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"Systems trauma": A qualitative study of work-related distress among service providers to people experiencing homelessness in Canada

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ABSTRACT

Service provision to people experiencing homelessness is challenging and stressful work. Yet, there is a dearth of evidence on how the work experiences of service providers contribute to mental health distress and wellness. This qualitative study examined the contributing factors to workplace mental health among service providers to people experiencing homelessness in Canada, with the aim of establishing a causal theory for how work-related challenges cause distress. In-depth interviews were conducted with 40 service providers working in the homeless service, supportive housing, and harm reduction sectors across Canada. Data were analyzed using a grounded theory-informed approach. The workplace mental health of service providers was centred on the concept of "systems trauma," which refers to the structural and systemic factors that exacerbate the difficulty of service providers' work, putting them at-risk of work-related mental health distress. "Systems trauma" had multifaceted causes and consequences, as did the organizational- and individual-level factors that protected service providers against its impacts. Overall, the findings highlight how the same sociopolitical context that negatively affects people experiencing homelessness also shapes the workplace mental health of service providers. Supports for managing moral distress, policy and public initiatives to improve the valuation of work with people experiencing homelessness, dedicated funding for workforce development, and further investment in primary and secondary prevention of homelessness are recommended to promote workplace mental health.

1. Introduction

A sizeable workforce exists in Canada to support over 235,000 people who experience homelessness each year (Gaetz et al., 2016). This includes approximately 6000 workers in the homeless service sector and another 155,000 in the broader social and community service sector (Toor, 2019). Service delivery to people experiencing homelessness can be highly rewarding, with providers deriving satisfaction from working relationships that are grounded in respect and meaningful connection (Kidd et al., 2007; Twis et al., 2022). However, the work is also stressful and challenging (Peters et al., 2022; Wirth et al., 2019a). Community organizations that serve people experiencing homelessness are often under-resourced and have limited capacity to address housing and support needs (Baptista et al., 2020; Olivet et al., 2010). Yet, because of the high demand for services, providers may be saddled with large caseloads and unrealistic expectations (Peters et al., 2022; Wirth et al., 2019a). The fragmentation of homeless service systems and their lack of integration with the healthcare sector is another service provision barrier that can lead to frustration and job dissatisfaction among workers (Mullen and Leginski, 2010). Further, service providers are frequently exposed to critical events in the workplace, such as directly experiencing or responding to violence and overdose, in addition to chronic stressors, such as verbal abuse and property damage (Kerman et al., 2022a). The severity of these events and the other sectoral challenges have implications for the workplace mental health of service providers to people experiencing homelessness.

There is a growing body of evidence on the mental health and wellness of service providers who work with people experiencing homelessness.

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Research prior to the COVID-19 pandemic has shown that this workforce experiences higher rates of posttraumatic stress and common mental health problems than the general population (Lemieux-Cumberlege and Taylor, 2019; Waegemakers Schiff and Lane, 2019). Studies conducted during the pandemic replicated these findings, while also suggesting that the pandemic and worsening overdose crisis may be exacerbating distress levels (Aykanian, 2022; Carver et al., 2022; Kerman et al., 2022b). Poor mental health among service providers not only impacts workers, it also has implications for service delivery. A study of supportive housing providers found that those with lower levels of compassion satisfaction perceived lower therapeutic supportiveness in their workplaces (Schneider et al., 2022). Taken together, the research highlights that the workforce serving people experiencing homelessness is vulnerable to mental health problems, which may undermine support approaches and outcomes for service users.

There are occupational and non-occupational factors that contribute to the mental health of service providers who work with people experiencing homelessness. Beginning with the latter, service providers have higher rates of adverse childhood experiences and lived experience of homelessness than the general population, which may put them at greater risk for mental health problems (Aykanian and Mammah, 2022; Kerman et al., 2022b). Occupational factors that can negatively impact the mental health of service providers include the emotional burden of the work, heavy workloads and unreasonable expectations, low wages, and insufficient training and supervision (Olivet et al., 2010; Peters et al., 2022; Twis et al., 2022; Wirth et al., 2019b). Less is known about how structural and systemic problems impact the work and mental health of service providers to people experiencing homelessness. Further, to our knowledge, experiences of moral distress, which is stress and emotionality associated with the ethical dimensions of professional practice (Pauly et al., 2009), have not been studied among service providers to people experiencing homelessness. Moral distress has been theorized to manifest in partial response to structural barriers (Mänttäri-van der Kuip, 2016; Pauly et al., 2012) and is associated with greater symptoms of depression, anxiety, posttraumatic stress, and burnout among healthcare workers (Plouffe et al., 2021). Similarly, the challenges that undermine outcomes in homeless service systems and related community sectors may also increase the risk of work-related distress for providers.

This qualitative study examined the experiences and contributing factors to workplace mental health among service providers to people experiencing homelessness in Canada. The primary research question was: How do the work-related experiences of service providers contribute to mental health problems? A secondary research question explored: What do service providers identify as the protective factors against workplace mental health problems? Qualitative data were analyzed as part of a larger mixed-method study (Kerman et al., 2022a, 2022b). The study was approved by the research ethics board of the lead author's institution.

2. Material and methods

2.1. Participants

Recruitment for this study began with an extensive online search of community services and networks that provide supports to people experiencing homelessness in each province and territory of Canada. The online survey was then distributed by email to over 300 agencies across the country. Service providers at these organizations and networks were eligible to participate in the online survey if they: [1] were 18 years of age or older; [2] worked in the homeless service, supportive housing, or harm reduction sectors; and [3] provided direct services to people experiencing homelessness. At the end of the online survey, participants were asked if they were interested in participating in a follow-up interview to further discuss their workplace mental health experiences. Of the 701 participants who completed the online survey between November 2020–January 2021, 244 expressed interest in taking part in a follow-up interview.

