

**Frontline Workers with Lived Experience
and Traumatic Stress
In the Homelessness Sector**

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A Major Paper
submitted to the Faculty of Environmental and Urban Change
in partial fulfillment of the requirements for the degree of Master in Environmental Studies
York University, Toronto, Ontario, Canada

April 22, 2022

Abstract

In the last forty years, various sectors have highlighted the importance of focusing on the well-being of service providers. Informally amongst my co-workers in the homelessness-serving sector, many have noted there has undoubtedly been a greater emphasis in the last ten years to enhance the support offered. Specifically, we have seen the embracing of peer workers, or frontline workers with lived experience (FWLEs), in addiction and mental health, with great value on their contribution to that sector (Miler et al., 2020). While the homelessness sector has made some progress in recognizing the contributions of frontline workers with lived experiences, we need platforms to amplify their voices to ensure the sector understands their relevance.

It is evident through the many discussions with my peers that the stigma of homelessness continues to impact how FWLEs navigate their places of employment and access support. It is also evident that they remain at risk of (a) traumatic events based on their history, (b) acquired traumatic experiences. This paper examines the reported experiences of frontline workers in the homelessness sector, past research, and personal experiences as frontline staff with past and current traumatic stress. At the time of writing, there has been no recent work that focuses on traumatic stress in FWLEs in the homelessness sector, and thus, there are many inherent gaps. Acknowledging this research absence, this paper presents a pivotal pathway for supporting FWLEs in the homelessness sector.

Foreword

At the start of my studies, I identified the importance of sustainable and affordable housing for marginalized populations. I intended to look at the lack of sustainable housing for marginalized individuals and the fact that despite many initiatives, unless individuals presented as belonging to the mainstream of the general populous, they were not afforded quality housing options. My initial areas of concentration in my plan of the study included Affordable Housing, Community Housing and Planning, and Sustainable Housing for Marginalized populations.

Through the progression of my work, in conjunction with my work as a senior leader managing a large housing department, I noticed a direct emotional impact in providing support and services to disenfranchised individuals. Frontline workers and program managers were being impacted.

In reflecting on the knowledge gained in the early parts of my study, I then shifted my focus. Courses in Social Planning, Trauma-Informed Care, Social Policy, and Planning gave me the tools to more critically examine not only the structural environments in which supports and services are provided to marginalized individuals experiencing homelessness, but also the need to improve the psychological environments in which frontline workers with lived experience work.

This major paper expanded my knowledge in research development and data interpretation. It let me explore opportunities to connect research to policy for the social good while ensuring sustainability and suitability of responses to the problems my research uncovered.

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Dedication

Frontline staff has been referred to as caregivers, first responders, frontline workers, or case managers, depending on their work location or specialty. Within the homelessness sector, the terms frontline worker and case manager or caseworker are used interchangeably to refer to those providing direct service to vulnerable, impoverished, and at-risk individuals impacted and affected by homelessness. Regardless of the title, many agree that frontline workers play a critical role in ending homelessness. Those who have their own experience of homelessness play a pivotal and unique part in connecting to a population they have become too familiar with from their own experiences. FWLEs bring a perspective of community care and compassion to their work, and thus one cannot underestimate their contributions. This body of research aims to shine a light on the need for research on traumatic stress experienced by FWLEs in the homelessness sector.

I want to dedicate this body of work:

To all the frontline staff who work in the homelessness sector, specifically those with lived experience who have reminded me of their unique perspectives. Your can-do spirit, the resilience you bring to work while working in chaotic environments, and weathering the storm of your journeys inspire me daily.

To the managers, directors, and leaders who ensure they prioritize self-care and wellness as part of their supervision model in doing this work.

To Tracey Ferguson who taught me many things about being Frontline with lived experience doing this work, demonstrating heart, pride, and compassion to those trying to join you on the frontlines. Your generosity of time is priceless.

To Richard Potts (deceased), who believed I had lots to offer as a newcomer to Canada. Your knowledge and wisdom guide my work as I support Toronto's most vulnerable.

Thank you all.

