, lack of funding, lack of move on opportunities and that has slowly been going down anyway (Leo).

It's the overload of their caseloads [community mental health services] that it means that people have to wait weeks, months even to be, not necessarily months but, I think it's a six week wait at the moment ... so yeah that's from the mental health side, that's linking people into those services that we have assessed as needing support and then we are having to support them longer term in the interim while they are waiting to be picked up. (Keira second interview).

The above typifies putting a *"sticking plaster over a burst artery"*, as the frontline workers are supporting their service users with limited resources which reduced the options in which they could support them.

Burston and Tuckett (2012) concluded that working with a lack of available resources can cause moral distress in nurses. Being *"caught in the middle"* was never-ending and the

helplessness that this engendered left them feeling that they were constantly knocking their heads against a brick wall:

We have a lot of staff who really do care about the service user group, that then invariably spills over into the frustration of when it's not possible for whatever reason to get the perceived support that, that person could get as if you are kind of knocking your head against a brick wall and I think eventually that takes its toll (Jenny).

Organisational constraints were, in part, due to austerity, along with service provision changes that were made because of the COVID-19 pandemic. COVID-19 had magnified issues, such as heavy caseloads, along with a quick turnover of rough sleepers to support, most of whom had complex needs. The policies the frontline workers were working within were changing frequently (daily at times) and this changing policy was also supported when analysing documents collected about responses about COVID-19 and homelessness. Austerity was seen to be a major cause of the organisational constraints. The participant below explained how the quality of service provided had withered over time. This had left him feeling sceptical about the quality of service that could be provided to rough sleepers:

You just get a little bit stressed, I think, so you know and there is such a high turnover of people that you don't feel like you are doing quality of work, like I used to do a lot more work previously when, before COVID, I think there is a big turnover of people now so erm you don't get to do quality work with them like that you used to be able to and follow things through (Ade second interview).

These findings support the research by Hodwitz et al (2022) in which homelessness workers in Canada had experienced moral distress when working during the COVID-19 pandemic.

The experience of being caught in the middle was not only distressing and frustrating to the frontline workers but it also damaged the relationship between them and their service users.

5.3.2 Facing Violence and Trauma: "They kick off with us"

Participants faced violence in the form of verbal and physical attacks on themselves and other service providers and through witnessing self-harm amongst the rough sleepers;

*"They come in and when we say we can't provide that they then **kick off with us**".*

A violent eruption could occur suddenly without warning, and examples given by participants included being threatened with a large weapon; *“it was brandished in our direction”*; being spat at; and receiving ongoing death threats, *“they’ve threatened to kill me and follow me home”*. The physical aggression was mainly aimed at property or buildings, *“they take it out either on the phone that they’re using, the room that they are in or the person that is in front of them, which is usually us”*, however all participants acknowledged they had either experienced verbal and physical violence from rough sleepers themselves or witnessed it directed at their colleagues:

We’ve never been physically assaulted or anything like that, but we’ve had, you know, things smashed or a mirror smashed things like that, people storm... people usually self-manage it and storm out and slam the door or shouting you know as they go, we have had a few veiled threats you know sort of people saying you know I’m quite a dangerous person you know and you don’t know what I can do and things like that, you know... (Keira second interview).

We witness aggression, and verbal, mainly usually verbal aggression but it is quite you know [sighs] quite a physical threat behind it, I mean they are shouting in some people’s faces sometimes (Keira first interview).

We have some clients that come in and you know they continually abuse our staff (Mary).

Nurses moral distress was also found to be higher if they experienced unacceptable behaviour from patients or their family (Oh and Gastmans 2015). Lipsky (2010) acknowledges that it is common for the clients of street level bureaucrats to react angrily to the workers decision-making. Participants did not always feel safe at work and were alert to the possibility of a serious incident involving a rough sleeper occurring in their day-to-day job, describing themselves as constantly *“on guard”* whilst at work:

There will be a major incident I believe it depends on the individual as well but if you have too much, of all of those types of people with those experiences then ultimately you know it could be someone losing their life, it could be you know someone being attacked, staff and other service users (Alex first interview).

These experiences are upheld in findings by Forte et al (2017), who concluded that after workers on a psychiatric ward had been involved in a serious violent incident, they became hypervigilant both in and out of the workplace. Another study on health care workers in Turkey found that when they had been either directly involved in a violent incident or had

witnessed a violent incident, they were fearful of incidents occurring at a later date (Akbolat et al 2021). The World Health Organisation (2021) acknowledge that the risk of violence to health care staff is great, and the frontline workers acknowledged they experienced this. A Swiss study on prison staff experiencing and witnessing violence found that both experiences increased staff members '*exhaustion and disengagement*' and staff felt less safe whilst at work (Isenhardt and Hostettler 2020: 196).

Abuse to frontline staff, in a variety of working roles, has been increasing over the years (Simpson 2019; Unison 2021) and there is now indication that abuse to health frontline staff has also increased since the COVID-19 pandemic (Ramzi, Fatah and Dalvandi 2022, Forgiione 2020). Participants reported that abuse towards them had increased during the first COVID-19 national lockdown, not only from the rough sleepers but also from the public:

Definitely had more verbal abuse lately definitely, I've done so many more incident reports lately for that and I am noticing it's not necessarily from the service users ... it's a lot more from the public (Ade second interview).

The literature on compassionate care demonstrated that this behaviour, of service users towards frontline workers, may impact negatively on being compassionate towards patients (Christiansen et al 2015), yet frontline workers understood and sympathised with the rough sleeper's anger and frustrations and accepted this as part of their daily work. They attributed the anger from the person experiencing rough sleeping to failings of the organisational and wider structural systems that they were working within. This is similar to findings by Symonds et al (2018) who found social workers were positioned between their service users and bureaucracy. Street level bureaucrats are often pulled in two directions, from the demands of their service to the needs of their clients (Lipsky 2010). The quotes below demonstrate the participants' understanding and compassion towards service users who had behaved aggressively towards them:

We just accept that, that's part of the... I mean we have to in a way, 'cause we understand it's their frustration of having no rough over their heads, no benefits you know, no food, no phone, so we understand what's behind it (Keira second interview).

Yeah, they are quite aggressive and verbally aggressive but that's just you know the situation that they are in. I think it makes them a little bit angrier because of the situation that they are in and if you, if you are rough sleeping and are

freezing and you are coming in and asking for something and then you are getting you know, the answer's not what you want, I should imagine it makes you a bit you know agitated (Ade first interview).

I think it's just something that we sort of accept on a daily basis, you know people shouting at us. I mean I had it yesterday with somebody who I couldn't...I just had to say we've got no vacancies you need to go to call (local authority dept name removed for anonymity). He was rough sleeping in his car, and he got, he started shouting at me and he had mental health issues, but it was just out of frustration because he like you know, felt like that no one was helping him (Ade first interview)

Caincross and Gardner (2014) found that social care staff reported higher levels of abuse from people with mental illness, learning disabilities and dementia. These co-morbidities are prevalent amongst people experiencing homelessness (Homeless Link 2014, Rees 2009, Stone, Dowling and Cameron 2018) which indicated that homeless frontline workers were at a higher risk of violence from service users than other comparable frontline services.

However, the participants underreported the abuse that they received as it was a regular and consistent occurrence “...happens so much it is normalised”. Within their workplace reporting abuse was deemed to be an extra layer of administration that the workers had little time for. For example, reporting abuse could involve contacting the police and/or filling in a lengthy form to send to the organisation management, with workers not always receiving feedback on these reports. Skills for Care (2013) have acknowledged that violence and abuse towards staff is a common occurrence and staff tend to underreport this issue, as Alex described “...if you were to record and report all the abuse that you got, you probably wouldn't have time to do anything else”.

Frontline workers regularly witnessed traumatic incidents and this exposure was part of everyday working life for them. When talking about her colleagues Jenny explained “...they see [the frontline worker] *horrendous things*”. Along with witnessing verbal and physical aggression they witnessed incidents such as rough sleepers self-harming, accidentally overdosing on recreational drugs, and death.

Sam had found a rough sleeper severely self-harming by slashing their legs and arms deeply with a broken bottle, he had called for an ambulance which had arrived, but the ambulance crew was not able to assist until the police arrived, due to the broken bottle being a potential weapon. This left Sam and his colleague dealing with this incident alone and unsupported, apart from the 999-call operator:

Every time I stepped forward, they [the rough sleeper] would cut themselves... the amount of blood I saw... I was scared they [the rough sleeper] would slash an artery and I remember taking advice from the operator about what to do if this happened.

Ade reported that the most traumatic experience he had experienced was finding someone dead, due to an accidental overdose of illegal drugs; “...it’s not very nice to be threatened but finding someone overdosed was horrible”, and Sam reflected on the impact these experienced had had on him:

I think seeing someone self-harming has affected me, [long pause] I think that because it was so extreme the one I seen, with me because of the way [the rough sleeper] was self-harming, I’ve seen a couple of people self-harming, I think now we have seen so many people, a couple of people doing it in such an extreme way, like hurting themselves... it gets you because you are not prepared for it.

Mirroring the experiences of participants in the study by Forte et al (2017), who concluded that after workers on a psychiatric ward had been involved in a serious violent incident, they became hypervigilant, both in and out of the workplace. Waegemakers Schiff and Lane (2019) found that homeless frontline workers underreported trauma due to the fear of not being seen as suitable to be working within the sector as there was a fear that others would perceive them as too emotionally weak to undertake that type of work.

Along with facing violence and trauma whilst at work, participants spoke of the need to be resilient and keep dealing with the challenges that they faced.

5.3.3 Get on and Deal with It

‘Get on deal with it’ depicts how the frontline workers had to accept that, even though it was a difficult and unpleasant situation, or that it was someone else’s responsibility, they had to

attend to whatever the issue was, even if they didn't want to. This was with little support from the organisations that they were working for:

*You know there is this kind of expectancy and I always remember back to a former head of service that we had and this kind of expectation that's what you are going to get because you work in this environment, so this almost and it's not mine, trust me, trust me it's not my view and I don't think it's [employers name removed] view anymore but this view that if you are a librarian and verbally abused they would do something about it but if you worked in customer services or face-to-face with this client group it was an expectation you've just got to **get on and deal with it**. I think that's still to a degree very true (Jenny).*

It was perceived by participants that the organisations they worked for were unsympathetic and unsupportive about the abuse the frontline workers received, with a culture of acceptance and tolerance that this kind of abuse will happen towards staff due to the complex needs of the rough sleeper. Working in an unsupportive environment is seen to increase the likelihood of moral distress occurring (Wilkinson 1987). They were frequently expected to work in isolation and without support from other organisations:

We are dealing that often, with that different environment and with staffing levels and skills and resources that are not appr [doesn't fully say the word appropriate] ... you know that are significantly less than some of those statutory services who will say no they are too demanding for us or too difficult for us work with, other than prisons or inpatient psychiatric wards (Val).

Participants were critical that other services across the sector, such as the criminal justice system, primary and secondary health care, and adult social care, signposted people to homelessness services without the referring service checking to see if the person referred would be eligible for help. This was perceived to be due to the other services acknowledging that dealing with a homeless person can take up a lot of time, resources, and expense:

There is a lot of services that have [sighs] just diverted people with you know without a moment's thought as long as it's not near us or near me then yeah, it's someone else's problem and that often ends up with people ending up at the [service provider-name] [laughs cynically] (Alex first interview).

It's all one big pot of government money but the department of health, housing and social care all fighting each other to protect their own little budget (Keira first interview).

Being able to “get on and deal with it” required a level of cooperation with the rough sleepers they supported. However, they were constantly faced with a high level of mistrust that rough sleepers had for all aspects of the systems within which the frontline workers worked in.

5.3.4 Lack of Trust

It was acknowledged by all the participants that most of the rough sleepers they supported have had adverse life experiences prior to becoming homeless. They have “*childhood trauma and adult trauma as well*”, and participants spoke of how many rough sleepers had already been through a variety of services and systems, such as being taken into care as a child by the local authority, the criminal justice system, and mental health services. All participants acknowledged that the rough sleepers were also affected by co-morbid conditions such as “*substance misuse and mental health*”.

Frontline worker explained the difficulties they faced in building a trusting relationship with a person experiencing rough sleeping due to their (the rough sleeper) past involvement with other services.

*How they have been brought up, mentally what’s happened to them or they have been abused or been neglect [didn’t finish word] or like I say from being homeless from a very young age or from coming out from care, different things affect different people and I think because they are just ... that’s how their life just is, it just carries on it just carries on and that’s why I personally think that when they come they show a lot of anger, it’s not because they don’t like us or sometimes, they don’t want to be at the place of where they are, it’s because what’s been happening to them and it’s a trust, **they don’t trust anyone** (Leo).*

People have moved around so much and been in care and in and out of services, and quite transient and never been in one place long enough to sort of engage or be picked up, but then it is worrying also that people that have been through services like social care and care (Keira first interview).

A systematic review and meta-analysis by Liu et al (2021) demonstrated a high proportion of adults experiencing homelessness having adverse childhood experiences with 89.8% of people experiencing at least one and 53.9% having at least four. These experiences contributed to the lack of trust they had for many areas of society and for people working in a position of power and professional capacity. Yet, a trusting relationship with support

workers is seen to be a crucial factor for to enable successful support to for people experiencing homelessness with complex needs (Bowpitt et al 2011a).

The frontline workers often bore the brunt of reactions to any policy being implemented, as they were the ones delivering the policy directly to the rough sleeper. In which case they could be classed as street level bureaucrats, as defined by Lipsky (2010:8), due to their policy interactions with the rough sleepers being *“immediate and personal”*:

When the actual cuts in services and reductions actually hit home and affects them directly that is when their frustrations are usually taken out on myself and colleagues (Alex first interview).

The response from rough sleepers was often described as negative. Participants were cognisant that, due to a lack of resources and an increased number of rough sleepers needing their support, they did not have sufficient time to spend with the rough sleeper, which meant that interactions between them were poor:

People are unhappy with what they perceive to be receiving, they don't feel that they are being treated fairly or sometimes respectfully and [sighs] and it's just a knock on effects of the cuts like I have said before the cuts that have brought in its just restricting in what you are able to do, so they don't sometimes they feel they are being listened to the service users and you know, its, its sometimes it's a knock on effect of that, they just, they don't feel that they are getting any service at all (Alex second interview).

Of relevance is the study by Armstrong et al (2021) who found that, due to high workloads, homelessness hostel workers did not have enough time to build a trusting relationship with the residents they were supporting. In exploring working within a psychologically informed environment during austerity, Watson, Nolte and Brown (2019) concluded that supported housing project workers did not have adequate time to spend with residents and due to the lack of resources available had to decide who was worthy of receiving resources available.

Due to a lack of resources and an increased number of rough sleepers needing their support, participants felt guilty that they were unable to spend the time needed with the person who was rough sleeping and this guilt added to the overall moral distress felt by participants:

You just get a little bit stressed, I think, so you know and there is such a high turnover of people that you don't feel like you are doing quality of work, like I used to do a lot more work previously when, before covid, I think there is a big turnover of people now so erm you don't get to do quality work with them like that you used to be able to and follow things through" (Ade second interview)

Despite the difficulties frontline workers had in building a good trusting relationship with their service users they were resolute in trying to support their service users to the best of their abilities.