Purposive sampling was used to recruit 30 interview participants. Two criteria were used for sampling: [1] service sector (homeless service, supportive housing, or harm reduction) and [2] region of Canada (West Coast, Prairie Provinces, Central Canada, Atlantic Region). Survey participants were categorized into 12 categories based on the two criteria, with 2–3 providers being randomly selected from each one.

An additional 10 service providers in senior leadership roles (e.g., managers, executive directors) at homeless service, supportive housing, and harm reduction agencies were also recruited. These individuals were recruited from a subset of the organizations that were sent the online survey and purposively sampled based on the same two criteria as direct service providers. The characteristics of the sample are shown in Table 1.

2.2. Data collection

In-depth interviews with service providers used semi-structured guides. These were comprised of three parts: [1] occupational role identification, [2] work experiences and the perceived impacts on mental health, and [3] recommendations for improving workplace mental health. Questions in the second part of the interview guide were informed by the *National Standard of Canada for Psychological Health and Safety in the Workplace*, which outlines workplace factors associated with mental health and safety (CSA Group and Bureau de Normalisation du Québec, 2013). Prompts were used throughout the interviews to differentiate between pandemic and pre-pandemic experiences and impacts. The semi-structured guide for senior leaders followed the same framework as the one for direct service providers; however, questions primarily focused on senior leaders' perceptions of direct service providers' mental health. All participants provided written consent and interviews

Table 1
Sample Characteristics ($N = 30$, unless otherwise noted).

Characteristic	*n/M*	%/*SD*
Gender		
Woman	22	73.3
Man	6	20.0
Nonbinary	2	6.7
Age	36.20	10.43
Ethnicity, White	23	76.7
Region of Canada[a]		
British Columbia	10	25.0
The Prairies	9	22.5
Ontario	10	25.0
Eastern Canada	11	27.5
Level of education		
High school or less	1	3.3
College diploma	5	16.7
Bachelor's degree	17	56.7
Graduate school degree	7	23.3
Primary service sector [a,b]		
Homeless services	13	32.5
Supportive housing	15	37.5
Harm reduction	12	30.0
Work role [a]		
Direct service	18	45.0
Team lead/coordinator	9	22.5
Program manager	7	17.5
Senior leadership	6	15.0
Full-time work (≥40 h/week)	26	86.7
Service delivery to small/remote communities [c]	7	23.3
Unmet need for mental health services in past year	8	26.7
Weekly use of alcohol (any amount)	18	60.0
Monthly or more frequent use of cannabis	14	46.7
Lived experience of homelessness	4	13.3

[a] $N = 40$.
[b] Some participants worked multiple jobs across service sectors or were employed by multi-service agencies that provided a range of supports.
[c] Small is defined as communities under 30,000 people; remote is defined as permanent settlements with at least 10 dwellings without year-round road access or rely on third party for transportation to large centre.

were conducted virtually using WebEx between February–April 2021. A $30 cash honorarium was provided to direct service providers who completed an interview.

2.3. Data analysis

Qualitative data were analyzed using a grounded theory-informed approach (Corbin and Strauss, 1990). This approach following the coding steps by Corbin and Strauss (1990), with partial integration of the canons and procedures. Data analysis began with verbatim transcription of the audio recordings. During the transcription process, interview summaries were written for each interview, which were then used to develop an initial coding scheme. The coding scheme was primarily inductive, though additional deductive codes aligned with the *National Standard of Canada for Psychological Health and Safety in the Workplace* were also included (e.g., wages and income; organizational policies and bureaucracy; organizational recognition, supports, and growth; workload and staffing; interpersonal relationships). The coding scheme and interview summaries were then reviewed by three co-authors, with revisions being made to the coding scheme prior to beginning the first cycle of coding. Transcripts were uploaded to NVivo (Release 1.0) where the lead author completed line-by-line, open coding. Axial coding, which is intended to reassemble data that have been partitioned during initial coding, was then conducted to identify dominant and less important codes within three broad sets of codes: [1] work triggers for mental health problems, [2] work contributors to positive mental health, and [3] coping with the job (Saldaña, 2013). The three sets of codes excluded pandemic-specific experiences and impacts, which were coded separately, to maximize transferability of the findings to a post-pandemic context. Selective coding, which involves integrating and synthesizing categories to create a theory, centred around one core category (impacts of and responses to systemic and structural problems) was then completed (Saldaña, 2013). Ten theoretical model iterations were developed during the axial and selective coding processes, with the last author providing feedback during the analysis. Memoing was used during each phase of data analysis to document analytic reflections, emergent patterns, and possible connections in the data (Miles et al., 2014). Negative case identification, which involves looking for evidence to refute a construct, was also used to enhance rigor during the analysis (Miles et al., 2014). Survey data were used to describe the sample and explore differences by purposive sampling criteria. However, interview and survey data were not triangulated further.

Quotes presented in the results include participants' work role (direct service, service coordination, management), primary service sector (homeless services [HS], supportive housing [SH], harm reduction [HR]), and province (British Columbia [BC], Alberta [AB], Saskatchewan [SK], Manitoba [MB], Ontario [ON], Newfoundland and Labrador [NL], Nova Scotia [NS], Prince Edward Island [PE], and New Brunswick [NB]).

