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Sociology & Social Policy, 2026, 3(2), 83-96
https://www.hillpublisher.com/Journals/ssp/
ISSN Online: 3066-5698

An Exploration into the Predictors of the Professional Quality of Life of Frontline Workers in Homelessness

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How to cite this paper: Bethany Camp, Anam Elahi, Ahmed Waqas, Jacqui Regan, Colm Gallagher, Nick Maguire, Stephen Weatherhead. (2026). An Exploration into the Predictors of the Professional Quality of Life of Frontline Workers in Homelessness. *Sociology & Social Policy*, 3(2), 83-96.
DOI: 10.26855/ssp.2026.12.003

Received: July 16, 2026
Accepted: August 3, 2026
Published: September 8, 2026

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Abstract

Challenges across political, societal, and organisational landscapes can impact frontline workers' wellbeing in homelessness. This project aimed to explore predictors of Professional Quality of Life among 170 frontline workers in UK third-sector homelessness organisations. An online questionnaire collected demographic and employment information and measures of Perceived Organisational Support, Reflective Practice, Self-Reflection and Insight, Adverse Childhood Experiences, Compassion Satisfaction (CS), Burnout and Secondary Traumatic Stress (STS). Perceived organisational support significantly predicted burnout, STS, and CS. Self-Reflection and Insight also significantly predicted CS. Aligning with the implementation of psychologically informed environments, the importance of the employee-organisation relationship from the viewpoint of frontline workers is discussed, particularly concerning psychological needs. These findings support the need to consider the accountability and configuration of homelessness organisations. Integrating psychological needs satisfaction into current homelessness policy and practice might support targeted action to protect workplace wellbeing. There is a requirement for further exploration and evaluation of the factors that influence workplace wellbeing and research into understanding intersectionality differences, how trauma experiences affect frontline working, and evaluations into the effectiveness of reflective practice in relation to workplace wellbeing is required to enhance organisational support.

Keywords

Homelessness; Frontline Workers; Workplace Wellbeing; Compassion Satisfaction; Burnout; Secondary Traumatic Stress; Organisational Support

1. Introduction

Frontline workers in homelessness face numerous challenges stemming from systemic and structural limitations, including restrictive policies, inaccessible support services, and inadequate organisational provision to distressing

events, violence, and trauma experiences, increasing the emotional impact and adverse incidents (Kerman, 2022c, 2022d; Petrovich et al., 2020; Wirth et al., 2019a, 2019b). High staff turnover compounds these challenges, exacerbated by the COVID-19 pandemic, rising living costs, and societal stigma surrounding homelessness, with frontline workers facing underappreciation and marginalisation (Campbell et al., 2022; Frontline Network, 2022; Levesque et al., 2021; McCosker et al., 2024). Addressing these issues is vital to ensure quality care (Department of Communities & Local Government, 2008; Peters et al., 2021), therefore, this research examines factors influencing the quality of life of frontline workers.

1.1 Professional Quality of Life

Professional Quality of Life (ProQOL; Stamm, 2010) offers insights into wellbeing, comprising positive (Compassion Satisfaction; CS) and negative (Compassion Fatigue, including secondary traumatic stress; STS and burnout) aspects associated with helping roles. Peters et al. (2021) demonstrate that frontline work in homelessness directly affects ProQOL, leading to burnout and feelings of frustration and helplessness, increasing turnover and emotional detachment (Bademci, 2012; Kidd et al., 2007). Stress under time constraints and low self-belief were also identified as predictors of emotional exhaustion (Baker et al., 2007). Further existing findings indicate elevated levels of depression and stress among frontline workers, with significant associations with CS, burnout, and STS (Lemieux-Cumberlege & Taylor, 2019; Schiff & Lane, 2019). Petrovich et al. (2020) report moderate to severe levels of STS among homelessness service providers, while Schneider et al. (2021) revealed a high vulnerability to STS, significantly predicting burnout. Despite workplace challenges, practitioners experiencing STS were more likely to remain emotionally connected to clients, contrasting with the disaffection and apathy associated with burnout. CS may mitigate burnout and STS (Ferris et al., 2016; Lemieux-Cumberlege & Taylor, 2019), however high levels of compassion fatigue can limit its protective impact (Salloum et al., 2015; Thomas, 2013). Schiff and Lane (2019) found CS to be significantly low in 20% of participants, implying reduced positive emotions from supporting people. This experience risks reducing quality of care, and an 'emotional retreat' could worsen the experience of social exclusion for people experiencing homelessness (Chamberlayne, 2004).