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Acknowledgment

This paper would not be possible without the ongoing encouragement of my mom, children, Dorothy and Stacie, and family members both in Trinidad and Canada, for their patience and continued reminders that I can do it. Thank you to my friends who listened, read, and stayed up late listening to my many rants about this paper.

To Dr. Liette Gilbert, thank you for your guidance and encouragement in completing this paper. Your support during some of my most difficult times in academia has not gone unnoticed. I will remain forever thankful for your reminders and assurances that even through change, I can remain resilient and succeed.

To Dr. Jeannette Waagemakers Schiff, you are indeed a divine intervention. I am forever indebted to you for believing in me and taking me under your wings of learning, your strict but gentle guidance, and your mentorship. I would not have completed this work without you.

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Introduction

Frontline workers are at the helm of service provision in the affordable housing, shelter, and homelessness services sector. They connect vulnerable individuals living in poverty and experiencing homelessness to much-needed support and services and serve as an integral part of the social service sector. Service providers are tasked with supporting a client group whose long histories of trauma, concurrent disorders or disabilities, and other comorbidities can make for a chaotic and unpredictable environment if not well managed (Hopper et al., 2010). In their recent report, the City of Toronto highlighted frontline workers' commitment to supporting the homelessness sector and their tireless efforts while working in a challenging and ever-changing work environment (SSHA September 2020). This acknowledgment is welcomed as necessary for frontline workers to feel validated for their efforts and highlights the complexities of their work.

Historically, discussions on improving homelessness services and supports have focused on the service user and enhancing their service acquisition practices. They have emphasized system navigation for service users through the lenses of race, gender, ethnicity, and mental and physical disabilities, to name a few, and how these factors impacted their ability to access safe and affordable housing or shelter (Hwang et al., 2012). However, in recent times, there continues to be an emergence of a new discourse and focus on the caregiver or frontline worker in the homelessness sector. This emerging discussion has been dramatically amplified with the current global pandemic of COVID-19 and the opioid crisis epidemic.

Frontline workers provide support and services in the affordable housing and shelter sector, with a high concentration of homeless and marginalized populations (Gaetz et al., 2016). More importantly, this research draws from both lived and professional experiences as service users and practitioners. It also analyzes unique data sets from current research belonging to a more extensive study that focuses on the psychological impact COVID-19 has had on frontline staff in the homelessness sector conducted by lead researcher, Jeanette Waegemakers Schiff. It must be

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noted that past data focused on frontline staff in the homelessness sector and across the nonprofit sector; however, this research is the first that includes a subset of data that relates to FWLEs.

As a frontline worker in the homeless-serving sector, my lived experience of couch surfing had a direct bearing on my mental wellness. Now, as a director in a housing service provision agency, I am uniquely positioned to appreciate the value of having FWLEs in the workplace and their importance in ending homelessness. In addition, FWLEs in the workplace bring different relatability levels to service users that may not always be present in workers without lived experience (Feige & Choubak, 2019; Nelson, 2020).

This research paper examines the traumatic stress reported by frontline workers within the homelessness sector who have lived experiences with homelessness. To this end, this paper explores the intersection of homelessness, marginalization, and traumatic stress levels experienced by frontline workers with lived experience. This is particularly important because it highlights the service providers who have come into this work with their own experiences while supporting others with their respective challenges (Hopper et al., 2010). This paper critically examines FWLEs and how they are impacted by tension in the workplace compared to their co-workers who do not identify as having lived experience.

The chaotic environments where staff provide support and services to vulnerable individuals and families are unpredictable shifting landscapes. According to Hopper et al. (2010), individuals seeking help in the homelessness sector have a lengthy history of trauma, exposure to traumatic events, and struggles with addictions and mental health. This is important because frontline staff who have "experiences with trauma themselves may be triggered while supporting clients" (SAMHSA, 2014 p. 19).