2.4. Positionality and reflexivity

Critical realism is a mode of inquiry that aligns well with grounded theory-informed analysis and was the stance held throughout this research (Oliver, 2012). Critical realism posits that knowledge is subjective and socially constructed within an independent objective reality. Critical realism enables analysis beyond only what is empirically observable to causal mechanisms that explain why observable events occur through theory development (Fletcher, 2017). Hence, this mode of inquiry facilitates a search for causation to explain social phenomena that involve linkages between structures and observable events, such as individual mental health experiences (Fletcher, 2017).

Research team members had graduate school degrees in psychology, social work, and medicine. The lead author who led data collection and analysis is clinically trained in psychology, with a background in homelessness research and qualitative methods. Having experience in community mental health settings, but not the homeless service sector, the lead author is knowledgeable about aspects of community-based work, but is an outsider of the workforce being studied.

3. Results

The workplace mental health of service providers was centred on the concept of "systems trauma." "Systems trauma" refers to the structural and systemic factors that exacerbate the difficulty of the work and put service providers at-risk of work-related mental health distress. Three thematic components of "systems trauma" were identified: [1] *causes of "systems trauma"*; [2] *consequences of "systems trauma"*; and [3] *protection against the impacts of "systems trauma"*. Fig. 1 provides an overview of these components, as well as the interconnections between the *causes of "systems trauma"* and *consequences of "systems trauma"*. *Causes of "systems trauma"* were fundamentally shaped by the sociopolitical context in which service providers worked. This context yielded structural problems that affected the work of providers, which subsequently presented challenging work experiences. The *consequences of "systems trauma"* refer to the manifestations of work-related mental health distress among this workforce. *Protection against the impacts of "systems trauma"* describes the protective organizational factors and individual-level interventions used by providers to buffer against the distress caused by "systems trauma". There were few differences or accentuated findings in "systems trauma" between service sectors, with none emerging in *protection against the impacts of "systems trauma"*. These are described in the forthcoming sections where applicable.

3.1. Causes of "systems trauma"

3.1.1. Sociopolitical context

The work of service providers was contextualized by participants as occurring amidst interconnected sociopolitical crises. Participants described the backdrop to their work as being shortages in affordable housing, with some communities also having limited emergency shelter beds; a worsening overdose crisis; insufficient or inaccessible mental health services, particularly for acute care needs; and pervasive underfunding of social services. This sociopolitical context formed the basis from which service providers understood and framed their work and mental health experiences.

3.1.2. Structural problems affecting the work of providers

Three structural problems shaped providers' work experiences. First, service providers described working with people who experienced intersectional stigma and discrimination due to homelessness, substance use, mental illness, and Indigenous identity. Although this was an emotional and occupational challenge for providers in and of itself, participants perceived that the same stigmas could be transferred to them and their work: "When you work with a stigmatized population, you get painted with the same brush" (management, HS, ON).

The second structural problem relevant to service providers' work was limited sectoral capacity and resources. Providers identified both a lack of resources, particularly affordable and supportive housing, shelter beds, and acute mental health services, as well as gaps in support continuums. On the latter, gaps were most often reported for those needing high levels of support: "We work with people that have the highest needs, but we don't have 24-h support for them" (management, SH, SK). Sectoral underfunding could also yield limited organizational supports for staff wellness.

The third structural problem was a product of how service systems for people experiencing homelessness are organized. Participants, especially service providers working in homeless services, perceived that their sector was a "catch-all" in the social security net: "This sector being kind of a catch-all for when every other system doesn't do what they should be doing or people fall through the cracks of systems, and so there's a lot of frustration there" (management, HS, ON). This structural problem was further complicated by a perceived lack of integration with behavioural

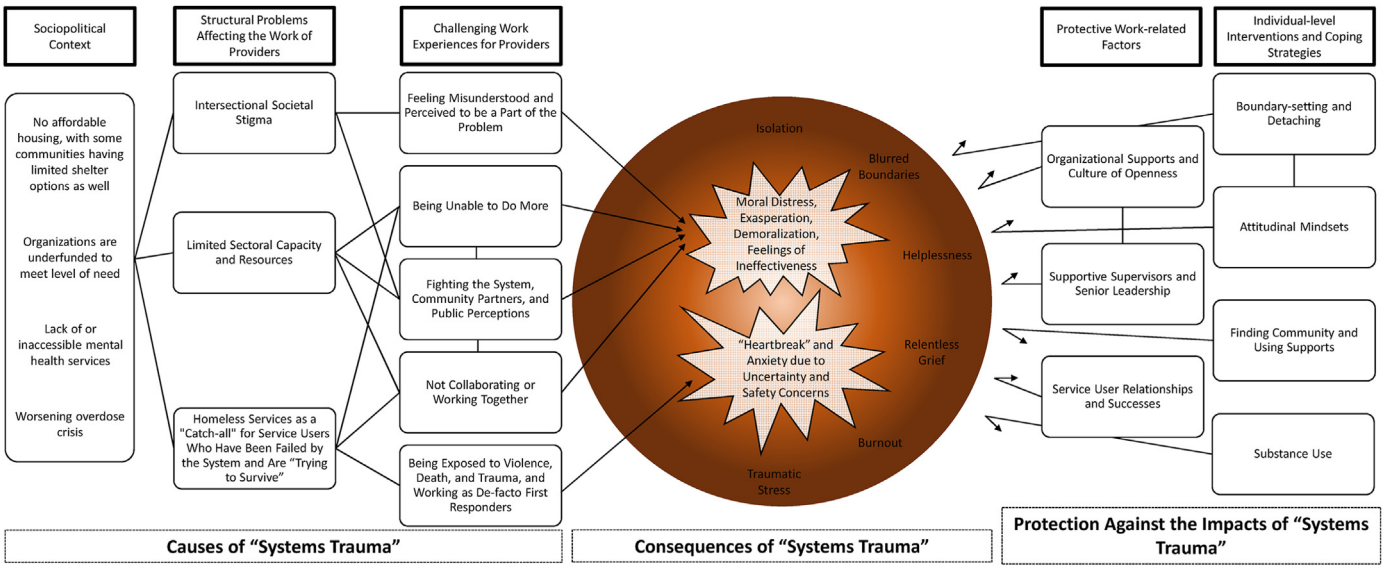

Fig. 1. Theoretical model of workplace mental health among service providers to people experiencing homelessness.

health systems. As a result, service providers were working with traumatized people who were desperately "trying to survive" after having been "failed" by health and social sectors.