The association between STS and Post-Traumatic Stress Disorder among frontline workers in homelessness is significant, with reported high rates of post-traumatic stress (Lemieux-Cumberlege et al., 2023; Schiff et al., 2019; Schiff & Lane, 2019). Limited research exists on the impact of personal trauma experiences. Aykanian and Mammah (2022) identified a high prevalence of Adverse Childhood Experiences (ACEs) among frontline workers in homelessness, and there are risks that workplace dynamics might act as 'triggers' to reactivate prior traumatic stress responses (Schiff et al., 2019), emphasising the urgent improvement of meeting workplace safety and wellbeing needs.

1.2 Organisational Support

The Job Demand-Resources model (JD-R; Bakker & Demerouti, 2007) highlights predictors of workplace safety and wellbeing in homelessness (Peters et al., 2021; Wirth et al., 2019a). It delineates how 'job demands' can lead to negative experiences associated with burnout and STS, whilst 'job resources' (e.g., appreciation, social support and financial security) are associated with job satisfaction, motivation, personal growth, and work engagement (Wirth et al., 2019a). Peters et al. (2021) concluded that job demands and resources associated with levels of self-efficacy, emotional support, trauma experiences, and perceptions of organisational support determine workplace wellbeing. Therefore, organisational-level intervention can positively impact individuals, enhancing the ProQOL of practitioners and the care they provide (Kulkarni et al., 2013). Addressing feelings of being unvalued, unsupported, and isolated, particularly among those with lived experiences of homelessness due to stigma, can be reduced through organisational support and promotion of inclusive practices (Carver et al., 2020; Kerman et al., 2022c, 2022d; Steenekamp & Barker, 2024). Perceived Organisational Support (POS) is positively associated with job satisfaction and self-determined motivation (Deci & Ryan, 2008; Gillet et al., 2013; Kurtessis et al., 2017), however, little is known about the POS and ProQOL of frontline workers in homelessness. This research starts to address this gap, which is especially important when the risks of experiencing burnout and trauma are involved, due to them being occupational hazards that services should prepare for and respond to by protecting employee wellbeing (Bride, 2007).

Specialist psychologically informed frameworks such as Trauma-Informed Care (TIC; Hopper et al., 2010;

SAMHSA, 2014) and Psychologically Informed Environments (PIE; Keats et al., 2012; Johnson & Haigh, 2010) create structures of organisational support. PIEs prioritise safe relationships and foster psychologically safe organisational cultures (Benson & Brennan, 2018; Edmondson & Bransby, 2023). Although RP supports frontline workers' wellbeing, challenges in engagement exist, particularly for those experiencing burnout and STS (Schneider et al., 2021). The empirical foundations of PIE in homelessness are limited, with concerns about reliability and effectiveness. Due to the framework's inherent flexibility, an eclectic mix of its principles have been implemented across contexts (Breedvelt, 2016; Phipps et al., 2017). To further understand the mechanisms that underpin the value of RP in homelessness, this research explored reflection in relation to the ProQOL of frontline workers.

1.3 The Present Study

This study used a cross-sectional quantitative design using self-report questionnaire measures of POS, RP, ACEs, Self-Reflection and Insight (SRI, Grant et al., 2002; Silvia, 2021) and ProQOL. As displayed in Figure 1, this study aimed to measure four key predictor variables (POS, RP, ACEs, and SRI) to explore whether they predict the three outcome variables within ProQOL (CS, STS, and burnout). We hypothesised that:

H1a. The more RP sessions attended, the higher level of SRI.

H1b. Higher perceived usefulness of RP will be related to higher levels of SRI.

H2a. Higher POS, SRI and lower ACEs will predict higher CS and lower STS and burnout.

H2b. Evidence shows that the more ACEs someone experiences, the higher risk of them experiencing difficulties relating to their physical and psychological wellbeing (Anda et al., 2006). It was therefore hypothesised that ACEs will explain greater variance in the indices of ProQOL than POS and SRI. The study was approved by the Clinical Psychology Review Committee and the Research Ethics Committee at the University of Liverpool.