5.3.5 Doing Their Best

To abate their moral distress participants described doing their best to support the rough sleeper in any way they could. *"You are just **trying to do the best** with what time and what resources that you have"*. One frontline worker recognised that there were limitations to what could be achieved within their job remit and cared for the rough sleeper by trying to ensure that, at the very least, basic needs were met:

*I just do **the best** that I can with the tools that I have got and just try and you know make it easier for the service users as much as I can, to try and take each day as it comes and try and help them and I think you have to take it back to the simple things when you working with our client group and just you know, just something as simple as giving someone an extra sandwich for their tea, or giving them a blanket when they are rough sleeping, or give them, giving them some toiletries and a clean towel, I think it's just taking it back to simple things sometimes and making it more comfortable for them [the rough sleeper] (Ade first interview).*

This statement upholds the metaphor of using a sticking plaster to deal with a burst artery as the participant uses whatever tools he has at his disposal to support his service users however he can.

One participant acknowledged that, despite trying her best to support the person who was rough sleeping into accommodation, often all she could offer was emotional support. However, she was saddened by this:

We can listen to them, they can offload, cry and be distressed and then talk to us and feel a bit better for doing that but they are still going out to the street (Keira first interview).

Similarly, Lei was visibly distressed and angry when discussing the little support, he could offer to a rough sleeper who was experiencing severe mental distress:

Their mental health is deteriorating, their thoughts of self-harm and suicidal thoughts, wanting to end their lives, not having that security, jumping from hurdle to hurdle to even trying to access the most basic thing. You know getting, not having enough beds for them to sleep in, you know that Maslow's hierarchy of needs is the basics, water, food you know a bed we can't provide that for them. Well, we can provide it a little bit but not all of them. People are getting turned away from having a bed or somewhere to sleep.

A British Medical Association (2021) survey found that 28.7% of doctors thought that working in organisations that did not uphold raising concerns about service failures contributed to moral distress of doctors. This was also the position for the participants; they were anxious about experiencing an adverse reaction from their employing organisations if they were found to be critical of organisational policy and procedures discussed during their interviews:

[Participant looks at the recording device and laughs nervously] *You can delete that if you want* (Mary).

Because the numbers are growing, [lowers voice] even though I don't feel the true numbers are being... I will probably get done for saying that (Lei).

I need to be careful of what I say (Keira, first interview).

I always have to be careful when I say this and that why I always ask if this is anonymous (Jenny).

What drove the participants was the thought of a successful outcome for the rough sleeper, *"Fighting your corner for the service users, and that's what keeps you going really, is the service users, you know, fighting for them really"*. This supports findings from research by Wirth et al (2019) who explored the working conditions of social workers who support refugees and the homeless in Germany. The researchers concluded that one of the positive and motivational aspects of the social worker's job was any successful outcomes the workers achieved for their service user. However, the 'fight' frontline workers spoke of may cause conflict within organisations. Scanlon and Adlam (2006:12) argue that a great number of homeless staff have extensive opposition to statutory services and *"...staff become cast in the role of the hero, doing a dirty job in difficult circumstances in order to clean up somebody's mess"*, which in turn can cause conflict within the organisations and

therefore staff supporting people experiencing homelessness being ineffective in carrying out their job role. This implies that the “fight” participants spoke of was detrimental to the frontline worker, the organisation they worked for and the rough sleeper whom they were supporting.

The moral distress experienced by the participants due to lack of resources was further perpetuated by the number of obstacles they faced in trying to support their service users.

5.4 Too Many Obstacles

The category, “*too many obstacles*” addresses the numerous, continued difficulties and systematic barriers that frontline workers encountered when they accessed and navigated services and systems across health, care, housing and the DWP. Four themes “*falling through the gaps*”, “*law gets in the way*”, “*forgotten entities*” and “*an ideological stance*” support this category. The obstacles left staff feeling powerless, insignificant, disenfranchised, constrained, and frustrated at the systems they were working within, all of which amplified their moral distress.

5.4.1 Falling Through the Gaps

Participants identified mentally ill rough sleepers as “***falling through the gaps***” in services, that is, the rough sleepers they were supporting had either been assessed and rejected by other services or did not meet the other services criteria for assistance. The concept of falling through the gaps is becoming more recognised. For example, the “Make Every Adult Matter” (Meam Coalition 2018a), a group of charities, which represent frontline organisations, states that people who have a mix of issues across; homelessness, substance misuse, the criminal justice system and mental health, often fall through gaps in service provision. Personality disorder is prevalent amongst the homeless population (Shelter 2008), and statutory services often exclude people with this diagnosis (Royal College of Psychiatrists 2020a). Participants explained that this was a common diagnosis for the rough sleepers they were supporting. “*I find a lot more ADHD and personality disorders amongst the homeless*”, and “*...depression and anxiety, personality disorder*”, were conditions commonly encountered by the frontline workers.

There is a growing consensus to work with homeless people in a psychologically informed environment (Maguire 2017, Liu et al 2021, Reeve et al 2018, CFE Research and the University of Sheffield 2020, Moreton et al 2021, Meam coalition 2022, Moreton, Welford and Milner 2022, Moreton and Welford 2022, Pawson et al 2022, New System Alliance 2023) due to their often-traumatic backgrounds (Mental Health Foundation 2017). Yet participants spoke of feeling overwhelmed, hopeless, and distressed, analogous to the feelings of those they were attempting to support, as they were unable to offer support and time for them. This is in keeping with the work of Zacka (2017:123) who argued that staff are frequently dealing with the contradiction of why they began the job and the realism of the task in which they can only apply “*patchwork solutions*” to issues. Rough sleepers were in dire situations and frontline workers were hampered by their lack of power and were unable to give timely support, supporting the premise by Young, Froggatt and Brearley (2017) that feeling powerless due to a conflict of values at work can cause moral distress. Alex expressed his frustration in a situation where a rough sleeper, with a severe mental health illness, did not meet the threshold for hospital admittance, consequentially this left homelessness services supporting the person in the community and all the risks associated with this:

There’s people that clearly aren’t in the right place because their mental health is too, it’s too extreme for us to be actually handling with or dealing with it so but then you know they could be assessed at a mental health unit and be told there’s nothing that they need there (Alex first interview).

Participants felt that, due to structural failings, there was often missed opportunities to support people in the right way at the right time and people were being set up to fail, in keeping with research evidence that experiencing organisational constraints cause moral distress (Wilkinson 1987, Burston and Tuckett 2012, British Medical Association 2021).

One participant was exasperated when giving an example of a rough sleeper with a substance misuse issue who had been detoxed in prison/hospital and was placed in inappropriate accommodation when back in the community. The inappropriate placement meant that the rough sleeper was living with others who were actively misusing substances and resulted in the person beginning to misuse substances again:

If someone has come out of uhm hospital or uhm prison and prior to going in either, they've had an alcohol or drug problems, I think bringing them into a hostile environment which arguably becomes a sweetie shop.... we miss an opportunity when they are, whether that's in hospital because they have had to go in with a physical issue and they have had to have specific medication to support them around the withdrawal of drugs and alcohol, that we still miss an opportunity (Val).

It was common for people to be discharged from prison with no accommodation or support in place, which meant that people began rough sleeping again:

They could be coming out of prison and anything, just dumped and they might just go and live in a tent somewhere (Mary).

The above further epitomises the “*sticking plaster*” metaphor, as the participants found that the tools and resources that have been put in place for the person experiencing rough sleeping failed.

One of the obstacles that contributed to rough sleepers falling through the gaps was legislation that prohibited the frontline workers from providing adequate support for them.

5.4.2 Law Gets in the Way

Studies on moral distress have demonstrated that the wider service systems, including the law, can cause moral distress (Wilkinson 1987, Burston and Tuckett 2012). Participants felt that the legislation and wider policies that they were working within often acted as a barrier to mentally ill rough sleepers accessing support, and made their job supporting the rough sleepers even more challenging:

*It's sort of having to prove it isn't it and its difficult if someone's got like a mental health issue and they are rough sleeping and then they have got to try and prove that they've got all this for the housing officer and then **law gets in the way** (Ade first interview).*

Frontline workers believed that the threshold of ‘*being found as vulnerable* (Housing Act 1996b) was very high, “...an awful lot of people who we see in that rough sleeping group would not be deemed as having a priority need as far as homeless legislation is concerned”. Being classed as vulnerable by the local authority was important, as this assessment can determine whether the rough sleeper is in priority need for housing, and therefore being

owed a housing duty from the local authority, which means the rough sleeper can be offered temporary or permanent accommodation (Shelter 2022b). The homelessness code of guidance (Department for Levelling up, Housing and Communities 2021) acknowledges that ultimately the local authority decides on the vulnerability of the person being assessed; yet recommends that local authorities work with a larger multidisciplinary team for their opinion. Participants were critical of the local authority having this responsibility and they felt there was a disparity between, being found as vulnerable and therefore having a priority need for severe mental ill health illness, compared to a physical illness under the Housing Act (1996b). The complexity of these situations is epitomised in the example below of a rough sleeper who had been previously so unwell that they had been detained under the Mental Health Act, yet were not found to be in priority need, under the applicable housing legislation, as they (the rough sleeper) were not currently under mental health services:

If you are diabetic and reliant on insulin and therefore need a fridge, that's enough alone to be eligible for priority need but someone with a severe mental health disability that has had previous sections, unless you have got consistent engagement with a consultant psychiatrist that you can access quickly you can't get that priority need under the same legislation (Abdul).

The “unseen” nature of mental illness creates barriers in accessing housing and benefit services (Pybus, Pickett, and Lloyd 2017: A70) and people who are rough sleeping may focus on “support needs arising from drug and alcohol use, mental ill-health or the simple need to escape” (Bowpitt et al 2011b:32). Participants were disapproving of how the law, and subsequent code of guidance, was interpreted by the local authority, when a person was being assessed for vulnerability for mental illness, “When its mental health, its less obvious and its down to, its, more subjective isn't it”?

Another concern was the evidence needed by the local authority to prove the rough sleeper's vulnerability for the appropriate housing legislation. Although it is the local authority's responsibility to establish if someone is vulnerable, in practice the onus was often put on the rough sleeper to prove this vulnerability. For example, they may have to obtain a supporting letter from a professional (such as a consultant psychiatrist or social worker) to assist with this. Frontline workers were concerned that this was too difficult to

arrange and deliver without support, particularly for rough sleepers with a mental health condition, due to their illness and often chaotic lifestyle:

A lot of people [rough sleepers] are using drugs all they are consumed with is getting that and they want to go out and do that, they don't want to sit on the phone for ages on a benefits call, and end up you know, and they end up saying oh forget it, I've got to you know, do something else instead (Ade).

Local authorities were relieved of some of their duties under the Care Act (2014) during the pandemic, this meant there was a lack of urgency to assess rough sleepers unless they were thought to be at high risk of harm due to unmet care needs (Reyes 2020).

Participants were critical about the effect of the Homelessness Reduction Act (2017) and the rough sleeper initiative which, as discussed in the introduction chapter, was designed to support people irrespective of their priority need status (Homeless Link 2018b) and to reduce the number of people rough sleeping. Participants felt that the support needed to be greater to be effective:

I don't believe it's improved anything, in fact you are still seeing the same numbers of people, even probably more (Alex first interview interview).

The rough sleeper incentive has given some resources to potentially to engage with people, what it hasn't really done is again, acknowledge that you need very high levels of intensive social care support to go alongside any housing, so effectively it's still very much an emergency response for people (Val).

Since the rough sleeper initiative, it has got better in terms of accommodation but there is a lack of support in mental health, and, you know, food and everything (Ade first interview).

The approach was to make rough sleeping “less visible”, however, participants felt that the local authority was hiding the true number of rough sleepers in the local area. They were sceptical about the number of people accounted for in the local rough sleeper snapshot, which, since 2018, has been used by the government in establishing how effective the rough sleeper initiative was in bringing down the number of people rough sleeping (Ministry of Housing, Communities and Local Government 2019a). Ultimately it was felt the number of rough sleepers counted was not a true reflection of the number of people rough sleeping:

Whatever they say is the official number you could probably close to double it, and then probably come up with a closer, figure, you know, more realistic figure (Alex first interview).

We know there's rough sleepers out there who are not picked up on the figures because they are not caught on that count, on certain counts, you know weekly counts, or we know that the yearly count has always been a, what's the word, well just a guess really, it's never been a true reflection of homelessness, of rough sleeping, because you know even when people have been counted it's, you know, it's played down (Keira first interview).

I don't think it's a true story when they [the local authority] go out to do their counts (Lei).

Participants were positive that people were accommodated under the 'Everyone In' initiative', which, as part of the government's public health response to COVID-19 during the initial lockdown, ensured that all rough sleepers were accommodated (Cromarty 2021). As commented on by one participant, *"it has been good in terms of getting people off the streets"*. There was a recognition that entrenched rough sleepers had agreed to be accommodated, *"we got people come in who had previously been resistant to services"*, as before the pandemic some rough sleepers would typically refuse any offer of temporary accommodation.

Although the basic housing needs for rough sleepers were met once they were accommodated, frontline workers explained that, despite other complex needs of the rough sleepers, there was little or no other support available to help them maintain the accommodation. *"They [rough sleepers] are put in somewhere but then there is just no support when they are in there"*. This was also a finding in the Fitzpatrick, Watts and Sims (2020) study.

There was a concern about rough sleeper's mental health needs not being recognised and supported when they were placed in temporary accommodation. This appeared to be a national issue, as physical health needs were prioritised over mental health during the pandemic (Dissanaayaka, N. cited in Johnson 2020).

When accommodated under the initiative by the local authority, rough sleepers were not given access to some essential household items to make their accommodation homely. This left rough sleepers isolating in sparse and uncomfortable living conditions:

They [the rough sleepers] were given [accommodation] with basic furnishings i.e., a bed and a fridge and a cooker but no pots, no pans, no bedding, no towels and then when it was provided through a [name of local authority] there was a period of time that elapsed, the urgency wasn't there, the urgency didn't meet the urgency that was there to get people indoors (Abdul).

Staff from these organisations were home working, which meant services could only be contactable by telephone or online. Many rough sleepers placed into accommodation were unable to contact services this way as they did not have access to a smartphone or Wi-Fi.

These situations further frustrated the frontline workers:

They are not getting the support that they need 'cause we can't have agencies coming in because of Covid and you know and it's just really... We've got to see people, to talk to people over the phone it's impossible (Ade first interview).

As a result, some were evicted from their tenancies, upholding other accounts across the UK where accommodated homeless people were being evicted from accommodation during COVID-19 due to antisocial behaviour (Groundswell 2020a):

We've had loads of people coming back and getting kicked out again because the support is not there when they get there, so they are just sort of shoved in without a, you, know a support package (Ade first interview).

The law and policies that surround supporting people who were experiencing rough sleeping were seen to be failing the needs of the rough sleepers with a mental illness. These systematic structural barriers were amplified during the COVID-19 pandemic and participants were morally distressed as they witnessed structural and service failings yet were powerless to assist people and were constrained in acting in a way they saw as ethically correct in supporting people experiencing rough sleeping.

However, these were not the only obstacles to supporting and accommodating the needs of rough sleepers. They faced further exclusion due to lack of access to basic technology that was required to enable them to access appropriate systems.

5.4.3 Forgotten Entities

'Forgotten entities' refers to digital barriers and subsequent exclusion faced by rough sleepers, when they attempted to access services including the DWP, housing, health, and social care. Face-to-face contact ceased during the COVID-19 lockdown and contact with services was expected to be made by telephone or the internet. Rough sleepers did not have access to the technology to be able to use services in this manner, and this appeared to be completely overlooked by organisations:

*...the people [rough sleepers] that we work with are like a **forgotten entity of people** who don't have access to smart phones, peoples that, whose priorities isn't necessarily going to be a smart phone, people that do have a phone but then don't have access to the internet (Leo).*

[Rough sleepers] are people [who] haven't got a phone, a mobile phone, they haven't got an email address, they haven't got access to a computer.... and we find that really impossible [pause] because our computers they won't let us go create a Gmail account or anything, so that's a really, really big barrier (Ade first interview).