3.1.3. Challenging work experiences for providers

Service providers experienced five behavioural and emotional challenges that were directly tied to the structural problems affecting their work. These challenges subsequently shaped how mental health distress was experienced: [1] being unable to do more; [2] being exposed to work-related violence, death, and trauma; [3] feeling misunderstood and perceived to be a part of the problem; [4] fighting the system, community partners, and public perceptions; and [5] not collaborating or working together. Being unable to do more and being exposed to work-related violence, death, and trauma were described as occurring often in the workplace and were foremost contributors to distress among providers.

3.1.3.1. Being unable to do more. Providers' inability to further address the unmet needs of service users due to limited sectoral capacity and the structure of service systems was a commonly expressed frustration. For example, the failings of other service systems were perceived to result in individuals having needs that could not be addressed by "catch-all" homeless services: "There's nothing that I can do. It just makes me feel very little, like there's nothing that I can do for this person [to obtain housing]. And, it's just frustration and sadness" (direct service, HS, BC). The scarce resources led to desperation among providers in which they engaged in "a vicious cycle of trying to grasp at straws" (direct service, SH, PE). The inability to do more was not only experienced by direct service providers but also by those in senior leadership roles, as limited financial resources yielded barriers to increasing wages and expanding employee benefits.

3.1.3.2. Being exposed to violence, death, and trauma, and working as de-facto first responders. The work of service providers involved repeated exposure to critical events, either by witnessing or responding to them in the workplace, or hearing service users' recounts of trauma. Supporting individuals who were in "survival mode" and "a place of last resort" meant that service providers frequently worked as first responders in the workplace, a role made even more common by the overdose crisis: "You start feeling like 'I'm gonna burnout,' especially, like in 2017, I lost seven clients in a month with the fentanyl crisis" (direct service, HS, BC). These events could occur suddenly, yielding an ever-present uncertainty for providers that was not always limited to work hours: "Just going to bed every night, not knowing if you're going to get woken up at 3:00 in the morning because someone's dead in the emergency shelter" (management, HS, ON). Secondary trauma exposure could also be unexpected despite its frequent occurrence: "Some young people will meet you day one and just [let out] here's my awful story and you might not be quite prepared for it and … [outreach workers] could be seeing up to 60 to 80 youth per day, so they're potentially hearing multiple stories day over day" (management, HS, NL).

3.1.3.3. Feeling misunderstood and perceived to be a part of the problem. The societal stigma experienced by service providers could lead to them feeling misunderstood within their personal support networks. This stemmed from a perceived lack of awareness about people experiencing homelessness and what it is like to work with this population. Discriminatory comments about people experiencing homelessness were one way providers felt that their work was misunderstood: "I've also heard people say like, 'Oh, you're just working with people who are draining the government, and like they're on welfare and they're lazy,' and I'm like, 'OK. What about their trauma? What about all these walls they come up against?'" (direct service, SH, AB). However, providers more commonly felt misunderstood in response to extolment by friends and family, such as "How can you do what you do? My God, you're amazing" and "Oh, I could never do that." Said one, "It's sad that people think that my job is some sort of superheroing, because it's not. It's literally resource navigation … people think that you need to be something special to be able to just talk to a human at a bad time" (direct service, HS, BC). Another added that their employment was simply the response to a community need: "People talk like, 'Oh, this is a calling, and you have to be chosen.' I'll be like, 'Yeah, that sounds ridiculous. That sounds like we went to Hogwarts.' … We're not special people. We're just the only people here right now who are responding to overdoses" (direct service, HR, ON). Glorifying comments about providers and their work could then impede access to support: "You feel like you can't say, 'I got really frustrated today' … we're all just people who are not saints, we have bad days, and we have ugly feelings sometimes" (management, HS, ON).

Service providers could also feel unwanted because of their communities perceiving them to be a part of the social problem that they were working to address. This included community attitudes that characterized service providers as "poverty pimps" who were "capitalizing off of poverty and like only doing this work to get money" (service coordination, SH, ON). Said another, "You'll get called a poverty pimp. This is a big one that's coming out now. You provide services for people, and they

say, 'Look, we have all these homeless, drugged people on the street. Why are we paying these poverty pimps? They aren't taking care of these people'" (management, HS, BC). Relatedly, service providers using harm reduction approaches were perceived to be "enabling" substance use among service users: "There was a bit of it [stigma] when we first started introducing naloxone and harm reduction into our communities … [due to] the thought that that's enabling" (service coordination, HR, BC).

NIMBY ("Not In My Backyard") sentiments were another product of societal stigma that could be levied at service providers: "We are trying to build a new building that's close to our shelter and we are getting this discourse about, 'There's an overconcentration of services' and this sort of thing, and we're also getting an interesting form of NIMBYism that we, as service providers, are not serving the clients properly or like we're not fixing the problem" (management, HS, ON). Several negative cases were also present in the findings, with these participants highlighting either strong support from municipal government or reclamation of the insults directed toward them. On the latter, one said, "Our logo is literally a bleeding heart, so we kind of just accepted it and we wear it as a badge of honor" (direct service, HS, AB).