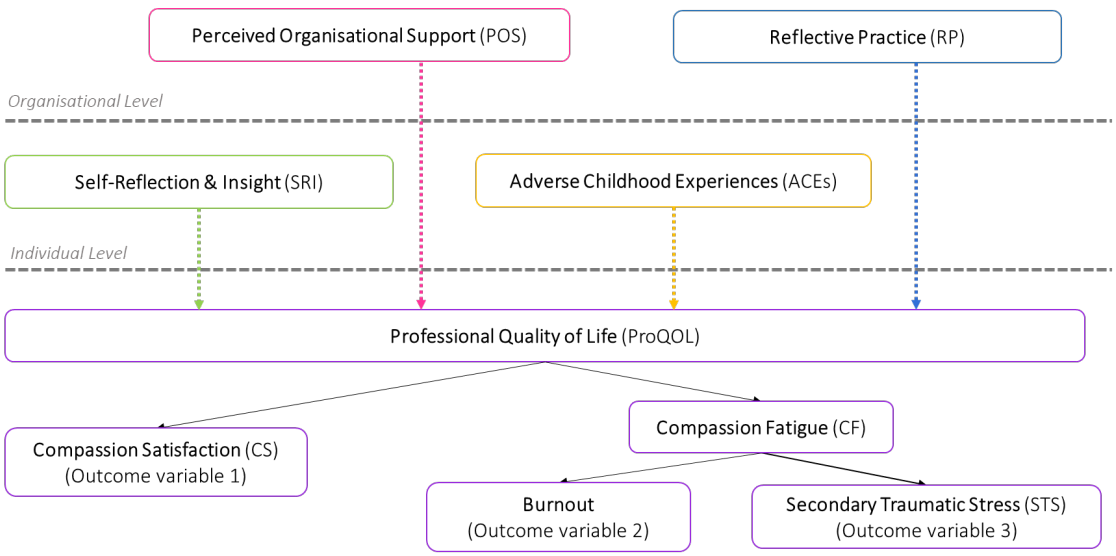

Figure 1. A Conceptual Model of Organisational and Individual Level Predictor Variables of ProQOL.

2. Method

2.1 Procedure

The study was conducted online using Qualtrics survey software from December 2022 to January 2023. Participants received detailed information about the study, provided anonymised informed consent, and completed a questionnaire covering demographic information and the measures, including ProQOL, ACEs, POS, RP, and SRI. Debrief information, including support resources, was provided post-study. Participants had the option to enter a draw for ten £25 vouchers, with email addresses kept separate from research data to ensure anonymity. Results were disseminated via email to interested parties. Expert by Experience consultation was provided by a Project Worker from a Harm Reduction service, ensuring clear project communication and inclusivity in study advertisement refinement.

2.2 Sample

All participants (N = 170) were frontline workers from third-sector homelessness organisations across the UK, encompassing various roles such as support, management, administration, and personal care provision. Snowball sampling via email and online advertisements, including Twitter, facilitated recruitment. Organisations and frontline workers were contacted via email to request distribution of the study advertisement and Qualtrics questionnaire link. Recruitment efforts spanned multiple organisations and included promotion at a PIEs training in Manchester and in a relevant newsletter. Eligible participants were those with a minimum experience of 10 hours per week in client-facing roles for at least three months, aligning with baseline criteria from Lemieux-Cumberlege and Taylor (2019). Participants were excluded if they were under the age of 18 and were unable to speak English fluently. Demographic and occupational details are presented in Tables 1 and 2.

2.3 Measures

2.3.1 Demographics and Employment

Questions were asked regarding participants' age, gender, ethnicity, area of workplace (e.g., Northwest England), working hours, length of time in current role, general job role category (e.g., Support Worker), security of employment (e.g., paid employment), benefits and supports (e.g., opportunities for professional development and emotional support), amount of experience working in and lived experience of homelessness.

2.3.2 Professional Quality of Life (ProQOL) Questionnaire

The ProQOL (Stamm, 2010) comprises three 10-item subscales assessing CS and compassion fatigue (i.e., burnout and STS), scored on a five-point Likert scale from 'Never' (1) to 'Very Often' (5). Subscale totals were calculated separately, consistent with recommendations (Stamm, 2010). ProQOL demonstrates good construct validity and internal consistency, particularly among homeless service providers (Kerman et al., 2022b; Lemieux-Cumberlege & Taylor, 2019). To reduce participant burden, a 9-item short version (Galiana et al., 2020) was employed, maintaining reliability and validity. Subscale scores, ranging from 5 to 15, were used in analysis, with higher scores indicating greater CS, burnout, and STS. Internal consistency within this sample, assessed via Cronbach's alpha, yielded α = .75 for STS, α = .77 for burnout, and α = .83 for CS.

2.3.3 Adverse Childhood Experiences Checklist (ACE)

The ACE Checklist (Felitti et al., 1998) is a 10-item scale identifying ACEs before age 18, including psychological, physical, and sexual abuse. Participants respond 'yes' or 'no' to each item, with responses summed to create a score (range: 0-10). A 'prefer not to say' option was included for ethical reasons. ACE scores correlate with physical and psychological health issues (Anda et al., 2006) and demonstrate adequate reliability (Dube et al., 2004) and internal consistency (α = .88; Murphy et al., 2014), enhancing its validity (Wingenfeld et al., 2011). In this sample, Cronbach's alpha was α = .79.

2.3.4 Perceived Organisational Support Scale (POS)

POSS (Eisenberger et al., 1986) is a 36-item scale measuring employees' perception of organisational support (Eisenberger et al., 1986). Shorter 16 and 8-item versions have been developed, showing comparable effectiveness to the original (Rhoades & Eisenberger, 2002; Worley et al., 2009). Peters et al. (2021) highlight the importance of measuring organisational support in homelessness literature. This study used the 8-item version (α = .90), with responses ranging from 'Strongly Disagree' (1) to 'Strongly Agree' (7), averaged to create an overall score (range: 1-7). Higher scores indicate greater perceived organisational support. Cronbach's alpha for this sample was α = .92.