The administration system for Universal Credit was seen as particularly troublesome for rough sleepers as many did not have access to a telephone or a consistent telephone number and were not able to afford to pay for internet access; "*With the universal credit, it's the access to the internet, the lack of consistent telephone number*" and organisational IT constraints prevented frontline workers assisting the rough sleeper to set up an email address:

At the moment the housing app, application process is really difficult because they have made... [sighs] we can't even do the forms at the moment because they have made it so that the person has to have an email address, we can't make up an email address for people because there are restrictions on our computers so that's been really, really difficult (Ade first interview).

The digital exclusion to accessing benefits was also reported in Thomson et al's (2020) study that explored the health impact of people experiencing homelessness claiming Universal Credit. Also of relevance is the Frontline Network Annual report which reported that 93% of frontline workers found digital access to Universal Credit was problematic to their service users (Marshall 2021).

Accessing services and other support during the COVID-19 pandemic was seen as extremely difficult. The participant below explains how a vulnerable service user was unable to access a GP due to service organisational constraints regarding registering as a patient during the COVID-19 lockdown:

Like getting someone registered with [name of GP practice] has been impossible as well because they have to go to get registered, they can't just do it over the phone, they have to go and pick up forms, so you know that's been a barrier as well, cause for example I have had someone in a wheelchair who had to you know, had to needed some forms, there needs to be a different process so they should be sending the forms to us or something (Ade first interview).

Accessing mental health support also became telephone based during the pandemic and it was difficult for some rough sleepers to discuss sensitive subjects over the phone. The telephone appointment system was viewed as inflexible and inept for a rough sleeper with a chaotic lifestyle and/or high support needs, and consequently appointments were regularly missed:

What's been difficult is getting in touch with other services like I've said before, like getting in touch with probation and getting people too... cause a lot of people find it difficult to speak on the phone so and that's the only way you can get a CPN now or a probation worker or anything else, you've got to do it over the phone and it's been really difficult, and it's really difficult to pin someone down, like when someone's chaotic, it's hard to say right you've got an appointment at 10 o'clock tomorrow morning, you know can you... whether someone's chaotically drug using you know and got a mental health issue as well and have been rough sleeping it's hard to get them to (laughs) to come at a certain time (Ade first interview).

Rough sleepers often used day or drop-in homeless services to contact other services and would frequently be signposted to other agencies whilst there. These centres were mainly closed during lockdown or had opening hours and capacity restricted. Staff from other services were also working at home during COVID-19, which intensified the difficulties rough sleepers had in accessing wider services:

Actually, to be [sighs] for them to be contactable, easily contacted you know there has to be somewhere for them to actually reach the services (Alex).

Due to the public health response to COVID-19 the denial of access to services was amplified. Services were inaccessible and frontline workers were therefore powerless to help the rough sleeper to complete fundamental tasks, such as making a claim for benefit or

making a housing application, which hampered their agency and autonomy in being able to support the person experiencing rough sleeping as they saw fit. The participants felt that this barrier was created by the ideological stance taken by the government both prior to and during the pandemic.

5.4.4 An Ideological Stance

The difficulties in initially claiming the benefit, with the overall DWP administration processes, and the time it took to resolve issues, was attributed solely to government ideology:

*I think it's a top-down approach to reduce the benefits budget really, I think it's a directive really to approve less people, make it harder for people for people to actually claim benefit, it's **an ideological stance** (Keira first interview)*

A frequent experience was the long waiting time to get through to the DWP via the telephone, which commonly took over an hour. Along with feeling annoyed themselves, at the amount of time waiting to speak to an advisor at the DWP, they were also dealing with the impatience rough sleepers were experiencing. Frontline workers explained that rough sleepers would become so irritated, whilst on hold, that they would often abandon the call, which ultimately left the benefit issue unresolved. Resources were overstretched and it was felt that the length of time it took to contact the DWP used up valuable time that could have been better used elsewhere:

Getting through to the benefits as well it takes ages on the phone, the service users get impatient you know, like I was saying before, because they, a lot of people are using drugs all they are consumed with is getting that and they want to go out and do that, they don't want to sit on the phone for ages on a benefits call, and end up you know, and they end up saying oh forget it, I've got to you know, do something else instead, so it is difficult, you know it's really difficult for us as workers to sit on the phone (laughs) to the benefits with the music going on you know and waiting, you've got to be really patient and it takes a long time and I do feel they deliberately make it difficult for people trying to claim, I think it could be a lot easier (Ade interview one).

So, we'll ring up with them for the application form, we'll help them with the application, we attend the assessments with them, it's like a long process (Lei).

Frontline workers found that most of their service users were eventually awarded Universal Credit, “they all seem to be getting Universal Credit”, however it was felt that the amount

paid continued to leave them in poverty; *“He says after paying his bills and all the other stuff he has to pay, the rent here or... he’s just left with £4”*.

Deductions and sanctions from Universal Credit were perceived as being high and left little money for people to live on:

If they are paying you know close to £160-£165 a month [Typical temporary accommodation costs] and then they have got deductions that are already coming from advance payments, they are having sometimes between £50 and a £100 to last them for the month (Alex first interview).

Participants felt that this financial insecurity negatively impacted on rough sleepers’ mental health:

They are homeless and have a mental health problem on top of that and then the benefits all of a sudden, they go to the bank to get their money out and there’s no money (Mary).

Applying for Personal Independence Payment (PIP) was not a straightforward process for the frontline worker to assist the rough sleeper with. There were several stages to go through; making a telephone call with the rough sleeper to get a personalised claim form to be sent out, assisting the rough sleeper to fill in the claim form, which is 50 pages long, and often attending a face-to-face health assessment (Gov.UK 2021b) to support the rough sleeper. All these processes impacted adversely on the worker’s time. The participants time continued to be affected negatively if the claim was not initially awarded; *“It takes up about two hours to do the form and then [pause] supporting letters on top if they’ve not being awarded”* (Lei). They then became involved, if necessary, in the mandatory reconsideration process and/or appeal process to challenge the DWP initial decision.

Participants were upset at witnessing the distress experienced by rough sleepers when they were ‘hounded’ by the DWP to attend optional appointments regarding returning to work. They saw this as having a detrimental effect on the mental health of the person experiencing rough sleeping. One participant was visibly infuriated by this; *“the job centres are hounding people and pressurising people”* to attend appointments.

Once claimants are assessed as having limited capability for work and work-related activity, due to ill health or disability, they are not required to attend work focused appointments (Department for Work and Pensions 2020), yet frontline workers found that the rough sleepers they were supporting were called in regularly for this type of appointment, even though, in theory, the person experiencing rough sleeping was exempt. This caused considerable anxiety for the rough sleeper as they were frightened of the consequence of not attending appointments, such as being given a benefit sanction (Universal Credit 2021). The DWP state that if benefit claimants make their work coach aware of any vulnerabilities that the work coach will take these into account (Department for Work and Pensions 2021), however this is guidance, and it is unclear how this is implemented:

I've had it where people where in the support groups and they were still hounded to come in for interviews... Why? and she's [the job centre worker] ooh but its compulsory, but he doesn't have to come yeah, they ring them up and tell them to come in and of course they panic (Mary).

I've had to go with service users that are absolutely I'm going to use it, pooping it, they are in such a mess. Her anxiety just hit the roof, she couldn't sit still, she was you know shaking and the number of times I had to you know try to calm her down, it's unbelievable (Lei).

Participants witnessed considerable anxiety experienced by rough sleepers with a mental illness when they were requested to attend a face-to-face assessment appointment for PIP. Witnessing this anxiety contributed to the moral distress felt by participants as they believed that the assessment process was brutal and unnecessary in its administration. Participants observed that the benefit health assessors, along with the structure of the assessment, lacked compassion towards people with a mental illness. They felt that the process needed to be overhauled to make it easier and less traumatic for the person experiencing rough sleeping:

The people [the rough sleeper] that can't, don't make them go through it, do it over the phone, don't make them come out for a face-to-face when they are absolutely in, they are so distressed (Lei).

The PIP assessment process has been heavily criticised historically for not being transparent enough (Gray 2017, Field 2018) and findings from this research suggests that workers mistrusted the assessment process. They were not confident that the assessment process was fair and were sceptical that the reality of the care and support needs of the rough

sleeper with a mental illness were acknowledged. Their experiences at these assessments led them to be cynical overall about the assessment process:

When it comes to the decision its often disregarded or played down or sometimes it comes back and you think well was I in the same assessment?
[laughing] (Keira first interview).

It was felt that the questions asked by the assessor during the face-to-face assessment process were often not suited to the rough sleepers' particular illnesses and/or disabilities. Questions were seen as broad in nature and leading. This was a particular concern to one participant who attended an assessment with a rough sleeper who had dementia and did not have insight into their illness and how it affected their everyday life. It was felt that the assessor did not have suitable knowledge about someone with dementia and was not sensitive to the support needs that this rough sleeper might have had. The frontline worker was exasperated further by the assessment process as she was told off by the assessor when she began breaking down the questions to make them simpler for the rough sleeper to understand. The participant felt she was treated as insignificant, and that her own expertise in supporting someone with dementia was ignored, and she became powerless in supporting the rough sleeper. This supports the research by Morley, Bradbury-Jones and Ives (2021) who found that the likelihood of moral distress increased when professional status was not recognised when advocating for patients:

I've been there with people one guy with dementia and other people that have sat there and then when they are asked [by the assessor] oh can you do this, oh yes I can do that and then the person thinks that they can or is just answering and even when I've said well actually [name of rough sleeper] you do need a bit of help with that don't you, they [assessor] just says to you oh we need to hear that in their own words, thank you and they shut you up really, which to me we are there for a reason, you know I'm a [profession removed for anonymity] this person has dementia or learning disabilities, learning difficulties they need that advocacy, they need that person there with them to help explain the situation, because they will just answer yes, or I can do, Can you cook? yes, Can you shop? Oh yes and [laughs] without even breaking it down and saying actually you do need help with that [name of rough sleeper] or budgeting or planning your shopping and somebody to go with you, you know because otherwise they would just say, yes, I can shop, yes, I can wash, yes, I can dress, yes, I can do my washing not understanding, just misunderstanding the question (Keira first interview).

This was akin to the House of Commons Work and Pensions Committee (2018) who, when examining PIP and ESA assessments, were critical that assessors lacked specific knowledge about the conditions they were assessing.

The obstacles and barriers encountered by the frontline workers were further impacted on by the lack of resources both within their own specific organisations as well across the wider services.

5.5 Lack of Resources

Participants found that ‘lack of resources’ was endemic within their own organisation and across wider services such as housing, health, and social care; these included funding to services, service access, and the time the worker can spend with their service user. This had a detrimental effect on the frontline workers. The themes for this category were *“squeezed and stretched services”*, *“a fractured system”* and *“withdrawal of services”*. The lack of resources affected frontline workers in various ways, such as having a high workload and working out of their job remit. The COVID-19 pandemic was seen to have amplified the lack of resources available. Like their feelings when faced with obstacle and barriers, they felt disillusioned, constrained, and powerless by the lack of resources, all of which contributed to their moral distress.

5.5.1 Squeezed and Stretched Services

“Squeezed and stretched services” denotes how the frontline workers attempted to access services that were at full capacity *“services are **stretched** and chaotic everywhere”*, and *“it’s the system being **squeezed both ends**...it’s difficult, it’s a battle to get them into hostels a lot of the time and also into mental health services”*. Services within the area had very little provision to offer, *“it’s just been cut after cut after cut”*, with particular emphasis on blaming the government and austerity policies, *“since the Tories have been in everything has been cut and cut and cut”*. Participants were working within organisations that had experienced extensive funding cuts *“you know, continue to do more with less that has, has just been the mantra”*, yet had increasing demands placed upon them due to the high volume of people needing support:

It's more difficult to carry out your job because of the lack of funding and investment in the service really and you are not really able to actually, sometimes see through a full, a full, the proper journey with the service users so to speak (Alex second interview).

I'm quite frustrated in the way that things have become in homeless networks and sectors really, that it's been a gradual withering down of services and a reduction of services by the government (Kiera second interview).

What's getting harder for our services, is all the cutting down, they are closing down all these hostels, they are closing down you know sort of places where the homeless can go, they are closing them down so in a way it's harder for us to try and support the homeless because of the resources are being cut (Lei).

One of the biggest areas of concerns was the cuts in staffing numbers across the whole of the homelessness sector and the organisations the participants were working within, “*there is loads of barriers [long pause], but I think that's probably the main one not having enough staff*”. The cuts in staffing levels meant higher workloads and consequentially diminished quality of support offered to people experiencing rough sleeping. This caused staff to question their effectiveness in working within the sector due to the amount of work they had:

Everything has been cut even further because the staff are down to the bare bones almost now, you know we've not got any other services around, we've not got [name day centre service] there, we haven't got any other support so, its, it's made it ten times harder (Alex second interview).

The staff team have been reduced dramatically even before Covid over the years so that's had an impact on capabilities to do the job and also just feeling able to do the job (Alex first interview).

The metaphor putting a “*sticking plaster over a burst artery*” is relevant here as the participants experienced an increasing number of people needing support, with a limited number of staff available so the support offered was superficial.

The British Medical Association (2021) survey found over half of respondents felt that not having enough staff to treat patients properly added to the moral distress experienced. A lack of resources was found to heavily increase the likelihood of moral distress occurring (Burston and Tuckett 2012). However, Lipsky's (2010) viewpoint is that staff who work as street level bureaucrats will always work with a lack of

resources as the demand for services will always exceed the resources available, even if resources are increased.

These cuts and pressures on services are representative of national trends in England, with cuts to mental health beds (Anandaciva et al 2020), underfunding mental health services (King's Fund 2019), and cuts to local authority spending to homeless services (Oakley and Bovill Rose 2020). These are alongside an increase in rough sleepers (Wilson and Barton 2021) and increased demand on mental health services (British Medical Association 2019 and Royal College of Psychiatrists 2020b), and this reduction in homeless service provision was seen to have increased moral distress in homelessness workers in Canada (Hodwitz et al 2022).

Other services within housing, health and social care were deemed by participants to be invisible to the rough sleepers that they [the frontline worker] were supporting. Support offered by homeless services is rarely joined up, with agencies working in silos (Blood et al 2020, Masters and Freund 2020). Rough sleepers were perceived as not being aware of what other services they could go to for advice, support, and assistance:

We suggest and signpost to other areas and they are totally oblivious and don't know where this service ...and everything that's available to them. They are not aware what is available to them (Mary).

It's mainly if people don't know where to go then they don't know how to access it, do they (Keira first interview).

The invisibility of services supports findings by Reeve (2011:2), who argues that this could be attributed to the lack of importance that is placed on single homelessness services, with single homeless people being "*hidden from support, advice and statistics*", which then prevents them going into support systems. However, overall, participants felt that the fault lay with homelessness services, as they prefer to work in isolation without scrutiny, "*I think in some ways the homeless sector has exacerbated that because it does create siloed services*".

When attempting to refer rough sleepers into services that had had funding cuts since austerity, there was a consensus that service quality from participants own organisation and wider services was poor. This was believed to be due to the pressure that services were under, and that services could only meet the basic needs of homeless people:

*The funding cuts or the lack of funding available to the third sector and to public services service has meant that there is a decrease in the capacity but then the pressures are there from above to increase the capacity, so then the services quality has then been **stretched** too thinly (Abdul).*

The lack of resources in the NHS service meant that, even if rough sleepers had eligible needs, they were unable to get access to mental health support, due to high service demand and waiting time for services:

Overstretched CMH [doesn't fully say CMHT] community mental health teams community services, crisis teams, you know lack of resources, lack of resources in that they are overstretched and the number of cases that they have (Kiera second interview).