3.1.3.4. Fighting the system, community partners, and public perceptions. Another consequence of limited sectoral resources and societal stigma was that service providers needed to 'fight' to effect change or obtain funding. Related to the experience of being unable to do more, providers also felt that their work was continually in opposition to the systems in which they worked: "You're thinking about ways to beat the system almost. Right? To try and get [service users' support needs met], which should not be the case" (direct service, HS, PE). Infighting between community partner organizations was a potential result of vying for limited governmental funding: "Everyone is fighting for the same funding … that's what creates a bit of friction amongst organizations" (direct service, SH, NS). This could undermine a sense of collaboration between agencies, another challenging work experience: "It's really crappy when we're pitted against each other trying to get the same funds and have to trash talk each other's programs to get the same funds when, really, we're all part of the same system and it would be so much more effective if we were collaborating more effectively" (service coordination, SH, BC).

Some service providers also engaged in fighting roles because of intersectional societal stigma. This included responding to observed discrimination in the community and online: "I've gotten myself really amped up on Facebook when there has been like a news post about like a new supportive housing unit coming in or a new shelter, and of the hundreds of comments are like, 'Oh my God, my kid goes to school 2 km from there'" (direct service, SH, BC). Although providers acknowledged consequences to "exerting all this energy to try to like stand up for what I know is true and right," some felt drawn into injustice-based conflicts as "not speaking up feels like betrayal." Senior leaders also experienced dilemmas related to their staff fighting back against stigma and discrimination through activism due to fears of repercussions: "I have to really hold them back and bring them in a lot. They'd be doing freaking protests on City Hall steps with dead bodies … we'd lose our funding" (management, HR, BC).

3.1.3.5. Not collaborating or working together. Many service providers perceived a lack of collaboration in their work due to limited sectoral resources and the organization of service systems. Tied to the previously described experiences of fighting the system and community partners, service providers lacked a sense of collaboration with other agencies. This problem often arose when unsuccessfully supporting service users to access crisis care or ongoing supports for behavioural health needs. Homeless service and supportive housing providers also experienced lack of collaboration in the form of behavioural health services "dumping" service users onto them with limited communication and supports: "Oftentimes, I get calls from social workers in hospitals that want to dump their clients on me once they're getting discharged out of the hospital. So, I think that there's just a lot of miscommunication and stuff going on that could be collaboration" (direct service, SH, NS). Compared to the systems level, lack of collaboration within organizations was discussed less often.

Service providers in smaller communities could experience a lack of collaboration due to there being few, if any, other agencies supporting people experiencing homelessness. Service providers of harm reduction programs outside of large cities were particularly vulnerable to this: "We're the only people kind of doing that work here. Sometimes, it feels like we're in a bubble" (service coordination, HR, BC).

3.2. Consequences of "systems trauma"

The challenging work experiences produced two types of emotional responses among service providers. The first was multifaceted, involving experiences of moral distress, exasperation, demoralization, and feelings of ineffectiveness. The second was anxiety from workplace unpredictability and "heartbreak" from the deaths and traumas of service users — a more unique consequence of work-based violence, death, and trauma exposure. If these emotion states went unresolved, they could grow into more longer-lasting experiences of distress, such as isolation, traumatic stress, helplessness, burnout, relentless grief, and blurred boundaries.

3.2.1. Moral distress, exasperation, demoralization, and feelings of ineffectiveness

Moral distress was experienced in a range of work-related contexts. This was most commonly the result of providers feeling unable to do more for service users due to structural and systemic barriers: "There's vicarious trauma … but it's exacerbated by the inability to help people move through the systems. There's so many barriers in place, there's so many hoops. There's waiting lists and processes, and that's the biggest thing. We could do so much. We know what these guys need or what would help them. We can't" (management, HR, BC). Service capacity limits, organizational policies that conflict with personal values, and desperation to secure housing for service users were other sources of moral distress. This was acutely felt among emergency shelter workers that were involved in turning away people due to capacity limits or issuing service restrictions: "If we ban someone, they have nowhere to go, which basically is just an arrest sentence … the fact that it's just us and, if we kick him out, there's nowhere, and, as far as I'm concerned, that's pretty inhumane" (direct service, HS, AB). Housing placements for which success was not anticipated also yielded moral distress, as this could put others in the building at risk and jeopardize access to housing for future individuals: "It's that whole balance of you know this client is not going to do well, how do you reconcile that moral dilemma of still supporting them to find housing, despite the fact that it may be putting other people at risk? Well, that's a stressful dilemma" (service coordination, SH, ON). Moral distress was not limited to the workplace, as providers could also experience this when contrasting their personal lives to those of the individuals they served: "To come home and climb into a bed after you've just covered somebody up outside in −20 [degrees Celsius] with a tarp, you know, it's pretty tough to do that. Or, you meet somebody that hasn't eaten for four days and you're sitting in front of a steak dinner that you just threw on your barbecue" (management, HS, AB).