2.3.5 Reflective Practice

Participants were asked about their receipt of RP, frequency of attendance, and perceived usefulness.

2.3.6 Self-Reflection and Insight Scale (SRIS)

SRIS (Grant et al., 2002) comprises 20 items across three subscales: Engagement in Self Reflection, Need for Self-Reflection (α = .90), and Insight (α = .80). Ooi et al. (2021) recommends adapting the SRIS for studies with healthcare professionals due to its strong psychometric properties. Silvia (2021) developed a 12-item version using Item Response Theory, maintaining balance between Self-Reflection and Insight. The Self-Reflection (α = .87) and

Insight (α = .83) subscale reliability was very good. Responses were recorded on a 7-point scale ranging from 'Strongly Disagree' (1) to 'Strongly Agree' (7). Total scores, indicating higher SRI, ranged from 12 to 84. The 12-item scale demonstrated strong reliability and dimensionality. Using Cronbach's alpha, this sample's internal consistency was α = .85.

2.4 Analysis

Statistical analyses were performed using SPSS version 28. An a priori power analysis was conducted using G*Power (Faul et al., 2007) for a linear multiple regression with a fixed model and R^2 increase. The analysis involved three predictors (ACEs, POS, and SRI), aiming for 80% power at p = 0.017 to detect a medium effect size, based on similar variables explored previously (Lemieux-Cumberlege & Taylor, 2019). With ProQOL divided into three constructs, the critical p-value was Bonferroni-adjusted to 0.017 (0.05 / 3), necessitating separate analyses for each construct. To address H1a, Spearman's Rho correlation analysis was conducted, and H1b was assessed with an independent samples t-test examining the association between RP and SRI. For H2a and H2b, hierarchical regression analyses were conducted separately for each ProQOL subscale. Given previous research has highlighted a relationship with ProQOL, the first step of the hierarchical regressions consisted of the demographic and organisational variables: age, ethnicity (Aykanian et al., 2022), gender, sexual orientation, perceptions of receiving adequate pay (Levesque et al., 2021), length of time working in homelessness (Kerman et al., 2022a), clinical supervision, debriefing, training, perceptions of receiving adequate training (Kerman et al., 2022d; Lemieux-Cumberlege et al., 2019) and lived experience of homelessness (Kerman et al., 2022c), as shown in Table 1 and Table 2. Descriptive statistics of the outcome and predictor variables are presented in Table 3. The hierarchical regression analyses comprised four steps: (1) inclusion of all potential covariates, (2) addition of POS, (3) inclusion of SRI, and (4) addition of ACEs. Accounting for covariates, POS, SRI, and ACEs, four to 11 significant predictors were controlled for in the power analysis. The change in R^2 in each subsequent model assessed the variance explained by each predictor.

The following covariates were entered as binary variables (1 = yes, 0 = no): clinical supervision (received vs. not received), debriefing (received vs. not received), training (received vs. not received), perceptions of adequate training (yes/no), and lived experience of homelessness (yes/no). Age was entered as a continuous variable (years), length of time working in homelessness was entered as a continuous variable (months/years), and perceptions of adequate pay was entered as a binary variable (yes/no). Gender, ethnicity, and sexual orientation were dummy-coded with the majority group as the reference category.

Participants' data were excluded if they failed to meet eligibility criteria or completed less than 20% of the measures. No outliers were identified upon data examination. See Supplementary File 1 for more details regarding data preparation. No evidence of multicollinearity was observed. Normality was upheld based on Q-Q Plots.

3. Results

3.1 Demographic Information

The analysis included data from N = 170 participants. As shown in Supplementary File 2, 43% of the sample worked in Northwest England. Most participants (76%) were aged 25 to 54 and identified as White – British (79%). The 2021 census list of ethnic groups was used, with an optional free-text box for gender self-definition, yielding responses from 52 participants (30% of N = 170). Gender was not included as a covariate in the regression analysis due to the low response rate. Of those who responded, 73% identified as female. As depicted in Supplementary File 3, one participant volunteered, excluding paid employment from the regression analysis as a covariate. Roughly half of the sample deemed their pay sufficient and received emotional and social support from their organisation. Many participants (90%) received training, with the majority (67.9%) considering it adequate.

3.2 Descriptive Statistics

Descriptive statistics for all measures are provided in Supplementary File 2. While short-item measures for ProQOL, POS, and SRI were validated, their adoption in the literature remains limited. Therefore, scoring and interpretation guidance for the full-item scales were followed. The mean t-score for all ProQOL subscales was 50.00 (SD = 10.00), consistent with literature values and similar studies (e.g., Schneider et al., 2021). High score ranges across STS and burnout subscales of ProQOL suggest some participants experienced significantly high levels of STS (n = 17) and

burnout (n = 46), while CS showed a narrower range, indicating average to high levels. The sample was categorised according to cut-off scores (Stamm, 2010) as shown in Table 1.