Staff were overwhelmed and felt exhausted with the high volume of work, and they were often doing work out of their job description. *"The numbers of staffing have been reduced dramatically and you are expected to do everything".*

One participant explained, that due to other homelessness/housing services not being able to offer immediate support to secure a tenancy for a service user who had been offered one, her team had to *"drop everything"* to support the service user sign for the tenancy and secure furniture for it. She felt obligated to work out of her job remit to support the mentally ill rough sleeper or *"they wouldn't go, or they'd be back on the streets again"*. She had to do this without any support from other services. Doing this extra work could be seen as resisting austerity (Hastings and Gannon 2021, Dobson 2020) as, due to other services having no resources available to support the person experiencing rough sleeping in a timely manner she and her team stepped in to ensure that the service user received adequate support.

This culmination of a lack of staff and homelessness services was damaging to the relationship frontline staff had with rough sleepers as they couldn't spend the necessary time with them, which caused the frontline worker to doubt their own ability in carrying out their job effectively:

The staff that has been decimated over the last few years, the numbers and the, the number of homeless people hasn't decreased so you know they are (the rough sleeper) all fighting for the same few minutes of attention from the staff (Ade second interview).

The lack of resources was also seen to cause a breakdown within and across the organisations, that is the frontline workers saw the system as one that was fractured.

5.5.2 A Fractured System

Participants felt that services across, housing, health and social care were disjointed and did not work effectively together in supporting people experiencing rough sleeping; *"We have a **fractured system** that doesn't join up all the pieces"*. They believed that each service performed their own assessment, based on *"their criteria, rather than looking at what the overall of an individual"*.

Frontline workers acknowledged that there needed to be a single pathway to support rough sleepers to enable them to be effective in the support they give. Within the local area there were a variety of organisations giving support to issues that rough sleeper had, this included mental and physical health, substance misuse, criminal justice, housing, and welfare. The workers were supporting rough sleepers within their own remit and there was concern that without strong multidisciplinary working, rough sleepers were falling through gaps in service provision or support needs were being missed due to this:

There's about ten people in the revolving door all running around all doing their little bit with the individual, nothing really is seriously being joined up and making those interventions and until we get to that point where there is one doorway, and we are generally you know there is a multiagency approach to people. I think we will continue to have that problem (Val).

Of relevance is a multi-site study across Europe by Canavan et al (2012) who interviewed a range of people with a variety of job roles supporting people who were mentally ill and

homeless. The researchers found that a lack of partnership working was a common barrier to accessing treatment.

Participants were critical that organisations working in silos meant that the needs of the rough sleeper were not truly reflected within local policy. It was felt the organisations were working to pacify the organisations commissioner rather than dealing with the true local needs of the rough sleeper:

Although they all say they are working for homeless people, they are not... it's not, it's not an integrated commissioning structure, so they are all accountable, responsible [inaudible word] to their own commissioners (Val).

Frontline workers felt that it was important to acknowledge that homelessness is rarely just a housing issue and rough sleepers needed holistic support delivered by an integrated service structure with improved collaborative working to be successful in moving people on:

We haven't reached the point yet where services are that organised and I shall say personalised to that individual to do whatever intensive work needs to be done to start to address the other issues, it's not just homelessness (Jenny).

Although there are human costs to rough sleeping it was recognised that there were financial costs too. However, there was a consensus amongst the participants that stopping someone who was entrenched in rough sleeping was not financially viable to the government, as not one commissioning service would make any immediate savings:

So we can argue that if we actually put proper interventions in the long term, there would be longer term savings for the public purse around admissions, hospital admissions, mental health, acute admissions, err anti-social behaviour, criminal justice, all those sort of things but the challenge is there is no cash savings but no one body makes savings and that's why there's problems with rough sleepers, because they do cross over so much (Val).

The failing to fund services appropriately supports “*putting a sticking plaster on a burst artery*”, as the frontline workers felt that, with the proper tools and resources at their disposal, they could support their services users more effectively.

The move towards funding voluntary services, rather than statutory services, to deal with homelessness, was viewed as not cost effective by the participants; “*it's cheaper [long pause] or seen as cheaper*”. This type of service provision was also seen as unsafe, both to

the people who worked for the voluntary organisations and to the person experiencing rough sleeping:

When you have a statutory provider they have certain statutory provisions and health and safety and risk management and then when you've got lots of voluntary and people doing it voluntarily there is no co-ordination to that and things can get missed and there can be a lot of, sort of dodgy situations where people are going out all hours in the morning to try help people on their own in the streets, you know sort of walking the streets looking to help people (Keira first interview).

Participants believed that, within other organisations and services, there was a perception that homeless frontline services could support someone to access accommodation and support immediately, without the need for assessment or any other support processes, resulting in misinformation being communicated to the rough sleeper:

People are getting misinformed from other services so for example these two professional people came in with a couple of rough sleepers and [name of local authority] had told them at lunch time to present at the [name of service provider] at six o'clock and they'd get help, so that was misinformation and then it caused you know, the people to get angry, so the professional people were quite angry as well to be honest, because they were, had you know been told the wrong information and then [sighs] people had to go back and rough sleep, now if [name of local authority] had given them the correct information in the day then they you know, they probably would have got accommodated, but instead they got you know told the wrong information so that was really bad and we are finding that a lot that you know other services are given the wrong information out (Ade second interview).

They also felt that this misinformation contributed to aggression towards the frontline workers from the rough sleepers:

They [the rough sleeper] have been passed from pillar to post all the time you know and I think I'd be frustrated, I mean I wouldn't verbally abuse anybody but I think I'd be frustrated you know so I understand where the frustration comes from because if you keep getting passed around all the time and given the wrong information then you are going to be frustrated aren't you? (Ade second interview).

The fractured system, that manifested because of lack of resources, was further compromised in that rough sleepers were often, either barred from a service, or specific services were withdrawn.

5.5.3 Withdrawal of Services

The participants were sceptical about how rough sleepers were often deemed as being difficult to engage with. The frontline workers felt that the issue was more about how services were set up and delivered, which made engagement particularly difficult for the often-complex needs and lifestyles of the rough sleeper. An area of concern was the ease of in which services could stop working with rough sleepers and withdraw support if it was deemed that the rough sleeper had disengaged with services. The feelings of the participants were that this was rather a failure of services towards rough sleepers; *“Well again with the upmost respect I think the issue is services find it difficult to engage with them...”*. All services were seen as ineffective in dealing with the needs of people who were rough sleeping, primarily due to the way they are set up and not recognising the specific needs of rough sleepers. Participants felt that rough sleepers often have unique and complex needs and services should therefore be flexible in their support rather than a ‘one size fits all’ approach to service delivery:

*They [other services] are not able to respond with people that are perhaps chaotic, can be aggressive, can be emotional, can be inconsistent, you know and therefore often they are **barred**, or **services** are actually **withdrawn** from them because they are deemed not able to get into the safety box that most services are set up for work too (Val).*

Frontline workers were critical of services and their rigidity in their approach regarding access and delivery. They thought that services had a narrow view on policy and legislation and needed to be more flexible. Many services follow a model of empowering service users (Local Government Association 2021), the aim of which is promote independence. However, frontline staff felt it was more straightforward to complete tasks following the rough sleeper’s agenda:

I do think that sometimes cause that you know, we are working with completely chaotic people and sometimes you need to give them, like I’ve just said, a bit of extra help so, you know, you need to do some things for them sometimes to make it easier and that would be easier if you could do that, I just find that some services make it difficult, definitely (Ade first interview).

There was also the perception that other services and organisations didn’t want to help people experiencing rough sleeping. For example, one participant described how, if someone was found to be experiencing rough sleeping by other organisations across

housing, health, care and the criminal justice system, the rough sleeper was sent to his organisation for support, despite the referring organisation having a duty of care to support the person experiencing rough sleeping:

But all of those other services, yeah, a lot of people get sent to us yeah, we do pick up the flak you know whether it is social care and health, police, hospitals, mental health all of that kind of thing, so yeah, it's a one stop shop (Alex second interview).

There is a lot of services that have [sighs] just diverted people with you know without a moment's thought as long as it's not near us or near me then yeah, it's someone else's problem and that often ends up with people ending up at the [name of accommodation] [laughs] (Alex first interview).

This occurred even when the person experiencing rough sleeping was open to and had a care-coordinator in another service. It was felt that some services did not want to be responsible for, or accountable to supporting the person experiencing rough sleeping, due to their complex needs:

Some people [that are homeless] can already be under services but are under services and then to send them to us and then to find that they are actually under another service.....

Interviewer: *I'm just trying to make sense of what you have said, is it that you think that services are not joint up? Or do you think there is an element of*

Participant: *Passing the buck, pass the buck (Mary).*

The example above was about a person experiencing rough sleeping who was open to a mental health service and had a community psychiatric nurse as a care co-ordinator, yet the mental health team wouldn't support them with any homelessness issues and referred the rough sleeper to frontline services.,

The Healthwatch study (2018) identified areas of concern for accessing healthcare were congruent with the experiences of the participants. They discussed difficulties and barriers across all service systems that may be involved in supporting the rough sleeper including housing, health, social care and the DWP. Despite understanding how the system 'works' it was seen as problematic to frontline workers and overwhelming to the rough sleeper, who was unlikely to have prior knowledge across all the systems to access support:

If it's difficult for me with the knowledge and expertise to access, so if it was someone that was independently trying to navigate their way through the

systems with additional needs it feels near on impossible and that's from the voice of the service user (Abdul).

A significant issue, that was both a barrier and a resource issue, was the complexity of accessing services across, health, social care, housing and the DWP. Due to the often-chaotic lifestyle of rough sleepers, it was seen to be doubtful that they would be able to access services and navigate systems without the help of staff to guide them through the processes:

There's a lot of reattempting needed, so there is a lot of consistency needed with engagement from the service user and independently and without encouragement and without that support its just unlikely (Abdul).

Lack of resources leading to squeezed, stretched and fractured services were identified by the participants. Along with the additional impact of services being withdrawn or rough sleepers being barred from services, these contributed to the moral distress of the frontline workers who, most of the time, found themselves in impossible situations. As Zacka (2017:205-206) argues, this results in *"a bureaucratic pathology that leads to a breakdown in individual moral agency"* due to having to *"act in ways that run against the professional moral identity or role conception that they had been encouraged to adopt up to that point"*.

5.6 Chapter Summary

Presented within this chapter is a co constructed theory of how and why frontline workers experienced moral distress, when supporting mentally ill rough sleepers, during welfare reform, austerity measures and the COVID-19 pandemic. The explanatory theory of moral distress demonstrated that frontline workers experienced *"moral distress"* due to working with a *"lack of resources"* and having *"too many obstacles"* to navigate whilst supporting the person experiencing rough sleeping. Both these categories influenced the moral distress experienced by frontline workers, as they wanted to help and support the mentally ill rough sleeper yet were unable to do so, at least not to the level they desired. They witnessed services systematically fail and frequently exclude mentally ill rough sleepers across housing, health, social care and the DWP. The frontline workers were constrained in their own actions by organisational policy and procedure, along with wider policy and legislation. The service failings negatively impacted the relationship the participants had with their

service users, with the service users often taking out their frustrations on the frontline worker. All the above resulted in the frontline worker experiencing moral distress.

Chapter Six: Conclusion and Recommendations

6.1 Introduction.

Frontline homelessness workers, who support rough sleepers with a mental illness, work within challenging conditions. The broad aim of this research project was to explore how the welfare reform agenda, austerity measures and the COVID-19 pandemic affected frontline workers who support mentally ill rough sleepers in the Midlands geographical area. Using constructivist grounded theory an explanatory theory of moral distress was developed.

This chapter begins by discussing in more detail the different elements of the model and how they explain “moral distress”. I then move on to discuss the implications the model has across a range of policy and legislation that surround supporting people experiencing rough sleeping with mental illness and the frontline staff who are supporting them. I then and made recommendations based on these. The chapter moves on to discuss the originality and contribution this thesis makes to the field. Next the strengths and limitations of the study are discussed along with further research recommendations. In the final section I discuss how I plan to disseminate the research findings and conclude this chapter and thesis.

The co-constructed explanatory model shows how frontline workers, who supported people experiencing rough sleeping and mental illness, found working within austerity, welfare reform and the COVID-19 pandemic. The core category was “moral distress”, with two sub-categories of “too many obstacles” and “lack of resources”. All of the dimensions and domains included in these categories affect, influence, and perpetuate the outcome of moral distress experienced by the frontline worker. The theory explains a complex relationship of human emotion against economic, social, and political policies and legislation that the frontline workers work within.

6.2 Moral distress

The core category of moral distress has its origins in nursing ethics. The definition of moral in the Cambridge Dictionary (2023a) is “*relating to the standards of good and bad behaviour, fairness honesty etc, that a person believes in rather than laws*” and “*behaving in*

ways considered by most people to be correct and honest", demonstrates that at its basic sense morality is seen to be the notion of *"rules or principles that governing human behaviour which apply universally within a community or class"* (Strawson 1961:4). Distress is defined as a feeling *"extreme worry sadness of pain"* (Cambridge 2023b). Within psychological studies empathetic distress means that the individual experiencing empathy tries to reduce the other persons distress (Batson, Fultz and Schoenrade 1987).

Throughout this study the participants spoke of situations and gave examples of how people experiencing rough sleeping and mental illness were treated unjustly across housing, health, social care and the department for work and pensions due to organisational and systematic constraints and the distress they experienced due to this. Despite their best efforts and feeling morally obligated (as frontline workers) to improve the circumstances of the people they were supporting they were often unable to improve the life of the people they were supporting. Moral distress is the dilemma of not being able to do what is right due to due to organisational constraints (Jameton 1984) and recognises the role of emotions when caring and supporting people (Jameton 2017). Although there have been criticisms that focusing solely on constraint in moral distress (Fourie 2017), in this study the frontline workers were continually unable to provide the ideal level of support they desired due to systematic and organisational constraints across housing, health, social care and the department for work and pensions. They witnessed first-hand the devastation this caused to the people they were supporting and therefore experienced distressed due to this.

Moral distress has been researched extensively in the discipline of health care, particularly within nursing (Jameton 1984, Wilkinson 1987, Corley 2002, Rushton, Kaszniak and Halifax 2013, Spenceley et al 2015, Mares 2016, Young, Froggatt and Brearley 2017, Ando and Kawano 2018, Morley Bradbury-Jones and Ives 2021, British Medical Association 2021, Caram et al 2022). The experience is continuing to be investigated further, following the outbreak of the COVID-19 pandemic (Lake et al 2021, Guttormson et al 2022, Hodwitz et al 2022).

Previous research within the area of frontline worker experiences has tended to focus on the experience of "distress" of homelessness workers and has used different terminology

and various measurement scales (Ferris et al 2016, Waegemakers Schiff and Lane 2019, Rogers, Thomas and Roberts, 2020).

This research has upheld and built upon the work of Jameton (1984) and the British Medical Association (2021) in that working within system constraints causes moral distress as the frontline workers were unable to support people in a way they saw as best and therefore meet their ideal standards of what support should be. It has strengthened the theory as it has been applied to another sector who provide care and support to people who may be vulnerable.

Moral distress provides a conceptual tool in understanding the phenomenon that the frontline workers experience. The co-constructed explanatory model is therefore a *“conceptual bridge that links the conclusions of the study to other groups and settings”* (Wills et al 2007: 438). Along with experiencing feelings of disillusionment, frustration, cynicism, one of the main emotional responses to the moral distress experienced in this study, were feelings of powerlessness, in part due to the lack of professional status given to people working within frontline homelessness services. This research also adds to the work of Young, Froggatt and Brearley (2017) and Ando and Kawano (2018) on powerlessness and moral distress in nursing, and Armstrong et al (2021) in homelessness hostel workers as it gives a greater understanding of how a lack of professional status was a factor in the moral distress experienced by the frontline worker as they were unable to advocate their perception of an ideal outcome for the people they were supporting.