Exasperation, demoralization, and feelings of ineffectiveness were related emotional responses that could occur concurrently with or separately from moral distress as a result of the same challenging work experiences. Feeling misunderstood and fighting public perceptions often yielded a sense of anger among providers: "I see things on social media of people like bashing certain people and groups that I've worked with, it literally shatters me and it angers me" (direct service, SH, AB). Being unable to do more and the lack of collaboration produced complex emotional reactions, with exasperation, demoralization, and a sense of ineffectiveness all being present at times: "If you're at a standstill and somebody's working with you because you're trying to help them find housing, and that's just not a possibility, you're definitely not feeling like

accomplished or anything" (direct service, SH, NS). A supervised consumption site worker described the emotional experience of providing life-saving overdose response interventions, only to watch people then return to the harsh reality of homelessness, "It's very depressing as hell when, at the end of the night, although you've saved someone's life, you're sending them out back into the streets. And, if you're in this work for a long time, you have a good sense about what that entails for people and it's very unpleasant to put it mildly" (direct service, HR, ON). Overall, given the long waiting lists for services and low vacancy rates in communities, providers felt like they were "on a hamster wheel" with the challenges that they experienced in the workplace, making these emotional responses common and reoccurring.

3.2.2. *"Heartbreak" and anxiety due to uncertainty and safety concerns*

A distinct emotion response to violence, death, and trauma exposure were feelings of "heartbreak" and anxiety. The former occurred in response to repeated exposure to the trauma histories and deaths of service users: "Sometimes, those stories that you hear can be heart-wrenching" (direct service, HR, AB). Said another of the impacts of the ongoing overdose crisis on service providers, "The opioid crisis is the biggest threat currently and I think it's a daily stressor, as well as a daily source of grief" (management, HR, NS). The unpredictability of the work and constant possibility of violence, suicide, and overdose also led to feelings of anxiety among service providers. On leaving a street outreach job, one participant said, "I experienced some level of burnout by the time that I needed to switch positions and a lot of that was anxiety of worrying about what clients were going to do and not knowing what I was walking into wherever I was going for my shift. So, like going to the homeless shelter, you didn't know if you're going to drive up there and witness somebody like beating the crap out of somebody or that sort of thing" (service coordination, HR, AB). Barriers to accessing care for service users in crisis also yielded anxiety for providers: "We've had clients who have disclosed suicidal ideation, being a risk to themselves, and taking them to the mental health ward of our hospital and they're being denied. Not being deemed either high enough risk or they're full or that sort of thing … it just adds to the stress of, 'What's going to happen to this person?'" (service coordination, HR, AB).

3.2.3. *Paths to longer-lasting consequences of "systems trauma"*

The two emotional responses to work challenges could precipitate more longer-lasting forms of distress when left unaddressed or insufficiently managed. This could include isolation, traumatic stress, helplessness, burnout, relentless grief, and blurry boundaries. On the latter, service providers described disregarding organizational rules and safeguards to provide needed support: "There's still work that needs to be done and there's people that don't have anything and I'm not really willing to just let that be, so I definitely go too far with it a lot" (direct service, HS, AB). Some providers discussed this process as occurring quickly, such as following a critical event or a short series of repeated difficult situations: "I've responded to multiple hangings and have had to cut people down and I know that other staff in our agency have, too, and certainly you immediately see people go off on a leave after something like that" (management, HS, ON). However, distress more commonly worsened incrementally due to cumulative exposure to hardship and trauma: "With the burnout or compassion fatigue that I see in staff, it's very rarely one incident. It's that death by 1000 cuts type of thing where you're like, 'I'm fine, that didn't affect me. I don't need to debrief, it's okay,' and then it just happens over and over again until you're at the point that you're like, 'I can't do this anymore'" (management, HS, ON). Both these paths involved growing distress related to perceived failings (e.g., "we're failing people," "our systems are failing our clients") that become too burdensome for providers who felt powerless to change this reality.

3.3. *Protection against the impacts of "systems trauma"*

Two sets of factors buffered service providers against the harms associated with *"systems trauma"*: [1] protective work-related factors and [2] individual-level interventions and coping strategies.

3.3.1. *Protective work-related factors*

Organizational supports and a culture of openness, supportive supervisors and senior leadership, and service user relationships and successes were identified as having a positive effect on work attitudes. Beginning with the former, providers appreciated organizations that had cultures of openness to discussing difficulties and challenges, involved debriefing as a regular part of practice, and offered adequate benefits and training. Strong organizational supports were often linked to supportive supervisors and senior leadership. Service providers underscored the importance of supervisor approachability, openness, and warmth. Further, it was important to direct service providers that senior leadership be knowledgeable about workplace mental health and engage in mindful hiring practices: "When your organization is hiring just anybody off the street, you're not going to feel supported, and you're not going to feel like you can do your job properly because you're also worrying about your co-staff not doing their jobs properly" (direct service, SH, BC). Supervisors and senior leadership having past direct service work experience was perceived to increase the likelihood that they understood the nature and challenges of direct service work: "I've worked for people who have never done like that frontline kind of position and they don't have a clue what it's really like out there … if you have a supervisor that did that actual position themselves, they remember what it was like doing it, so they kind of have a clear idea of what is manageable" (direct service, HR, AB). If organizational management did not have such experience, knowledge of direct service work could be achieved through other intentional efforts (e.g., regularly shadowing and consulting staff, having mechanisms that allow direct service providers to participate in organizational decision-making). Alignment between provider values and those of the organization, as implemented by senior leadership, as well as diverse representation among management, also promoted workplace mental health through a sense of belonging and togetherness.

Service user relationships and successes were often cited by service providers as a primary reason for doing the work and a key factor in what kept them in the sector: "What keeps me going is the people that I work for. You know, especially when you see somebody getting better" (direct service, SH, BC). Overcoming systemic barriers made the successes of service users more rewarding: "It's a natural high for me when I see a person meeting a goal successfully, rekindling something with like a natural support, or getting into the housing program they've had their name on for months" (direct service, SH, AB).

3.3.2. *Individual-level interventions and coping strategies*

Service providers identified four interventions and coping strategies that they used to manage work-related distress: [1] boundary-setting and detaching; [2] attitudinal mindsets; [3] finding community and using supports; and [4] substance use.