Table 1. Descriptive Statistics for Measures

Measure	Means (SD)	Median	Range
ProQOL STS	7.50 (2.27)	7.00	3.00 – 14.00
ProQOL Burnout	8.80 (2.70)	9.00	3.00 - 15.00
ProQOL CS	11.98 (2.25)	12.00	6.00 - 15.00
ACE	3.20 (2.60)	3.00	0.00 - 10.00
POS	4.80 (1.50)	4.90	1.00 – 7.00
SRI	62.74 (11.15)	62.00	30.00 – 84.00

Note. Standard Deviations (SD) in parenthesis. ProQOL = Professional Quality of Life; STS = Secondary Traumatic Stress; CS = Compassion Satisfaction; ACE = Adverse Childhood Experiences; POS = Perceived Organisational Support; SRI = Self-Reflection and Insight.

Table 2 presents participant ProQOL subscale cut-off scores. Most participants reported high CS (74%), with average levels of burnout (68%) and STS (82%). However, 27% reported high burnout, and 10% high STS. CS levels negatively correlated with burnout and STS, while STS positively correlated with burnout.

Table 2. Professional Quality of Life Participant Subscale Cut-off Scores

Cut-off Score	Compassion Satisfaction *n* (%)	Burnout *n* (%)	Secondary Traumatic Stress *n* (%)
Low 25th Percentile (0 - 4)	0 (0.0)	8 (4.7)	13 (7.6)
Average 50th Percentile (5 - 10)	45 (26.4)	116 (68.2)	140 (82.2)
High 75th Percentile (11+)	125 (73.5)	46 (27.0)	17 (10.0)

Most participants (78.8%) reported at least one ACE, with 40.5% reporting four or more. The most reported ACEs were parental separation, emotional abuse, substance abuse, and psychological distress within the home, consistent with Aykanian and Mammah (2022). As shown in Supplementary File 4, areas where the highest percentage of participants perceived to be unsupported by the organisations for which they worked related to believing their complaints would be ignored, the organisation having very little concern for them and does not care about their general work satisfaction.

3.3 Associations Between Reflective Practice and Self-Reflection and Insight

Spearman's Rho correlation was run to examine the association between the frequency of RP attended with the level of SRI. There was a statistically significant weak positive association between these two variables, r_s (122) = .17, n = 124, p = .032. To address H1b, perceived usefulness of RP and SRI were compared. Those who perceived RP to be useful (n = 105) scored similarly on the SRI measure (M = 64.00, SD = 11.39) compared to those who did not perceive RP to be useful (n = 21, M = 63.29, SD = 9.48). Levene's test did not indicate unequal variances (F= .513, p=.475). Independent sample t-test revealed that the association between perceived usefulness of RP and SRI was not statistically significant, t(124) = .269, p = .394.

3.4 Exploring Predictors of ProQOL

Separate hierarchical multiple regressions were performed for CS, burnout, and STS to address H2a and H2b. The initial stage of all regressions involved entering ten potential covariates identified from literature on ProQOL in

frontline workers in homelessness. These covariates aimed to control for their variance contribution, as the study focused on the distinct impact of POS, SRI, and ACEs on ProQOL indices.

3.4.1 Predicting Compassion Satisfaction

In the first step all ten covariates were entered. This first step accounted for a significant proportion of the variance in CS, F (10, 159) = 4.813, p <.001, R^2 = .232, 23% of the variance in R^2 change. The second step consisted of adding POS, which accounted for a significant proportion of the variance in CS, ΔF (1, 158) = 48.789, p <.001, R^2 = .413, 18% of the variance in R^2 change. The third step consisted of adding SRI. This model accounted for a significant proportion of the variance, ΔF (1, 157) = 11.408, p <.001, R^2 = .453, 4% of the variance in R^2 change. The fourth step consisted of adding ACEs. This model accounted for a non-significant proportion of the variance, ΔF (1, 156) = .000, p = .907, R^2 = .453. The fourth step included all predictors, including all covariates, POS, SRI, and ACEs. Overall, the final model accounted for approximately 45% of the variance in CS, F (14, 155) = 9.948, p < .001. As shown in Table 3, the covariates that significantly predicted CS were length of time working in homelessness, receiving clinical supervision, and perceiving training to be adequate. In line with H2a, higher levels of POS and SRI were also found to be significant predictors of CS. However, ACEs did not significantly predict CS in this model.