Due to working within disjointed systems and services that refused access to the people they were supporting, the frontline workers felt that they were *“caught in the middle”*. They were therefore unable to support the rough sleeper as they saw fit, which was central to experiencing moral distress (Jameton 1984). Zacka (2017: 4) avers that this affects workers moral agency as they are *“caught in a predicament”* due to needing to be *“sensible”* and deliver public policies against a backdrop of conflicting demands, such as poor resources. To be a moral agent there needs to be an awareness of moral principles like caring and justice (Stueber 2019). The workers were in constant dilemmas, as due to the restraints of the system they were working within, meant they could not care and support people as they

would like. They were working in situations that they had minimal control over. Kolb (2014:18) claims that advocates claim a “*moral identity*” and therefore not being able to live up to the ideal of this identity may cause the worker distress.

The frontline workers were also “*facing violence and trauma*”, a finding that builds on and upholds the work of Lipsky (2010) and Zacka (2017). Lipsky (2010) and Zacka (2017) acknowledge that street level bureaucrats have to give reasons for decisions made directly to the public and therefore have to deal with the personal responses and emotions (including anger) from people about the decisions they have made. Scanlon and Adlam (2022:6) note that when someone is “*unhoused*” they experience being “*dis-respected, dis-possessed, dis-inherited, dis-enfranchised, dis-appointed, dis-membered*”. Street level bureaucrats understand that they will be held personally responsible for any failures whilst delivering services (Zacka 2017) and it was clear that the participants sympathised and understood why anger was directed at them. Although there is an increasing amount of literature about frontline workers increasingly facing violence at work (Caincross and Gardner 2014, Simpson 2019; Unison 2021), there is little research that focuses on this experience for frontline homelessness workers. This study suggests that experiencing verbal and physical violence and/or threats at work was a common occurrence and similar to research by Reeve et al (2018) and Moreton et al (2022) the participants attributed this to service users taking their frustrations of services and systems out on the worker. The research upholds findings from other studies that this was classed as an occupational hazard (Simpson 2019, McIlory 2019, Radley, Langenderfer -Magruder and Schelbe 2020). They continued to feel compassion for their service users however, which contrasts with findings by (Christiansen et al 2015) who concluded that experiencing violence may impact negatively on compassionate care. Lipsky’s (2010) framework suggests that to cope with the demands of frontline work they will withdraw emotionally from their service users, however the participants in this study did not do this.

The workers in my study worked with people who had complex needs, dealing with incidents and situations in isolation and without support from other services and their own working organisations. They become frustrated, angry, and disillusioned at this occurrence

which supports Wilkinson (1987) findings that working in an unsupportive environment can cause moral distress.

Although no diagnostic tools were used within this study, findings do not indicate that frontline workers were experiencing symptoms of other trauma types such as post-traumatic stress disorder, vicarious trauma or burnout. This is contrary to findings by Wagemakers Shiff and Lane (2019) who concluded that frontline homelessness workers experience high incidences of post-traumatic stress.

In this study the frontline workers were expected to *“get on and deal with it”*, in-so-much as they worked with people who had complex care needs, and due to other services not being set up to deal with these needs or being simply unable to, the workers were often left dealing with circumstances and situations that they were not trained for. Lipsky (2010) claims that street level bureaucrats morale is affected by peer group expectations and similar to research by Armstrong et al (2021), there was totally unrealistic expectations and misconception about the job role of the frontline worker from other services across health, social care and the DWP. This left the worker themselves feeling frustrated.

A further contributor to their moral distress was *“lack of trust”* from the people they were supporting towards them as service providers. The frontline workers recognised that they were unable to give the quality of support that could help build a trusting relationship with their service users which added to their distress. Prior to accessing homelessness services their service users had experienced prior trauma some since childhood which upholds research by Buhrich, Hodder and Teesson (2000) Taylor and Sharpe (2008), Fitzpatrick, Bramley and Johnsen (2013). This meant that often the person experiencing rough sleeping was untrusting of the frontline workers and workers **wanted** to spend time building trust and rapport with their service users to enable them to give effective support, However, due to system constraints and lack of resources they were unable to do so, upholding research by Cream et al (2020) and Armstrong et al (2021). This was distressing to the frontline worker as they knew that being able to build a trusting relationship would make a positive impact on the person experiencing rough sleeping (Meam Coalition 2020 and Cooke et al 2022). They knew the importance of building trusting relationships with their service users

and wanted to spend the time to do this, however due to their high caseloads and the high turnover of people they were distressed as they were unable to do this.

Similarly, in research by Sweeny et al (2018), Dobson (2019), Blood et al (2020) and Moreton, Welford and Milner (2022) austerity was seen as detrimental to homelessness services and wider services due to service cuts, closures, and reduction in staff numbers across health, social care, housing and homelessness services. Practically, this meant an increase in demand for service support with fewer resources to help. Due to how services are commissioned in silos, participants were overwhelmed, working in isolation supporting people who had complex needs, which upholds research by Lord, Tickle and Buckell (2021).

In attempting to reduce their moral distress the frontline workers described *“doing their best”* to support the rough sleeper in any way they could. Research has demonstrated that people who work in advocacy roles adopt an inherent moral identity that allows them to feel their work is worthwhile (Kolb 2014), and people with a strong moral identity are more likely to act in way that they feel is right (Hardy and Carlo 2011). This research supports previous findings that workers are working out of their job remit in an attempt to protect their service users as much as possible from the reality of austerity (Cream et al 2020, Dobson 2020, Hastings and Gannon 2021). The frontline workers were clearly doing their upmost best in attempting to support their service users as much as they could in challenging conditions and situations. They were committed to supporting their service users and commitment and resiliency has been found to improve the competency and self-belief in homelessness workers (McDonald and Hale 2021). They were frequently working out of their job remit and challenged other services to provide good quality services to those they were supporting. This builds on the study by Wirth et al (2019), who found that the *“fight”* was a motivating factor for German Social Workers in supporting their clients.

Moral distress was perpetuated due to the frontline workers having *“too many obstacles”* to navigate across policy and legislation, and a *“lack of resources”* to carry out their work. This further compounded their ability to do the right thing for the people they were supporting. COVID-19 meant that *“organisations were faced with another layer of complex challenges under the pressure of economic, social and political uncertainty”* (Petzinger, Jung and Orr

2021:141). As found in previous research, the participants spoke of different service and systems that were difficult to navigate, with many having complex administration procedures (Cream et al 2020). This supports previous research that service and systems are too rigid for people who are experiencing multiple exclusion homelessness (Moreton et al 2022, Pawson et al 2022). The frontline workers were working within local and national policies and given information which was “*vague, ambiguous and conflicting*” (Zacka 2017: 11). They witnessed decisions made by other services that they felt were morally and ethically incorrect, and homelessness was often viewed as a housing issue by other services, without other care needs and vulnerabilities taken into consideration.

Frontline workers were working with people who had very complex needs, despite this, and akin to findings by Lord, Tickle and Buckell (2021), the participants were the main people coordinating services to assist the person experiencing rough sleeping and mental illness. Their service users had a range of other needs including severe physical health illnesses, domestic violence and substance misuse. The participants were exasperated at the lack of flexibility and the barriers that their service users experienced when they were attempting to access services. There were different eligibility and thresholds for gaining access to various services and the people the participants were supporting often did not meet these thresholds, despite the opinion of the frontline worker. Similar to findings by Goodwin et al (2022), the COVID-19 pandemic created another set of barriers for workers to be able to carry out their work as they saw fit. Due to the public health response many services stopped face-to-face appointments and service users were digitally excluded from service access, yet often other services were referring to the organisations whether appropriate or not. This was labelled, in a Canadian study, as “*system dumping*” (Goodwin et al 2022: e5770). The participants worked within disjointed systems, that had received budgetary cuts over the last 10 years, producing a “*burst artery*” over which they were expected to apply a “*a sticking plaster*”, setting an almost impossible task. Similar to findings by Morley, Ives and Bradbury Jones (2019), austerity was seen to be causing avoidable ethical dilemmas to frontline workers due to cuts in services. The lack of resources was mainly attributed to cuts due to austerity, and this research upholds previous studies that found lack of resources contributes to moral distress (Burston and Tuckett 2012, British Medical Association 2021).

6.3 Implications and recommendations to policy

This empirical research has demonstrated that there are a number of implications to policy and practice at both a micro and macro level across a range of areas, to reduce moral distress experienced by frontline workers whilst they are supporting mentally ill rough sleepers. This research upholds previous research that policy across all services and systems is inept and contradictory to the needs of people experiencing homelessness (Moreton, Welford, and Milner 2022:8, Reeve et al 2018, New System Alliance 2020). Therefore, several recommendations are made.

6.3.1 Mental health reform/policy implications

The results of this study have implications for mental health reform and policy. Similar to previous research (St Mungo's 2016a, St Mungo's 2016b, Homeless Link 2022, Marshall 2022) mental health services were seen by the frontline workers, in this study, as being overwhelmed. Gaining access to both primary and secondary mental health services was extremely difficult, with inpatient care being viewed as particularly hard. Frontline workers managed mental health risks, that they felt were too high in the community, without any support from mental health services. The research indicated that frontline workers were regularly dealing with people in crisis and there was a dearth of preventative mental health support available. Similar to findings by Reeve et al (2018), the frontline workers were being relied on to give mental health support whether they had training or not. Often this population was left without any mental health support at all (McDonagh 2011). This increased their feelings of responsibility towards their service user (Moreton et al 2021). The participants witnessed rough sleepers overall wellbeing deteriorating due to this, which in the long term will place greater demands on services and therefore public finances.

Recommendations for health reform/policy:

- In attempting to reduce health inequalities amongst people experiencing homelessness, the government has pledged £30 million pounds to address the mental health of rough sleepers as part of the NHS long-term plan (Public Health England 2020). Although the funding from the government, as part of the long-term plan, is welcome there should be further funding to ensure people experiencing

rough sleeping with a mental illness are able to immediately access primary and secondary mental health services as needed.

- Amendment to part 7 of the Housing Act (1996) to ensure people are classed as being in priority need and owed fully duty under the act if they are experiencing rough sleeping and have a mental illness. This will ensure that temporary accommodation is made available to them, so they are able to receive planned treatment and recover from their illness.
- There needs to be national funding into commissioning specialist services, such as dual diagnosis for mental health, and substance misuse, to enable rough sleepers with complex conditions to receive timely and effective support that meets their individual needs.
- There should be an NHS mental health professional within homelessness services who works closely with both the NHS, housing, homelessness and social care services to ensure that there is an understanding of the mental health needs of the local rough sleeping population and risks are managed by all organisations.

6.3.2 Fiscal policy implications

The government acknowledge that, compared to the general population, people who experience rough sleeping are more costly to public finances (Public Health England 2020). Yet this research has demonstrated that frontline workers viewed all policies and services across housing, health, social care and the DWP failing the needs of the person rough sleeping which meant that potentially people were rough sleeping longer than necessary which caused an extra drain on the public purse. Comparable with previous research, austerity was seen to be detrimental to the provision of homelessness services (Reeve et al 2018, Dobson 2019, Blood et al 2020). The lack of resources experienced was attributed mainly to austerity, due to decreased funding within the homelessness sector, plus wider statutory and voluntary services. The lack of funding detrimentally impacted staff and service levels. This has negatively affected people experiencing rough sleeping as they have been unable to access support in a timely manner according to their needs. Upholding Carmichael (2020), the frontline workers were supporting people with increasingly complex needs due to a lack of support elsewhere. Services across health, social care and the DWP were seen to be inflexible and rigid in approach (due to their own lack of recourse) and

homelessness was treated only as a housing issue with other needs disregarded. Frontline workers within this study recognised that the current “one size fits all” approach was a barrier to receiving support which compounds people experiencing rough sleeping longer than necessary. There are broader repercussions to this with the person rough sleeping facing greater health and social inequalities and the public purse facing increased costs due to the costs associated with rough sleeping (New System Alliance 2020).

Recommendations for fiscal policy:

- Services across housing, health and social care should be equitable and allow a range of options for service delivery with an emphasis on face-to-face support for people experiencing rough sleeping, so individual needs are understood and met.
- Services to work in an interdisciplinary way with shared data agreements to ensure that the needs of the service user are fully met.
- Services to be flexible in their approach in engaging with and supporting people experiencing mental ill health and rough sleeping (Cream et al 2020).
- Greater funding is needed nationally, to increase service capacity across the homelessness sector and across the wider service systems that support rough sleepers in housing, health, and social care.

6.3.3 Welfare reform implications

Similar to Watts et al (2019), the frontline workers viewed welfare reform as increasing the amount of people who needed their support. People who were experiencing rough sleeping were unable to successfully navigate the benefit system and were left with no income. The frontline workers witnessed their service users in severe distress whilst claiming benefits, which upholds previous research that claiming benefit under welfare reform is damaging to mental health (Clifton et al 2013, Barr et al 2016, Shefer et al 2016, Rethink Mental illness 2017, Cheetham, Moffatt and Addison 2018, Mills 2018, Bond, Braverman and Evans 2019, Wickham et al 2020). The study also upholds research by Watts et al (2019) that supporting a rough sleeper to claim benefits impacted negatively on the frontline workers time and resources.

6.3.3.1 Universal Credit

The findings build on the existing evidence of Barton et al (2019) who concluded that it is difficult for people experiencing homelessness to navigate the Universal Credit system.

Contacting the DWP was seen as very difficult and there was a consensus that frontline workers had an increased workload due to the changes made to benefits because of the welfare reform agenda. Frontline workers were of the opinion that the people they were supporting, particularly those with complex needs, were excluded from claiming benefits unless they had intensive support to do so which greatly impacted on the frontline workers' time. The chaotic lifestyle of people rough sleeping and the needs of this population are not considered by the Department for Work and Pensions. The frontline workers viewed many structural barriers within the department for work and pensions that prevented people experiencing rough sleeping with a mental illness the support that they needed. The administration process of Universal Credit was seen as problematic for someone with complex needs. The digital by default stance the department took meant that it was extremely difficult for many people experiencing rough sleeping to apply for benefit/ and or resolve any queries due to their lack of digital technology (Groundswell 2020a, Boobis and Albanese 2020, Veasey and Parker 2021). In theory, claims for universal credit can be made on the telephone (Gov.uk 2023), however, speaking to an advisor over the telephone was also difficult, as the person experiencing rough sleeping would become frustrated at waiting times and terminate the call before it was answered. During the COVID-19 lockdown local job centres were closed, this meant that rough sleepers were only able to contact the department by using technology. This meant that important issues were left unresolved. People experiencing rough sleeping may experience greater levels of destitution due to this.

6.3.3.2 Work Capability Assessment

Frontline workers were also highly critical of the way the Department for Work and Pensions dealt with people who had a mental illness. They reported dealing with people in severe distress and anxiety due to being asked to attend work focused interviews when they had already been found to have a limited capability for work. This approach by the Department for Work and Pensions may increase people's recovery period as they cannot focus on their wellbeing.

6.3.3.3 Personal Independence Payment

The process to claim Personal Independence Payment was seen to be brutal and detrimentally effected the mental health of the people the frontline workers were supporting. Frontline workers spoke of the people they were supporting being distressed at the assessment process. Frontline workers who attended the face-to-face assessment were very untrusting of the decision-making process, were silenced in the assessment and had their expertise ignored. Supporting a rough sleeper to claim Personal independence payment impacted negatively on the frontline workers time which the workers resented as they felt the process was arduous and unnecessary. It was felt that the assessment interviews were unnecessary, and the information could be provided from the support worker. It's questionable whether the assessment interviews are value for the public purse as often the frontline worker would need to attend the interview to support their service user which took them away from their other work.