Boundary-setting and detaching was described as an "essential" skill needed for the work (e.g., leaving work on time, not engaging in work-related activities at home, physical distance between home and work). Providers primarily discussed the importance of boundary-setting and detaching in the context of supporting service users, including with their trauma histories: "I compartmentalize a lot. I'm pretty good at like even though I can be in a place with somebody, and I've heard stories that are so awful, I can leave it at work" (direct service, HS, BC). However, the skill was occasionally applied to relationships with colleagues as well, which could prevent further secondary traumatization: "There's the whole terminology of like 'sliming' people with their own, with maybe vicarious trauma that they picked up from clients. So, I try to set boundaries with my colleagues, too" (direct service, SH, NS). Despite the perceived necessity of boundary-setting and detaching, some providers found it challenging: "It's hard because, when I'm not working, I'm still thinking about them." (direct service, SH, AB).

Service providers described varied attitudinal mindsets that they

found beneficial for coping with the burden of the work, as well as for boundary-setting and detaching. Whereas some providers adopted willful attitudes, such as "If you run into a system challenge then you find a way around it. There's always different answers" (direct service, HS, BC), others took acceptance-based views and restructured expectations: "I really have tried to be thoughtful, sort of as a protective mechanism, to recognize like we're not going to be able to do everything for everyone, but we're doing the best we can for the people that show up at your door" (service coordination, HR, BC). The latter view was also key to recognizing that individuals are not responsible for the systemic and structural problems that affect service users: "If something does happen in the SIS [supervised injection site], like say God forbid someone dies in the SIS, this is not our individual faults. This is multiple systems" (direct service, HR, ON). Attitudinal mindsets, in conjunction with organizational safety policies and protocols, provided a sense of safety for some providers: "I've never felt unsafe at work. I'm a big believer in the way that you hold yourself around other people is what creates safety for you" (service coordination, HR, BC). Recognition of the positive elements of the job, including "small wins," was another part of attitudinal mindsets that could mitigate a sense of helplessness in the face of systemic and structural problems: "Every day there's at least one small win, and, if you just make it a practice that you're looking for one win, it's pretty good" (direct service, HS, BC).

Finding community and using supports was another coping strategy availed by service providers. Peer support from like-minded colleagues within and outside of service providers' organizations provided a sense of community and togetherness. The support of colleagues and professional networks was particularly instrumental following secondary trauma exposure and during periods of grieving. As previously discussed, the provision of employment-based benefits could be beneficial for buffering against *"systems trauma"* when service providers made use of these supports. This included taking breaks during the workday; using vacation or personal time to step away as needed; and accessing therapy and counselling, if available.

Substance use, which was primarily alcohol or cannabis, also enabled some service providers to "soothe" or "forget" the hardships they observed at work. Some expressed concerns about their use or that this had caused problems in the past: "After my first winter [working at an emergency shelter], I pretty much would just get home and pour four ounces of gin into a cup. Pretty much every night … I was just like racking my brain of like, 'I know I'm kind of broken from this'" (direct service, HS, AB).

4. Discussion

This qualitative study examined how the work of service providers to people experiencing homelessness in Canada affected their mental health, including what contributed to and protected them from work-related distress. The concept of *"systems trauma"* highlighted how structural and systemic problems that impact people experiencing homelessness also had varied negative effects on the mental health of individual service providers. The findings extend previous research on how affordable housing shortages and sectoral underfunding complicate the work of providers (Kidd et al., 2007; Olivet et al., 2010; Peters et al., 2022) by linking these problems to work-related distress. This conceptualization of workplace mental health among service providers to people experiencing homelessness facilitates a refined understanding of the contributory factors to work-related distress. Whereas vicarious traumatization and secondary traumatic stress focus on behavioural and cognitive changes that occur among workers as a result of direct or indirect trauma exposure (Newell and MacNeil, 2010), *"systems trauma"* offers a broader perspective on how work-related distress develops. Our findings highlighted how the pervasive structural and systemic problems encountered by providers can prime them for work-related distress exacerbations, which may occur in the forms of vicarious trauma and secondary traumatic stress. As many studies on vicarious trauma and secondary traumatic stress in social workers and social service providers have focused on organizational and individual-level factors (e.g., Choi, 2011; Kerman et al., 2022b; Molnar et al., 2020; Twis et al., 2022; Waegemakers Schiff and Lane, 2019), there is a need to consider how the broader sociopolitical context, including providers' experiences of working in such an environment, affect their mental health. Further, few differences were found between service sectors, with the exception of participants working in homeless services being more likely than supportive housing and harm reduction providers to perceive that their sector was a "catch-all" in the social security net. This suggests that the effects of structural and systemic problems on workplace mental health may be pervasive within community-based services to people experiencing homelessness. Accordingly, the work-related challenges precipitated by structural and systemic problems should be widely recognized within available workplace supports, such as training, supervision, and wellness initiatives.

In contrast to the causes of work-related distress, structural- and systemic-level elements were notably absent from the identified protective factors. Instead, service providers described a range of organizational and individual-level interventions and supports that had perceived positive effects on workplace mental health. This may be the result of the structural problems, such as the lack of affordable housing, inaccessible mental health services, and the overdose crisis, being pervasive across Canada (Belzak and Halverson, 2018; Gaetz et al., 2016; Moroz et al., 2020) and providers perceiving themselves to have minimal control over effecting change on these issues. Because of this, actions are needed at both the organizational and systems levels to promote positive workplace mental health among this workforce. Addressing protective factors within organizations, such as the establishment of supportive supervisors and senior leadership, cultures of openness, and adequate training, are key to providers feeling valued and supported. Facilitating access to affordable mental health supports through benefit packages is also recommended. At the systems level, the findings underscore the fundamental importance of primary and secondary prevention of homelessness that would reduce the level of need for crisis-based responses, which are stressful settings for service users and providers (Oudshoorn et al., 2020; Wirth et al., 2019b). This includes investment in building new affordable and supportive housing, developing eviction prevention interventions, and increasing income support rates to keep pace with rising housing costs. Scaling up Housing First programs, a best practice for stably housing people experiencing chronic homelessness (Aubry et al., 2020), is also recommended to expedite exits out of homelessness and reduce service providers' experiences of helplessness and moral distress.