Table 3. Hierarchical Regression Predicting Compassion Satisfaction

	Compassion Satisfaction							
	Model 1		Model 2		Model 3		Model 4	
Variable	B	*β*	B	*β*	B	*β*	B	*β*
Constant	13.268**	-	9.064**	-	6.593**	-	6.605**	-
Time working in sector	.173	.039	.505	.112	.711*	.158	.714*	.159
Clinical supervision	-.508	-.113	-.703*	-.157	-.627*	-.140	-.618*	-.138
Adequate training	-1.981**	-.414	-.739	-.039	-.818*	-.171	-.814*	-.170
POS			.823**	.548	.756**	.504	.757**	.504
SRI					.044**	.218	.044**	.218
ACEs							-.007	-.008
R^2	.232**		.413**		.453**		.453	
F	4.813**		10.125**		10.844**		9.948**	
ΔR^2	.232**		.181**		.040**		.000	
ΔF	4.813**		48.789**		11.408**		.014	

Note. * p <.05. ** p <.001. POS = Perceived Organisational Support; SRI = Self-Reflection and Insight. ACEs = Adverse Childhood Experiences. The full regression model output for Compassion Satisfaction is presented in Supplementary File 5.

3.4.2 Predicting Burnout

In the first step all ten covariates were entered. This first step accounted for a significant proportion of the variance in burnout, F (10, 159) = 4.759, p <.001, R^2 = .230, 23% of the variance in R^2 change. The second step consisted of adding POS, which accounted for a significant proportion of the variance in burnout, ΔF (1, 158) = 31.606, p <.001, R^2 = .359, 13% of the variance in R^2 change. The third step consisted of adding SRI. This model accounted for a non-significant proportion of the variance, ΔF (1, 157) = .287, p = .593, R^2 = .360. The fourth step consisted of adding ACEs. This model accounted for a non-significant proportion of the variance, ΔF (1, 156) = .270, p = .604, R^2 = .361. The fourth step included all predictors, including all covariates, POS, SRI, and ACEs. Overall, the final model accounted for approximately 36% of the variance in burnout. As shown in Table 4, the covariates that significantly predicted burnout were age and receiving clinical supervision, and perceiving training to be adequate. In line with H2a, higher levels of POS were also found to be a significant predictor of burnout, however, SRI and ACEs did not significantly predict burnout in this model.

Table 4. Hierarchical Regression Predicting Burnout

	Burnout							
	Model 1		Model 2		Model 3		Model 4	
Variable	B	*β*	B	*β*	B	*β*	B	*β*
Constant	7.037**	-	11.290**	-	11.800**	-	11.871**	-
Age	-.693**	-.309	-.475*	-.210	-.448*	-.199	-.443*	-.197
Clinical supervision	.568	.106	.765*	.142	.750*	-.139	.798*	.148
POS			-.832**	-.461	-.818**	-.454	-.816**	-.452
SRI					-.009	-.037	-.009	-.038
ACEs							-.040	-.039
R^2	.230**		.359**		.360		.361	
F	4.759**		8.032**		7.353**		6.777**	
ΔR^2	.230**		.128**		.001		.001	
ΔF	4.759**		31.606**		.287		.270	

Note. * p <.05. ** p <.001. POS = Perceived Organisational Support; SRI = Self-Reflection and Insight. ACEs = Adverse Childhood Experiences. The full regression model output for burnout is presented in Supplementary File 5.

3.4.3 Predicting Secondary Traumatic Stress

In the first step all ten covariates were entered. This first step accounted for a significant proportion of the variance in STS, F (10, 159) = 2.562, p = .007, R^2 = .139, 14% of the variance in R^2 change. The second step consisted of adding POS, which accounted for a significant proportion of the variance in STS, ΔF (1, 158) = 6.514, p = .012, R^2 = .173, 3% of the variance in R^2 change. The third step consisted of adding SRI. This model accounted for a non-significant proportion of the variance, ΔF (1, 157) = .004, p = .952, R^2 = .173. The fourth step consisted of adding ACEs. This model accounted for a non-significant proportion of the variance, ΔF (1, 156) = .136, p = .731, R^2 = .174. The fourth step included all predictors, including all covariates, POS, SRI, and ACEs. Overall, the final model accounted for approximately 16% of the variance in STS. As shown in Table 5, the covariates that significantly predicted STS were receiving debriefing and training. In line with H2a, higher levels of POS were also found to be a significant predictor of STS, however, SRI and ACEs did not significantly predict STS in this model.