Recommendations for welfare reform

- To make claiming benefits accessible for people with complex needs, immediately allow people experiencing rough sleeping alternative ways to make a claim for benefit.
- For people who have been deemed to have no capability for work due to mental illness to be able to "opt in" for work focused interviews.
- To abolish the current assessment process for personal independence payment and to cease face to face assessments for people claiming due to a mental illness. The Department for Work and Pensions to obtain the evidence needed on deciding on the claim directly from the health professionals involved in the person's care.

6.3.4 social care and housing legislation implications

There are barriers within social care and housing legislation and policies that currently surround homelessness and are failing the needs of people experiencing rough sleeping. The frontline workers had extreme difficulty referring to adult social care under the care act which upholds findings by Mason, Cornes and Dobson (2017). One key area identified was the failure of the Care Act 2014 assessment and eligibility process in supporting rough sleepers with a mental illness. Frontline workers were distressed at witnessing the barriers

faced by people experiencing rough sleeping with complex needs and became frustrated at the misunderstanding within the social care department that homelessness is only a housing issue. The frontline workers own expertise and knowledge of rough sleeper's support needs were not considered during the Care Act assessment process and the people they were supporting could not articulate their needs themselves. It was hard for the participants to access support, as the rough sleepers' needs were often too complex for service eligibility which upholds research by Armstrong et al (2021). It was difficult for the participants to engage other agencies to support their service users in a multidisciplinary way (Marshall 2022). This meant that people with complex needs were left without any social care support. During the COVID-19 lockdown care act assessments took place over the telephone which frontline workers felt was ineffective as the assessor would miss vital information that could only be picked up during a face-to-face assessment, for example, an unkempt appearance.

6.3.4.1 Housing legislation

Housing legislation was seen to be failing rough sleepers. The onus was on the rough sleeper to prove vulnerability, which was felt to be impossible to those with complex needs. Rough sleepers were therefore excluded from housing support due to not being able to comply with these requirements. People experiencing rough sleeping were going to frontline staff for housing support, however there were insufficient resources available, as half of all temporary accommodation had been closed due to austerity cuts. People experiencing rough sleeping were being sent back out onto the streets and this therefore meant people were rough sleeping longer than necessary and, as stated above, this has broader repercussions for the individual and society. Due to the public health response and the 'Everyone In' initiative during COVID-19, many people experiencing rough sleeping were placed in accommodation. However, when temporary accommodation was found for rough sleepers with complex needs, it was often unsuitable; without furniture and other adequate support which meant that some were evicted from their accommodation and began to sleep rough again.

Recommendations for social care and housing policy.

The Government should allow the lived experience of frontline workers to shape and influence changes in relevant legislation and policy. This could be achieved by the following:

- 1) **The Care Act 2014:** The Act should be made clearer on how to support rough sleepers. All adult social care staff, who undertake the assessments, should have specialised training in the complex needs of rough sleepers.
- 2) **Section 189 of The Housing Act 1996:** Currently a person experiencing rough sleeping is not automatically found as having priority need. A recommendation therefore is to make making rough sleeping a priority need category within the Housing Act, to allow people experiencing rough sleeping to automatically receive housing related support from local authorities.
- 3) **Annual rough sleeper count:** There was a strong consensus amongst participants that the numbers of people rough sleeping and therefore needing support is not recognised in central government statistics. This, in part, is due to the methodological approach of the rough sleeper count and how data is recorded. Changes need to be made in the way in which this data is recorded and monitored to ensure there is an accurate reflection of people needing support.
- 4) **Trauma Informed care to be implemented across housing, health, social care and the DWP.** This needs to allow people experiencing rough sleeping to be supported as an individual with recognition that individual needs will differ. Crucially there needs to be understanding that frontline workers need time to build trusting relationships with the people they are supporting in order to increase the chances of the person experiencing rough sleeping to engage and work successfully with the frontline worker (Reeve et al 2018, Moreton et al 2021, Meam coalition 2022, Moreton, Welford and Milner 2022, Moreton and Welford 2022, Pawson et al 2022, New System Alliance 2023).

6.3.5 Frontline worker support and education implications

It was clear that frontline workers were working in extremely challenging conditions and dealt with distressing incidents regularly. One of the reasons for moral distress occurring was the lack of power participants felt whilst supporting their service users, this in part was due to the homelessness frontline workers not being classed as “professionals” and having

their skills and knowledge disregarded (Corney et al 2018). The frontline workers worked with people who had complex needs, dealing with incidents and situations in isolation and without support from other services and their own working organisations (Lord, Tickle and Buckell 2021). It was clear, as found in research by Dobson (2020) and Hastings and Gannon (2021), that the participants were working extremely hard to alleviate austerity for their service users. This risks people burning out and ultimately leaving the sector.

Recommendations for support and education for frontline workers

- Frontline workers should be offered regular support/supervision and therapy as standard support due to the distressing nature of their workers (McCarthy et al 2020, Hough 2021, Moreton et al 2021, Meam Coalition 2022).
- As recommended by the Kerslake commission on homelessness and rough sleeping (2021) this study supports frontline homelessness workers to obtain professional accreditation and therefore have a similar professional status to other health and social care professionals, such as nursing and social workers. This qualification should be recognised across housing, health, social care and the DWP.
- There needs to be greater understanding throughout the wider services across, health, social care and the DWP about the role of homelessness frontline workers and the support they can give, which would help to minimise their workload and reduce workplace pressures.
- To reduce the feeling of isolation there should be a whole systems approach and joint commissioning of services for people experiencing rough sleeping (Blood et al 2020). Policy making should be joined up across sectors so there is an understanding of how a policy may affect another area (Thomson et al 2020), and how the policies impact on homelessness staff. Joint working across services should be standard and this would avoid duplication of work.
- All sectors across health, social care and the DWP should have a homelessness lead, and all staff within the sector should receive training about homelessness, rough sleeping and multiple exclusion homelessness, to aid awareness and understanding of the issues that this population face. This will also improve multidisciplinary working and ultimately improve the care and support for people experiencing rough sleeping.

6.4 Originality and Contributions to the Field

There is a scarcity of literature that explores moral distress, its causes and effect on frontline homelessness workers, who specifically support mentally ill rough sleepers, despite the challenging nature of their work. This study makes an original contribution to understanding how frontline worker support their service users through the construction of an explanatory theory of their experiences. The theory of 'Moral distress of frontline workers', describes a cause-and-effect relationship, where one or more things happen as a result of something else, that is, the cause or catalyst, of the barriers and lack of resources, brought about the reaction, or manifestation of moral distress. Moral distress was experienced by frontline workers because the structural and organisational barriers of 'lack of resources' and 'too many obstacles' constrained them from supporting their service users in the way they desired and which they believed the rough sleepers deserved. They likened these experiences to applying "*a sticking plaster to a burst artery*" as they were dealing with overwhelming situations but lacked the resources to deal with the situations they were faced with. The constraints detrimentally affected the relationship between the frontline worker and those that they supported and ultimately impacted on the frontline workers' wellbeing. The research aligns and adds to the discourse within social and health policy, in particular system change within homelessness service and systems.

6.5 Contributions to knowledge

Despite the complex needs of mentally ill rough sleepers there is dearth of research about the effects of working within multiple systems, services and legislative frameworks for frontline homelessness workers. Recent research has demonstrated that the outbreak of COVID-19 increased barriers in accessing services for people experiencing homelessness. Most services had to be contacted using technology and people experiencing rough sleeping did not have access to this equipment, support needs of rough sleepers were completely disregarded in the public health response to COVID-19 and the study adds to comprehension of how this also affected the frontline staff who were supporting them. The 'Everyone In' initiative was successful in accommodating people but similar to the findings of the Fitzpatrick, Watts and Sims (2020), there was a lack of practical and emotional support when people rough sleeping were placed in accommodation as part of the initiative.

There is a dearth of research that explores how frontline workers (including those with a professional mental health qualification) experience supporting their service users to apply for benefits and attend benefit assessments with their service users. The DWP administration system was viewed as harsh and unforgiving to the needs of the rough sleeper experiencing mental illness and a lot of time was taken in resolving issues by the DWP. The expertise of frontline workers was largely ignored, and services, systems, and legislation were seen to be failing the needs of the rough sleeper. This study has deepened knowledge and understanding of how these factors influence moral distress occurring.

The frontline workers were working with a lack of resources in their own organisations and trying to access services which also lacked resources and homeless services were working in silos. The lack of resources was mainly attributed to cuts due to austerity, and this research upholds previous studies that lack of resources contributes to moral distress (Burston and Tuckett 2012, British Medical Association 2021).

The research aim was to explore how frontline workers, who work and support one of society's most vulnerable groups of people, worked within austerity, welfare reform and COVID-19. Although acknowledging limitations to the study, which are discussed in more detail below, I believe I have answered the research aim and objectives. The overall research finds contribute to knowledge of how the austerity, welfare reform and COVID-19 caused moral distress in frontline workers who support people experiencing rough sleeping and have a mental illness. Using constructivist grounded theory, I have developed an explanatory theory of frontline workers' moral distress, which was co-produced with the research participants.

6.6 Contributions to Methodology and Methods

Along with contributing knowledge to the research area methodological contributions are also important as they allow new ways to explore behaviour (Bergh et al 2022). Although grounded theory methodology has been used across many research disciplines there is a scarcity of research using this methodology with frontline homelessness workers. There were many practical, ethical and moral issues faced during the research process, particularly

around keeping the participants details anonymous. This was required by the ethical committees that had given permission for the study to take place. During the interviews it became clear how important this was to the research participants as they were very fearful of an adverse reaction from their employing organisations due to the sensitive information which was discussed. Most of participants were ultimately discussing how their own organisation and others was failing themselves and people experiencing rough sleeping. Reflecting on this I believe that it was only due to my position as an insider researcher that the participants were as candid as they were. I took the trust the participants placed in me by disclosing this information seriously.

Similarly, to Saunders, Kitzinger and Kitzinger (2015), as a researcher I experienced conflicts and tensions around keeping participants anonymous without affecting the quality of the research data. Anonymity is often used interchangeably with confidentiality (Saunders, Kitzinger and Kitzinger 2015). Usually within research anonymity means collecting data without any participant information, and confidentiality means removing personal information from the data (Coffelt 2017). Anonymity is on a gradient from being completely anonymous to being identifiable (Scott 2005). All the participants gave informed consent, and that meant as per ethical approval they signed a participant consent form (Appendix 3 and 4), so it was impossible to not keep any participant information. As per the general data protection regulations and university guidelines this information was kept locked away, but I took extra care in not keeping any other information for longer than necessary. Most interviews were transcribed the day of the interview so I could immediately delete any audio recordings (essentially the voice of the participant) and, if any participants emailed me or sent me a text message, I would immediately delete the message to ensure nothing was kept digitally. I did not keep any data on cloud storage and ensured the mobile phone sim I had for participants to contact me was pin protected. I was careful therefore not to confirm where I was conducting the research to anyone who asked.

There was also a dilemma when anonymising the data, all identifying information such as place names, and buildings were removed however the participants were from a small sector that as an insider researcher I am part of, and I was anxious that keeping in certain words and phrases spoken would mean the participants would be identifiable, if someone

within the sector read the research later (Richards and Schwartz 2002). I changed one word in one statement due to this concern.

Normally, within qualitative research, demographic information about the participants is provided to facilitate trustworthiness in the findings (Cloutier and Ravasi 2020), however I felt providing detailed information, such as specific job title, gender, age, etc., would increase the risk of identifying the participants and the information on this table (Table 15) was kept brief. A further tension arose around using pseudonyms in the research findings as I wanted to give a number rather than a name to increase anonymity however this resulted in the findings and discussion chapter reading clinically, and after much debate with my supervisors decided to use fictitious names instead.

Due to the anxiety demonstrated by the participants, I discussed with my supervisors the possibility of embargoing the thesis. This left me conflicted, as I completed the research to try and improve things for workers in the sector and if the research was embargoed there would possibly be a considerable time before the work could be in the public arena. Eventually, after completing the thesis, I felt the data was anonymised enough not to embargo. Like Saunders, Kitinger and Kitinger (2015) I found anonymity was not a universal method and throughout the research process there has been tensions, debate and compromise around the issue. It is hoped that discussing the issues and practical measures taken to reduce the risk of participants being identified gives a greater understanding and insight into potential issues that other researchers may encounter when interviewing participants who disclose sensitive information.

6.7 Strength and Limitations to the Study.

There are various strengths to this study. All participants had worked in the sector for several years, most prior to the start of welfare reform and austerity, and were very experienced and knowledgeable frontline workers. Participants co-constructed the explanatory theory of 'moral distress' and therefore were involved in a way that enhanced trustworthiness of the study. I feel my position, as an insider researcher, benefited the study overall. I was able to build rapport quickly and be seen as an authentic researcher in the field (Chavez 2008). I understood the participants and the significance of the data

collected quickly (Hodkinson 2005) and I was also able to gather rich data due during the interviews process due to recognising the importance of certain information (Chavez 2008). Although the COVID-19 caused disruption to the research design, most of the research interviews took place during the early days of the pandemic, the first national lockdown and therefore in the immediate policy response of the “Everyone In” initiative. This gave a unique insight into how frontline workers experienced working within this policy.

Limitations also exist for this study. The research was conducted in a city within the Midlands geographical area and, as homelessness service provision varies across the UK (Crisis 2022c), it is acknowledged that different research results may emerge in other geographical areas. There were difficulties in recruitment, this was due to two factors, staff being too busy to take part, and the outbreak of the COVID-19 pandemic. As with a constructivist grounded theory position the research was conducted at a particular “*time, space and circumstance*”, and therefore if the research was repeated results may differ (Charmaz 2017b:4). Along with being a strength to the study researching during the COVID-19 pandemic also caused limitations. It must also be acknowledged that for the frontline workers, working within this unprecedented pandemic and changing public health policies and guidelines, may have had a greater impact on the moral distress experienced by participants. The study design was altered to comply with the public health response at the time, which meant the removal of participant groups, of patients and staff within the NHS.

As a qualitative researcher I have researched an area that I know Low and Hyslop-Margison (2021), and as discussed in the methodology chapter, I had the position of an insider researcher, due to my working history. Although I have taken steps to be reflexive through the research process, I acknowledge there could still be some bias in how data was analysed and interpreted.

6.8 Recommendations for Further Research

The explanatory theory developed in this study needs to be built upon and tested. The theory was constructed with a limited number of frontline homelessness workers, who worked within a specific geographical area. The theory needs to be expanded and tested with a greater number of frontline homelessness workers who work within statutory,

voluntary and third sector settings. Other frontline professions, such as social workers, the police, and probation officers may experience similar issues of moral distress, therefore the theory could be tested and expanded using these groups.

The results of this study have indicated that there are many areas that further research could be undertaken in exploring the research topic which would be important to policy makers, practitioners, and academics. There is much research into solving homelessness, yet there needs to be an increased amount of research which includes people who are currently working within a frontline role. Some of the existing research has included stakeholders, or those working in a management or administration position within the homelessness sector. Whilst this is useful, they may not have the working knowledge of how certain policies and procedures affect people experiencing homelessness and/or those with a mental illness. Frontline homelessness workers have a vast amount of knowledge and experience, and it is imperative that this knowledge is used and added to the discourse on homelessness.