Service providers in this study were subjected to stigma related to the individuals they served, which occurred in the forms of NIMBYism and degrading misperceptions about the value of the work and effectiveness of harm reduction. This experience is consistent with the concept of stigma by association (also known as courtesy stigma and stigma spillover), which involves the problems experienced by stigmatized individuals being transferred with a lesser intensity to those with whom they have contact (Goffman, 1963). To our knowledge, no previous study has examined this experience among service providers to people experiencing homelessness, though it has been found with related groups. Stigma by association was a central aspect of the work of service providers to sex workers in British Columbia, Canada, that exacerbated work-related stress and fatigue (Phillips et al., 2012). This research also linked the underfunding of health and social services to the devaluation of care work to marginalized groups — a finding that is consistent with the narratives of service providers in our study. Stigma by association has also been theorized to exacerbate the harms of the worsening overdose crisis, as service providers may not provide support to people who use drugs to avoid stigmatization (Tsai et al., 2019). Initiatives to improve the valuation of service delivery to people experiencing homelessness at the policy and public levels could be beneficial for reducing stigma by association within this workforce. Establishment of a workforce development strategy that outlines sectoral capacities; roles, skills, and

competency-based training requirements of service providers; and employee retention strategies and needs could be used to reduce the undervaluation of the workforce and advocate for more resources to support it (Mullen and Leginski, 2010).

Work-related distress occurred in a variety of forms among service providers. Current or past experiences of traumatic stress, burnout, and grief were common and are consistent with a robust body of research on the workforce (Aykanian, 2022; Kerman et al., 2022b; Lemieux-Cumberlege and Taylor, 2019; Peters et al., 2022; Petrovich et al., 2021; Waegemakers Schiff and Lane, 2019). However, moral distress was another mental health problem that was often linked to the work challenges encountered by providers. Although moral distress has been identified as a problem among almost all healthcare professionals (Whitehead et al., 2014), it has been minimally examined among social service providers. Yet, there appear to be strong parallels between these workforces in how moral distress occurs. Similar to past research on nurses (Corley, 2002; Tiedje, 2000), moral distress among service providers in this study was precipitated by powerlessness to do more for service users due to organizational and structural constraints, interpersonal conflict, and experiences of fighting the system. As moral distress has been linked to higher turnover intent among physicians and nurses (Austin et al., 2017), such experiences may be contributing to similar staffing problems in the homeless service and housing sectors (Aykanian, 2022; Olivet et al., 2010). Accordingly, it is imperative that agencies provide the supports needed to address moral distress within the workforce that serves people experiencing homelessness. Attitudinal mindsets grounded in acceptance and acknowledgement of the deleterious effects of structural problems on people experiencing homelessness was identified as protecting against the personalization of work-related challenges, including moral distress. This is consistent with recommendations for managing moral distress in healthcare settings (Pauly et al., 2012). Organizations could aim to strengthen providers' awareness of the connections between their own wellness and the structural determinants of health via training and supervision adapted from structural competency models (Downey et al., 2019; Neff et al., 2020).

This study had several limitations. First, data were collected during the COVID-19 pandemic, which may have affected the findings and their post-pandemic transferability. This limitation is partially mitigated by actions taken during data collection and analysis to identify and separate out pandemic-specific narratives, which are reported elsewhere (Goodwin et al., 2022). Second, it was infeasible to compare the perceived effectiveness of the organizational- and individual-level supports and interventions used by providers. As some approaches may be more beneficial to providers than others, this warrants further research. Third, some service providers worked multiple jobs across sectors, with others also working in multi-service organizations or having changed sectors during their careers. These work histories may have obscured the identification of further workplace mental health differences between the homeless service, supportive housing, and harm reduction sectors. Fourth, purposive sampling ensured that providers were represented from all regions of Canada; however, the capacity to detect geographic differences, including urban and rural variations, was limited given the heterogeneity of providers' work roles and service settings.

5. Conclusion

Work-related distress experienced by service providers in the homeless service, supportive housing, and harm reduction sectors was shaped by the same sociopolitical context that negatively affects people experiencing homelessness. Structural and systemic problems led providers to feel misunderstood and unable to do more, as well as repeatedly exposed them to workplace trauma and prevented more collaborative partnerships. Moral distress, exasperation, demoralization, anxiety, and anguish were among the emotional experiences that manifested from the work challenges experienced by providers. With cumulative exposure to critical events and other challenging work situations, these emotional states could become more longer-lasting forms of distress, such as burnout, traumatic stress, and relentless grief. Protective factors against workplace mental health problems included organizational supports and working relationships, as well as use of individual-level coping strategies; no structural or systemic protective factors were identified. The findings underscore the need for primary prevention of homelessness as a workplace mental health strategy in the homeless service, supportive housing, and harm reduction sectors. Supports for managing moral distress, policy and public initiatives to improve the valuation of work with people experiencing homelessness, and dedicated funding for workforce development are also recommended to improve the mental health of service providers.

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Contributors

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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