Table 5. Hierarchical Regression Predicting Secondary Traumatic Stress

	Secondary Traumatic Stress							
	Model 1		Model 2		Model 3		Model 4	
Variable	B	*β*	B	*β*	B	*β*	B	*β*
Constant	4.455*	-	6.303**	-	6.248*	-	6.199*	-
Received debriefing	.579	.128	.753*	.166	.749*	.165	.767*	.169
Received training	1.391*	.184	1.302*	.172	1.303*	.172	1.298*	.172
POS			-.362*	-.238	-.363*	-.239	-.365*	-.240
SRI					.001	.005	.001	.005
ACEs							.027	.031
R^2	.139*		.173*		.173		.174	
F	2.562*		3.002**		2.735*		2.521*	
ΔR^2	.139*		.034*		.000		.001	
ΔF	2.562*		6.514*		.004		.036	

Note. * p <.05. ** p <.001. POS = Perceived Organisational Support; SRI = Self-Reflection and Insight. ACEs = Adverse Childhood Experiences. The full regression model output for Secondary Traumatic Stress is presented in Supplementary File 5.

3.5 Post-hoc Analysis

SRI only partially associated with RP, therefore a post-hoc analysis was conducted to explore the associations between RP and ProQOL (see Supplementary File 6). RP perceived to be useful resulted in significantly lower levels of burnout and higher levels of CS. There were no significant associations between the frequency of RP attended and ProQOL.

4. Discussion

This cross-sectional study investigated predictors of ProQOL among frontline workers in third-sector homelessness services across the UK. RP, SRI, POS, and ACEs were assessed to determine their impact on the three ProQOL dimensions (CS, burnout, and STS). The results revealed that higher levels of CS were predicted by SRI and POS, indicating that workers who were more reflective and supported by their organisations reported greater satisfaction with their work. Negative associations were observed between CS and both STS and burnout, consistent with previous research suggesting that CS may mitigate psychological distress (Lemieux-Cumberlege et al., 2023). These findings align with broader literature on job satisfaction, indicating that increased POS and job satisfaction may reduce stress and burnout levels (Belias & Koustelios, 2014). Additionally, perceptions of organisational unsupportiveness, such as ignoring complaints or failing to appreciate employees' efforts, were associated with higher levels of burnout and STS. While these results partially support H2a by demonstrating that POS predicts ProQOL, they do not support H2b, as ACEs did not significantly predict CS, burnout, or STS variance, meaning that experiences of potentially traumatic events in childhood did not predict ProQOL.

These results contribute to the organisational support literature in predicting workplace wellbeing (e.g., Aldabbas et al., 2023; Ho & Chan, 2022; Kurtessis et al., 2017), and align with the JD-R model applied in homelessness research (e.g., Peters et al., 2021; Wirth et al., 2019a, 2019b). In the present study, debriefing and training emerged as significant predictors of lower STS levels, while clinical supervision and perceptions of adequate training were associated with higher CS and lower burnout levels, suggesting that these factors may serve as job resources to enhance workplace wellbeing. These findings further align with the Social Exchange Theory (Ahmad et al., 2022), explaining that when organisations invest in useful support that enables skill development and growth, POS increases, resulting in stronger feelings of identification with the organisation's objectives and values, enhancing team cohesion, productivity, and wellbeing (Khajuria & Khan, 2022). However, when supervision, training, and debriefing were controlled for in the current study, POS explained a significant proportion of the variance in the indices of ProQOL, having noteworthy clinical implications.

4.1 Clinical Implications

The significance of POS predicting CS, STS and burnout shows the importance of the employee-organisation relationship from the viewpoint of frontline workers. The employee-organisation dynamic is central to adequate organisational support, which requires more than simply offering forms of support (e.g., supervision, training, debriefing and RP). Organisational Support Theory, which underlies POS, acknowledges the essential fulfilment of employees' psychological needs for improving wellbeing, as well as many other positive workplace outcomes such as job satisfaction, work engagement, and reduced absenteeism (Ogbonnaya et al., 2018). Workplace wellbeing and performance are theorised to be mediated by the fulfilment of three universal psychological needs (i.e., 'relatedness', 'autonomy' and competency', Deci & Ryan, 2008). When integrated with the JD-R model, satisfaction of these three needs is predictive of lower burnout levels, even after controlling for job demands (Dreison et al., 2018; Patel & Bartholomew, 2021). Therefore, satisfying these psychological needs might improve POS, and subsequently ProQOL.

Satisfying competence needs, such as providing meaningful feedback and enabling skill development, can be challenging in homelessness due to people living transient lifestyles, hindering progress and can result in disappointment and self-perceptions around incompetence for staff (Lenzi et al., 2020; Levesque et al., 2021). Systemic factors might prevent meeting competence needs, for example, commissioning that is target-focused might pressure people to achieve unattainable standards, while overlooking the impact on ProQOL and the value of building safe relationships (Pleace, 2020). Homelessness organisational cultures may foster blame, particularly around critical incidents and risk management, potentially leading to heightened anxiety, guilt, and shame. Prioritising safe error