Participants went into the sector to help people and spoke of delivering compassionate support, yet they were continually constrained in giving the support they wished to because of working within and trying to access service and systems that all had austere resources. There is little evidence of how working in these conditions and with people in severe distress over a long period can affect the frontline workers own personal values, moral and ethics base, along with their well-being. Due to the current financial climate, with more cuts expected across the public sector further research is needed within the area (Boileau, O'Brien and Zaranko 2022). A longitudinal study, using mixed methods to explore this area in more detail, would be desirable. Also, using another qualitative methodology, such as hermeneutic phenomenology, would help give greater insight into the frontline workers experiences of how and why moral distress occurs. This approach could develop an understanding of how *'caring, healing and wholeness in relation to historical, social, and political forces that shape meanings of wellness, illness and personhood'* (Wojnar and Swanson 2007:175).

One notable research finding was an overarching feeling of powerlessness, in part due to other professions not recognising the frontline workers expertise in supporting people

experiencing homelessness, and a complete lack of understanding of the frontline workers role and responsibilities from other professions involved in supporting people experiencing homelessness. There is a dearth of research which explores the power dynamics and the working relationships between frontline homelessness workers and other professions within the sector.

The findings suggest that the participants found their service users were distressed at the lack of solutions available to them in resolving their homelessness and other issues. As per the original research design pre COVID-19 to ensure the often-unheard voices of mentally ill rough sleepers are heard and include them as participants. As part of this, I would also like to undertake participatory action research and work together with participants to challenge and improve policy and services for this population.

6.9 Dissemination of Research

In keeping with Health Research Authority Approval requirements, the Health Research Authority will be sent a summary of the research findings once the study has been closed. A summary of the findings will also be sent to all participants who have requested this. Preliminary findings were shared with some of the participants and “sources” in the sector as part of the co-construction process. The plan is to continue to present the findings to organisations and people who work in the sector. I have spoken to some of my former colleagues about the research findings across service settings and was surprised at the lack of awareness of moral distress, yet all the frontline workers I have encountered related to the theory and recognised that they had experienced moral distress during their work.

To date I have a narrative literature review to submit to the journal of housing, care and support and the plan is to submit the study findings to another journal and a draft is in preparation. Using my personal experiences of conducting sensitive research an article is in preparation discussing this, possibly to submit to the journal of Qualitative Health Research.

Due to COVID-19 conferences that I was due to attend were cancelled, these included conferences and symposium’s organised by Pathway and De Montfort University Faculty of Health and Life Sciences.

6.10 Thesis Conclusion

This thesis makes an important contribution to knowledge and adds to the existing literature on the experience of moral distress. The exploratory theory of moral distress explains how frontline homelessness workers were caught in a cycle, facing barriers, obstacles and lack of resources, as a result of austerity, welfare reform and COVID-19. Consequentially they were disabled from providing the support they believed people experiencing rough sleeping with a mental illness needed and deserved. mentally ill rough sleepers needed and deserved.

The theory offers new knowledge of how and why moral distress may occur in a frontline worker who support people experiencing rough sleeping and mental ill health. Frontline workers went into the sector to help people. They were working with a high number of people, with a decreasing number of resources to do so and this left them feeling angry, frustrated, and without agency and power. They were left working in isolation and had to navigate and overcome a many obstacles to be able to support their service users effectively. The system and service constraints were damaging to the relationship that the frontline worker had with the person experiencing mental ill health and rough sleeping.

The research findings have significance going forward as due to the cost-of-living crisis, homelessness rates will likely increase. These factors, plus planned cuts to public services suggests further austerity measures will be implemented as public services manage their budgets. This will put additional pressure across housing, health, and social care services, which in turn will impact on homelessness organisations and frontline workers in the sector. If austerity does occur without any increase to funding to homelessness and mental health services, along with changes to policy and legislation, frontline workers will be under even higher risk of experiencing moral distress.

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Appendix 1: Staff Participant Information Sheet

IRAS 264586

Version 6 24/10/19



Staff Participant Information Sheet

Title of Project: Mental health, homelessness, austerity and welfare reform in the midlands geographical area.

Name of Investigators: PhD Student Victoria Hall.

You have been invited to take part in a research study. Before you decide whether to take part, it is important for you to understand why the research is taking place and what it will involve. Please take time to read the following information carefully and discuss it with friends and relatives if you wish to. Please do not hesitate to ask if you would like further information or there is anything you do not understand. Take the time to decide whether you wish to take part or not. Thank you for taking the time to read this.

What is the study about?

The project aim is to look at your experience of how the welfare reform agenda and austerity measures are affecting those that are homeless and have a diagnosed mental illness. This research is being conducted as part of a PhD award.

What does the study involve?

Each staff member participant will be asked open ended questions about their own experiences of supporting patients who are homeless and have a diagnosed mental illness within the welfare reform agenda and austerity measures that have been ongoing since 2010. These interviews will be audio-recorded, however if you do not want the interview to be recorded notes can be taken by the researcher instead. Each interview may take up to one hour or slightly more. The audio-recorded interviews will be listened to and information from them wrote down. You will not be identifiable as you will be given a number instead of your name. The interview will take place in a private room in your place of work. If you give permission the researcher may contact, you at a later date to ask further questions or to check information (you do not have to agree to this to be a participant in the research).

Why have I been invited?

You have been invited because of your unique position of working with mental health patients whom are homeless. Patients will also be interviewed for their own perspectives.

Do I have to take part?

Your employer has given permission for you to take part in the research however participation is completely voluntary, and it is entirely up to you if you wish to take part or not. If you do take part, you will keep this information sheet and you will need to sign a consent form. If you do decide to take part, you may withdraw at any time without giving a reason for up to seven days after the interview is held. Any data collected up to this point will be destroyed.

I am interested in taking part, what do I do next?

Please email the researcher on the following.

Email Victoria Hall on P15238486@my365.dmu.ac.uk

What if I agree to take part and then change my mind?

You can withdraw from the study at any time for up to seven days after the interview is held, without giving a reason. Any data given to this point will be destroyed. If you become tired and want to rearrange the interview this will be attempted to be accommodated. If this is not possible all information you may have given during the interview will be destroyed.

What are the possible disadvantages and risks of taking part?

It is possible that discussing some of the issues raised during the interview may be upsetting however this is deemed to be a low risk due to your experience of working with adults who are in difficult situations. If you do become upset during the interview you will be offered a break to compose yourself or the interview can cease at any point. If you suggest you may be a risk to yourself or others this will be reported to a third party, e.g. your line manager or the researcher's supervisor as. If the interview does cause emotional stress you could call your GP or the employee welfare service. You will be giving up an hour or more of your time.

What are the possible benefits of taking part? There are no benefits for you to take part in the research although there is very limited research exploring how the welfare reform agenda and austerity measures are affecting mentally ill homeless people. You will be helping to demonstrate what support people with similar experiences to whom you work with need.

How will we use information about you?

De Montfort University will hold information about you for this research project.. This will include your name and contact telephone number on the consent form. People will use this information to do the research or to check your records to make sure the research is done properly. People who do not need to know who you are will not be able to see your name and contact details your data will be given a number instead. Once the study is over, we will keep the data to check the results, we will write our reports in a way that no-one can work out you took part in the study. De Montfort University will keep your information safe and secure.

Where can you find out more about how your information is used?

The researcher Victoria Hall in person
by email at P15238486@my365.dmu.ac.uk
or calling on: 07707887436

De Montfort University Data protection Officer David Parkes
By email at david.parkes@dmu.ac.uk

or calling on 0116 2577150

What are your choices about how your information is used?

You can withdraw from the research for up to seven days after the research has been carried out. If you withdraw within seven days any data collected about you will be destroyed, after seven days we will keep what information we have about you. We need to manage your records in specific ways for the research to be reliable. This means that we will not be able to let you see or change the data we have about you. If you agree the researcher will contact you at a later date by telephone to ask further questions if needed and/or obtain your current address details to send a copy of the research findings to.

Will my taking part in this study be kept confidential?

If you give permission the interview will be recorded on an audio recorded device which is encrypted. All recordings will be anonymised and no information about you will be kept on the audio recordings. The audio recordings will be transferred onto a password protected computer and immediately deleted from the recorded device. As soon as the interview has been transcribed by the researcher the recorded interview will be deleted from the computer. Any electronic information will be held on an encrypted USB stick and a password protected computer which has security software. Any information kept on paper will be kept in a locked cabinet. Every effort will be made to ensure that any information about you is kept confidential. Any information which is identifiable to you will be de-identified, however the researcher will keep a signed consent form which will include your name and possibly your contact telephone number if you agree to be contacted in the future and/or to send you information on the research findings if you request this. You will be given a number which will be used instead of your name on any other research documents. The researcher will comply with the Data Protection Act and the European general data protection regulation (GDPR). In accordance with DMU policy the research data will be kept for 5 years after the whole research project is completed.

What will happen to the results of the research study?

The research findings will be used in a PhD thesis. They may be also used in conference presentations, reports and journal articles. Direct quotes from participants may be used when publishing the research findings, however they will be anonymised. A summary of the findings can be arranged to be sent to you if you would like this.

Who is organising and funding the research?

This research is being organised as part of a PhD programme of study which takes place at De Montfort University.

Who has reviewed the study?

This study has been reviewed and approved by De Montfort University, Faculty of Health and Life Sciences Research Ethics Committee (project ref 3374) and the NHS Health Research Association, East Midlands, Leicester South (Ref no 264586).

What if something goes wrong or I have concerns or want to complain?

It is unlikely that this will happen, however if you have any concerns or wish to complain about this study please initially contact the researcher and/or the supervisor of the researcher. The supervisor's contact details are: Dr Stephen Handsley, Faculty of Health and Life Sciences, Room 5.12 Edith Murphy Building, De Montfort University, The Gateway, Leicester, LE1 9BH (0116) 2577883, shandsley@dmu.ac.uk

If you are not satisfied with the outcome please contact the administrator for the Faculty Research Ethics Committee, Faculty of Health and Life Sciences, De Montfort University, 3.35 Edith Murphy House, The Gateway, Leicester, LE1 9BH or hlsfro@dmu.ac.uk

Contact for Further Information

Victoria Hall
P15238486@my365.dmu.ac.uk
Mobile 07707887436.

Thank you for considering to take part in this study

Appendix 2: Key Informant Participant Information Sheet

IRAS 264586

Version 2 10/8/20



Key Informant Participant Information Sheet

Title of Project: Mental health, homelessness, austerity, welfare reform and Covid-19 in the midlands geographical area.

Name of Investigators: PhD Student Victoria Hall.

You have been invited to take part in a research study. Before you decide whether to take part, it is important for you to understand why the research is taking place and what it will involve. Please take time to read the following information carefully and discuss it with friends and relatives if you wish to. Please do not hesitate to ask if you would like further information or there is anything you do not understand. Take the time to decide whether you wish to take part or not. Thank you for taking the time to read this.

What is the study about?

The project aim is to look at your experience of how the welfare reform agenda, austerity measures and/or Covid-19 are affecting those that are homeless and have a diagnosed mental illness. This research is being conducted as part of a PhD award.

What does the study involve?

Each key informant participant will be asked open ended questions about their own experiences of supporting patients who are homeless and have a diagnosed mental illness within the welfare reform agenda, austerity measures and the recent Covid-19 outbreak. These interviews will be audio-recorded, however if you do not want the interview to be recorded notes can be taken by the researcher instead. Each interview may take up to one hour or slightly more. The audio-recorded interviews will be listened to and information from them written down. You will not be identifiable as you will be given a number instead of your name. The interview will take place over the telephone and if preferable once the Covid-19 lockdown restrictions are eased sufficiently in a mutually convenient place. If you give permission the researcher may contact, you at a later date to ask further questions or to check information (you do not have to agree to this to be a participant in the research).

Why have I been invited?

You have been invited because of your unique insight of how welfare reform, austerity measures and/or Covid-19 may be affecting mental health patients whom are homeless. Patients may also be interviewed for their own perspectives.

Do I have to take part?

Participation is completely voluntary, and it is entirely up to you if you wish to take part or not. If you do take part, you will keep this information sheet and you will need to give consent. If you do decide to take part, you may withdraw at any time without giving a reason for up to seven days after the interview is held. Any data collected up to this point will be destroyed.

I am interested in taking part, what do I do next?

Please email the researcher on the following.

Email Victoria Hall on P15238486@my365.dmu.ac.uk

What if I agree to take part and then change my mind?

You can withdraw from the study at any time for up to seven days after the interview is held, without giving a reason. Any data given to this point will be destroyed. If you become tired and want to rearrange the interview this will be attempted to be accommodated. If this is not possible all information you may have given during the interview will be destroyed.

What are the possible disadvantages and risks of taking part?

It is possible that discussing some of the issues raised during the interview may be upsetting however this is deemed to be a low risk due to your experience of working with adults who are in difficult situations. If you do become upset during the interview you will be offered a break to compose yourself or the interview can cease at any point. If you suggest you may be a risk to yourself or others this will be reported to a third party, e.g. the researcher's supervisor. If the interview does cause emotional stress you could call your GP or depending on your employee, the employee welfare service. You will be giving up an hour or more of your time.

What are the possible benefits of taking part? There are no benefits for you to take part in the research although there is very limited research exploring how the welfare reform agenda and austerity measures along with Covid-19 are affecting mentally ill homeless people. You will be helping to demonstrate what support people with similar experiences you have knowledge of need.

How will we use information about you?

De Montfort University will need to use information from you for this research project and this information will include your:

- Name
- Contact Telephone number and/or
- Email address

People will use this information to do the research or to check your records to make sure the research is done properly. Everyone involved in the study will keep your data safe and secure. People who do not need to know who you are will not be able to see your name and contact details, your data will be given a number instead. Once the study is over, we will save some of the data to check the results and/or for future research. We will write our reports in a way that no-one can work out you took part in the study. De Montfort University

will keep your information safe and secure. For more information about your privacy, rights and data protection at De Montfort University please go to <https://www.dmu.ac.uk/policies/data-protection/data-protection.aspx>

Where can you find out more about how your information is used?

The researcher Victoria Hall in person
by email at P15238486@my365.dmu.ac.uk
or calling on: 07707887436

De Montfort University Data protection Officer David Parkes
By email at david.parkes@dmu.ac.uk
or calling on 0116 2577150

What are your choices about how your information is used?

You can withdraw from the research for up to seven days after the research has been carried out. If you withdraw within seven days any data collected about you will be destroyed, after seven days we will keep what information we have about you. We need to manage your records in specific ways for the research to be reliable. This means that we will not be able to let you see or change the data we have about you. If you agree the researcher will contact you at a later date by telephone to ask further questions if needed and/or obtain your current address details to send a copy of the research findings to.

Will my taking part in this study be kept confidential?

If you give permission the interview will be recorded on an audio recorded device which is encrypted. All recordings will be anonymised and no information about you will be kept on the audio recordings. The audio recordings will be transferred onto a password protected computer and immediately deleted from the recorded device. As soon as the interview has been transcribed by the researcher the recorded interview will be deleted from the computer. Any electronic information will be held on an encrypted USB stick and a password protected computer which has security software. Any information kept on paper will be kept in a locked cabinet. Every effort will be made to ensure that any information about you is kept confidential. Any information which is identifiable to you will be de-identified, however the researcher will keep a signed consent form which will include your name and possibly your contact telephone number if you agree to be contacted in the future and/or to send you information on the research findings if you request this. You will be given a number which will be used instead of your name on any other research documents. The researcher will comply with the Data Protection Act and the European general data protection regulation (GDPR). In accordance with DMU policy the research data will be kept for 5yrs after the whole research project is completed.

What will happen to the results of the research study?

The research findings will be used in a PhD thesis. They may be also used in conference presentations, reports and journal articles. Direct quotes from participants may be used when publishing the research findings, however they will be anonymised. A summary of the findings can be arranged to be sent to you if you would like this.

Who is organising and funding the research?