cultures is essential for creating psychologically safe environments (Edmondson & Bransby, 2023; Kerman et al., 2022d; Lemieux-Cumberlege et al., 2023). Positive error cultures also promote autonomy satisfaction by empowering individuals to make self-directed choices, reducing coercion (Embregts et al., 2019). Psychological empowerment mediates between POS and job satisfaction (Maan et al., 2020) and associates with lower STS (Choi, 2017). Relatedness, based on attachment theory (Bowlby, 1979), enhances workplace creativity and competence through safe relationships (Itzchakov, 2022). Meeting relatedness needs prevents burnout in healthcare (Waddimba et al., 2015) and aligns with psychologically informed frameworks, reflecting the importance of emotional connection and feeling valued in workplace relationships (Ryan & Deci, 2022). Integrating POS frameworks into homelessness policy and practice might protect workplace wellbeing, with further exploration on factors influencing psychological needs satisfaction.

4.2 Strengths, Limitations, and Future Directions

The survey distribution coincided with the repercussions of the Covid-19 pandemic, whilst faced with the added personal and professional pressures of the rising cost of living (Frontline Network, 2022; Watts et al., 2022). Therefore, due to the cross-sectional study design, the extent to which POS and ProQOL were impacted by the wider socio-political-economic context is unknown and might not extend beyond this time point. Potential self-selection bias may have occurred, with individuals experiencing high burnout or STS opting out, while those feeling unsupported by their organisations may have been overrepresented.

Individual, contextual, and protective factors akin to those implicated in Post-Traumatic Growth (PTG) offer insight into why ACEs did not directly predict ProQOL. PTG factors, such as resilience, mediate the positive association between ACEs and PTG (Widyorini et al., 2022), emphasising the potential for increased wellbeing and resilience after traumatic events. This finding can reduce stigma associated with lived experience of trauma, evidencing how wellbeing and resilience levels can increase following traumatic experiences. When shaping services, whilst it is helpful to see the value of lived experience, it might also be helpful to consider the several factors that promote PTG (Henson et al., 2021) to enhance trauma-informed environments. ACEs were explored as an individual-level factor in the regression, with POS being significant as an external factor at the organisational level, therefore suggesting that ProQOL is more likely to be dependent upon wider factors, shifting some of the responsibility (regarding staff wellbeing) away from individuals and towards organisations. A significant percentage of variance was not explained in the regression models, indicating the requirement of more research in exploring other factors that significantly impact the ProQOL of frontline workers in homelessness. It is also important to highlight that the ACE ten-item checklist has faced criticism for its narrow scope, failing to encompass ACEs rooted in social inequalities and for not indicating the severity and frequency of individual ACEs, neglecting how contextual and protective factors shape subjective experiences (Madigan et al., 2023; Parker et al., 2020). Nuanced measurements of trauma are imperative for understanding the interaction with frontline work and informing TIC cultures.

Limitations in measuring RP concerning ProQOL were evident. Only two self-developed RP questions provided minimal categorical data. The assumption that SRI would positively correlate with RP was partially supported, as participants who attended RP reported higher SRI, although the causal direction remains unclear. As it was uncertain whether RP predicts ProQOL based on the relationship between SRI and ProQOL, a post-hoc analysis showed RP usefulness associated with lower burnout and higher CS. No significant association was found between RP frequency and ProQOL. Further exploration into the value of RP in relation to ProQOL, along with comprehensive measurement approaches considering practical factors and individual mega-cognitive components.

Limitations in participant sampling and analysis hindered exploration of intersectionality differences. The low response rate for gender precluded its inclusion as a covariate in regression analysis, resulting in uncertainty on its variance explanation across regression models. Most of the study sample identified as female and White, ages primarily covered the range of working-aged adults in the UK, and data on identity differences (i.e., ethnicity and sexual orientation) was limited when transforming data for the regression analyses. It is therefore uncertain how findings might extend beyond the sample demographic analysed. Further research is required to understand frontline workers' experiences, considering how individual and cultural differences intersect with power, privilege, and stigma.

4.3 Conclusion

Homelessness presents multifaceted systemic challenges that create unpredictable work environments for frontline

workers, impacting their wellbeing. This study explored organisational and individual factors that predict the ProQOL of frontline workers in homelessness. Results highlight that CS, STS and burnout are significantly influenced by the reciprocity dynamic between the individual and organisation. Considering the accountability and configuration of homelessness organisations is essential and clinical implications associated with psychological needs satisfaction are discussed. For example, evaluating homelessness organisation policy and practice on how frontline workers (a) are supported to develop competencies and build self-esteem, (b) are empowered to use their agency without coercive practices, and (c) feel respected, valued, and a sense of belonging in supervisory and peer relationships might improve POS, workplace wellbeing, recruitment and retention rates and quality of care. Further explorations into organisational support are required including understanding intersectionality differences, how trauma experiences affect frontline working, and evaluations into the effectiveness of RP in relation to workplace wellbeing.

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