This research is being organised as part of a PhD programme of study which takes place at De Montfort University.

Who has reviewed the study?

This study has been reviewed and approved by De Montfort University, Faculty of Health and Life Sciences Research Ethics Committee (project ref 3374) and the NHS and the NHS Health Research Association, East Midlands, Leicester South (Ref no 264586).

What if something goes wrong or I have concerns or want to complain?

It is unlikely that this will happen, however if you have any concerns or wish to complain about this study please initially contact the researcher and/or the supervisor of the researcher. The supervisor's contact details are: Dr Stephen Handsley, Faculty of Health and Life Sciences, Room 5.12 Edith Murphy Building, De Montfort University, The Gateway, Leicester, LE1 9BH (0116) 2577883, shandsley@dmu.ac.uk

If you are not satisfied with the outcome please contact the administrator for the Faculty Research Ethics Committee, Faculty of Health and Life Sciences, De Montfort University, 3.35 Edith Murphy House, The Gateway, Leicester, LE1 9BH or hlsfro@dmu.ac.uk

Contact for Further Information

Victoria Hall
P15238486@my365.dmu.ac.uk
Mobile 07707887436.

Thank you for considering to take part in this study

Appendix 3: Staff Participant Consent Form

IRAS 264586

Version 6 24/10/19



Staff Participant Consent Form

Title of project: Mental health, homelessness, austerity and welfare reform in the midlands geographical area.

Name of researcher: Victoria Hall.

Please initial all boxes if you agree

1. I confirm that I have read and understood the staff participant information sheet [**Version 6 24/10/19**] for the above study. ☐
2. I have had time to consider all the information, ask questions if I needed to and have had these questions answered satisfactory. ☐
3. I am aware that taking part in this research is voluntary and I can withdraw giving no reason for up to seven days after the research interview has taken place. ☐
4. I agree to the interview being audio recorded and then transcribed. ☐
5. I give permission to be re-contacted at a later date if the researcher has further questions or wants to check information with me. (I do not have to agree to this to take part in the research). ☐
6. I agree to non-identifiable quotes being used in a thesis, publications, or conference presentations. ☐
7. I understand that relevant sections of data collected during the study may be looked at by individuals from De Montfort University, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records ☐
8. I agree to take part in this study. ☐

9. I wish to be contacted after the whole study is completed to arrange for a summary of the research findings of the study to be sent to me. I agree to give a contact telephone number so the researcher can call me at a later date to confirm my address to send this information to.

☐

Print name of participant: _____

Date: _____

Signature: _____

Print name of person taking consent: _____

Date: _____

Signature: _____

Appendix 4: Key Informant Consent Form

IRAS 264586

Version 2 10/8/20



Key informant Consent Form

Title of project: Mental health, homelessness, austerity, welfare reform and Covid-19 in the midlands geographical area.

Name of researcher: Victoria Hall.

Please initial all boxes if you agree

1. I confirm that I have read and understood the Key Informant Participant information sheet [**Version 2 10/08/20**] for the above study. ☐
2. I have had time to consider all the information, ask questions if I needed to and have had these questions answered satisfactory. ☐
3. I am aware that taking part in this research is voluntary and I can withdraw giving no reason for up to seven days after the research interview has taken place. ☐
4. I agree to the interview being audio recorded and then transcribed. ☐
5. I give permission to be re-contacted at a later date if the researcher has further questions or wants to check information with me. (I do not have to agree to this to take part in the research). ☐
6. I agree to non-identifiable quotes being used in a thesis, publications, or conference presentations. ☐
7. I understand that relevant sections of data collected during the study may be looked at by individuals from De Montfort University and from regulatory authorities I give permission for these individuals to have access to my records. ☐

8. I agree to take part in this study.

☐

9. I wish to be contacted after the whole study is completed to arrange for a summary of the research findings of the study to be sent to me. I agree to give a contact telephone number so the researcher can call me at a later date to confirm my address to send this information to.

☐

Print name of participant: _____

Date: _____

Signature: _____

Print name of person taking consent: _____

Date: _____

Signature: _____

Appendix 5: Initial Staff Interview Schedule

IRAS 264586

Version 5 15/10/19



Project Title: Mental health, homelessness, austerity and welfare reform in the midlands geographical area.

Initial interview schedule for staff participants based on Charmaz (2014) constructivist's grounded theory. Questions may be modified as the interview and research project progresses.

Audio recording (if applicable): As you agreed this interview is being audio recorded. Are you ok to continue?

Mental Health

- In your experience are there similarities with homeless patients you work with? i.e. diagnosis, age, background of patient, detained under the Mental Health Act? Can you please tell me about these?
- How do you feel that being homeless impacts on your patient's mental wellbeing?

Benefits

- Can you tell me about any common issues that patients face when making a claim for benefits?
- In your experience can you describe any barriers that patients face when claiming benefit?
- How do you think the benefit system can be improved for those with a mental illness?

Homelessness

- In your experience are there common reasons for your patients to become homeless, if so, can you please tell me about these?
- In your experience how easy is it for your patients to access homeless service provision?
- Have you experienced any barriers in assisting your patients to find housing?
- How do you think the homeless services can be improved for those with a mental health diagnosis?
- Can you describe any successful outcomes for patients?

Other services

- How do you feel the welfare reform agenda/ austerity measures are affecting other services that work with your patients e.g., adult social care, local authorities housing depts and voluntary services?

Legislation

- How effective do you feel homelessness law/provision is in assisting those with a mental health illness?
- Have you seen an improvement since the Homelessness Reduction Act and the Local Rough Sleeper initiative begin in the local area? Can you tell me about this?
- In your experience how do you feel the welfare reform agenda and austerity measures are affecting your patients being rehoused/and or discharged from hospital?

Conclusion

- What do you feel are the most important ways for housing and benefit services to be improved for patients with a mental health diagnosis and are homeless?
- Do you feel there is gaps in any services that patients' access? Can you describe these?

- What has been helpful for you when working alongside housing and benefit services with a homeless patient?
- What else would you like to add?

Reference

CHARMAZ K (2014) Constructing *Grounded Theory*. 2nd Ed. London: Sage.

Appendix 6: Documents from COVID-19 literature to inform Key Informant questions

Document Selected	Data Analysed	Finding
WOODLEY, D. (2020) <i>Its services coming together- Dave Woodley the COVID-19 response for rough sleepers in London</i> . (Online) Groundswell. Available from: https://microsites.onourradar.org/covid19/its-services-coming-together-dave-woodley-on-the-covid-19-response-for-rough-sleepers-in-london/ (Accessed 18/06/20)	Blog Post from Groundswell funded homeless frontline worker during initial lockdown . Based in London	Rough sleepers' mental health deteriorating through the pandemic. Frontline workers working in very stressful situations "life or death" Success in Multi-disciplinary working
PATHWAY. (2020) <i>Brief Health Needs Assessment, GLA COVID 'Prevent' Limehouse and City Hotels</i> . (Online) Available from: https://www.pathway.org.uk/publication/brief-health-needs-assessment-gla-covid-prevent-limehouse-and-city-hotels/ (Accessed 01/06/2020)	Data about the health needs of two hotels during two days in May 2020	Lockdown meant health services came into contact with rough sleepers who had not engaged with services previously.
HOMELESS LINK. (2020) <i>COVID-19 and homelessness: actions for government</i> . (Online) Homeless Link. Available from: https://www.homeless.org.uk/connect/blogs/2020/mar/24/covid-19-and-homelessness-actions-for-government (Accessed 24/03/2020).	Blog from Homeless Link	Requesting that homeless workers are prioritised for PPE
WALL, T. (2020) Fears of 'catastrophic coronavirus outbreak' among homeless in hostels". <i>The Guardian</i> . (Online) 19 th April. Available from:	Newspaper article	Fear that dormitory accommoda

https://www.theguardian.com/society/2020/apr/19/fears-of-catastrophic-coronavirus-outbreak-among-homeless-in-hostels (Accessed 19/04/21).		tion in hostels will cause mass covid infection.
UNGPAKORN. R, (2020) 'Its and Opportunity to improve homeless people's health' (Online) Available from: https://www.rcn.org.uk/magazines/bulletin/2020/june/homeless-health-nursing-during-covid-19-pandemic (Accessed 14/10/2020)	RCN Bulletin	Day Centres closing, Rough sleepers engaging with Services and Health and wellbeing improving
RADSTONE-STUBBS, L (2020) Rough Sleepers must not be put back on the streets after lockdown, says top Tory. <i>The Guardian</i> . 16 th May. (Online) Available from: https://www.theguardian.com/society/2020/may/16/rough-sleepers-must-not-be-put-back-on-streets-after-lockdown-says-top-tory (Accessed 20/05/20)	Newspaper article.	Rough Sleepers Health and Wellbeing improving due to being accommodated.
BULMAN, M. (2020) Coronavirus: Homeless people 'scared and hungry' on streets despite promise to house them over the weekend. <i>Independent</i> . 30 th March. (Online) Available from: https://www.independent.co.uk/news/uk/home-news/coronavirus-homeless-people-uk-sleeping-rough-streets-housing-soup-kitchens-a9436726.html (Accessed 30/03/2020)	Newspaper Article	Due to closures of day centres and lack of government direction rough sleepers not able to access food and services
REYES, E. (2020) Coronavirus Act: Councils move to ditch social care duties. (Online) <i>The Law Gazette</i> . 23 rd April Available from: https://www.lawgazette.co.uk/news/councils-move-to-ditch-adult-social-care-duties/5104011.article (Accessed 01/5/2020_	Solicitors' publication	Local authorities allowed to ease duties under the Care Act because of the Coronavirus Act. No duty for assessment, care plans or

		to meet the needs of those assessed.
FLEW, L. (2020) Mind the Gaps: Social Security During the Pandemic. (Online) Child Poverty Action Group. Available from: https://cpag.org.uk/news-blogs/news-listings/mind-gaps-social-security-during-pandemic (Accessed 21/08/2020)	Child Poverty Action Group- Blog Post	People on with illness and disabilities are not being assessed under the Work Capability Assessment due to Covid delays.
THOMAS, R (2020) Government to make emergency changes to Mental Health Act. <i>HSJ</i> . 17 th March (Online) Available from: https://www.hsj.co.uk/government-to-make-emergency-changes-to-mental-health-act/7027149.article (Accessed 17/03/2020)	Online Health Journal	Reducing the doctors needing to be sectioned under the Mental Health Act.
PUBLIC HEALTH ENGLAND (2020) Guidance for the public on the mental health and wellbeing aspects of coronavirus (COVID-19) (Online) PHE. Available from: https://www.gov.uk/government/publications/covid-19-guidance-for-the-public-on-mental-health-and-wellbeing (Accessed 21/03/20)	Public Health England Advice	Tools suggested are accessible online which digital excludes populations.
JOHNSON, S. (2020) 'She was left with no one': how UK mental health deteriorated during COVID. <i>The Guardian</i> . 21 st Sept. (Online) Available from: https://www.theguardian.com/society/2020/sep/21/left-no-one-uk-mental-health-deteriorated-covid (Accessed 21/09/20)	Newspaper Article	Disparity with how mental health and public health was treated during lockdown. a
PICKETT, K. (2020) A much better new normal? Professor Kate Pickett on the impact of COVID-19. (Online) Available from: https://www.robinson.cam.ac.uk/news/much-better-new-normal-professor-kate-pickett-impact-covid-19 (Accessed 01/06/2020)	Opinion Piece	Hope that due to covid the importance of social determinant s of health

		will be recognised by policy makers etc.
<p>DURCAN, G. O'SHEA, N. and ALLWOOD, L. (2020) Covid-19 and the nations mental health. Forecasting needs and Risks in the UK: May 2020. (Online) Centre for mental health. Available from:</p> <p>https://www.centreformentalhealth.org.uk/sites/default/files/2020-07/CentreforMentalHealth_COVID_MH_Forecasting_May2020%20%281%29.pdf (Accessed 15/05/2020)</p>	<p>Centre for mental health predictions on the UK mental health since COVID-19</p>	<p>Frontline workers may have heightened risk of mental illness. MH impact will be worse to those with existing illness.</p>

Appendix 7: Initial Key Informant Interview schedule



Project Title: Mental Health, homelessness, austerity, welfare reform in the midlands geographical area.

Initial interview schedule for key Informants re Covid 19

Audio recording (If applicable) As you agreed the interview is being audio recorded. Are you ok to continue?

How effective do you feel the everyone in initiative has been?

How useful was the initial guidance and support from central government re Covid Responses for your service?

Were there any barriers faced to finding people housing?

Is the housing offered appropriate to people's needs?

Do you feel people are being given adequate support when housed under everybody in?

Were there any similar issues faced?

How effective do you feel other services (Mental Health/ Social Care/ Charities) were for people during the pandemic response?

Why do you think people were choosing to continue to sleep rough rather than be housed during the pandemic?

Central government has been criticised for being ambivalent in its approach to what happens next to people who have been housed under everyone in, what has been your experience of this?

From your experience so far during the pandemic, what do you feel the service demand will be once the pandemic restrictions ease?

What model of response to homelessness do you feel would be successful moving forward?

Looking at theories regarding shared traumatic reality/ bureaucracy Iron cage what do you think?

Appendix 8: Focused Coding Questions



Can you tell me about your biggest barriers or obstacles in carrying out your job?

How does it affect you carrying out your role?

How does it affect your working relationship with your service user?

How, if at all have your thoughts and feelings changed about the impact of the work you do with service users over the years?

People have mentioned that they witness and experience verbal and physical aggression from service users what is your experience of this?

Looking back why do you feel that this behaviour occurs?

How does these past violent experiences affect your working relationship with service users?

How does all of the above effect your wellbeing?

Can you tell me about your biggest barriers or obstacles in carrying out your job?

How does it affect you carrying out your role?

How does it affect your working relationship with your service user?

How, if at all have your thoughts and feelings changed about the impact of the work you do with service users over the years?

People have mentioned that they witness and experience verbal and physical aggression from service users what is your experience of this?

Looking back why do you feel that this behaviour occurs?

How does these past violent experiences affect your working relationship with service users?

How does all of the above effect your wellbeing?

Is there anything you would like to add that has occurred to you during this interview?

Appendix 9: Initial Interview Schedule for Patient Participants



Project Title: Mental health, homelessness, austerity and welfare reform in the midlands geographical area.

Initial interview schedule for patient participants based on Charmaz (2014) constructionist's grounded theory. Questions may be modified as the interview and research project progresses.

Audio recording (if applicable): As you agreed this interview is being audio recorded. Are you ok to continue?

Mental Health

- Can you describe your mental illness and how it affects you?
- How do you feel being homeless is affecting your mental health?
- For inpatients: do you feel being homeless is affecting your length of stay in hospital/Are you experiencing any barriers to being discharged?

Benefits

- What benefits are you claiming?
- Can you please describe the process you went through claiming benefits?
- What were your thoughts and feelings whilst going through this process?
- Did you have any difficulties claiming benefits? What were they? How did you manage this?
- How have you managed financially whilst in the process of receiving or claiming benefit?

Homelessness

- What contributed to you becoming homeless?
- Can you tell me about your thoughts and feelings about being homeless?
- Have you approached the local authority for help? If not, why?
- Can you describe the process of dealing with the local authority? and what were your thoughts and feelings during this?

Conclusion

- What do you feel are the most important ways for housing and benefit services to be improved for people with a mental health diagnosis and are homeless?
- Do you feel there are gaps in any services you use? Can you describe these?
- What has been helpful for you when dealing with benefit and homeless services?
- What would your advice be to someone who finds themselves in a similar situation?
- What else would you like to add?

Reference

CHARMAZ K (2014) *Constructing Grounded Theory*. 2nd Ed. London: Sage.