Frontline workers with lived experience in the homelessness sector play a vital role in ending homelessness because their personal experiences with homelessness provide insightful approaches to the work (Hopper et al., 2010). These experiences have led them to understand better those they serve while having empathy. Furthermore, "the people living it usually have the best understanding of the problem and what needs to be done to address it. Inclusion is especially

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vital in homelessness, though, because being excluded and silenced is a huge part of the experience of homelessness and poverty" (Lived Experience Advisory Council, 2016, p. 1). While great efforts have been placed on employee diversity and inclusion for FWLEs, it remains unclear how this cohort of employees is impacted by the trauma associated with working in the homelessness sector. The factor of trauma is essential to isolate and understand because as frontline staff provides support and services to individuals with various forms of trauma, they must be mindful of the impact of such interventions while attending to their self-care and resiliency (Elliot et al., 2005).

This paper begins with a literature review, followed by the theoretical approaches to observing past and current data sets and methodologies. Next, I present a detailed analysis of the data, and finally, I offer a candid discussion and conclusions regarding some early findings.

Section 1

Definitions and Table to Acronyms

Definitions

Burnout: “is persistent, negative, work-related state of mind in 'normal' individuals that is primarily characterized by exhaustion, which is accompanied by distress, a sense of reduced effectiveness, decreased motivation, and development of dysfunctional attitudes and behaviors at work. This psychological condition develops gradually but may remain unnoticed for long time by the individual involved. It results from misfit between intentions and reality in the job. Often Burnout is self-perpetuating because of inadequate coping strategies (Kulkarni, 2006).

Compassion Satisfaction: The ability of an individual to remain compassionate and maintain satisfaction in their work, despite facing various challenges (Stamm, 2010).

Frontline Workers with Lived Experiences: Frontline workers with lived experiences of homelessness who are currently providing services and supports in the homelessness sector.

Homelessness: Canadian Observatory on Homelessness (COH): "homelessness describes the situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means, and ability to acquire it." To clarify and define homelessness within Canada, COH acknowledges the complexities of homelessness that range beyond individuals sleeping rough (living on the streets) but include those couch surfing, those in temporary shelter accommodations, and those who lack access to affordable housing (Gaetz et al., 2012)

Resiliency: The ability of an individual to overcome various adverse negative experiences through healthy coping strategies aimed at fostering emotional wellness, with a focus on long term mental sustainability and rejuvenation (Stamm et al., 2010).

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Table of Acronyms

Acronyms	Definition
ACE	Adverse Childhood Experiences
FWLEs	Frontline Workers with Lived Experiences
LE	Lived Experiences
LEC	Life Events Checklist
NoLE	No Lived Experiences of homelessness
PCL	Post-Traumatic Stress Disorder Checklist
PCL-C	PTSD Checklist for Civilians
PRO-QoL	Professional Quality of Life Measuring Instrument
PTSD	Post-Traumatic Stress Disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
TIC	Trauma Informed Care
TIP	Trauma Informed Practices

Section 2 Literature Review:

Literature Review

This section explores some of the earlier work done in psychological safety related to frontline workers in helping professions. It introduces the discourse in a nonprofit organization supporting homeless individuals.

This research is based on an in-depth review of literature involving frontline workers in the homelessness sector. While there is emerging literature regarding frontline staff working in the homelessness industry, there is currently limited literature that focuses primarily on frontline workers with lived experience of homelessness (FWLEs) in the homelessness sector. While there has been a new shift in the awareness of the psychological wellness of those on the front lines in the homelessness sector since COVID-19, the attention FWLEs have received has been fractional. Furthermore, these frontline workers are greatly overshadowed compared with their peers in the mental health and addictions sector, social workers in hospitals and long-term facilities, nurses, firefighters, police, or doctors.

A contextual formulation was utilized to best frame and situate the unique environment in which FWLEs operate within the homelessness sector to provide support and services: homelessness, trauma, affordable housing, and shelters services are the numerator. At the same time, the ongoing denominator remains FWLEs. To this end, the exploration of homelessness is relevant in creating a visual mental map of the environment in which FWLEs work and their previously lived environments. I have discovered many studies regarding FWLEs in the addiction and mental health sector; however, no current research focuses on FWLEs in the homelessness sector.

Defining Homelessness

Over the years, homelessness has been defined and redefined, from living on the streets, living in shelters and group homes, dealing with the threat of facing evictions due to arrears or fleeing abuse, to being under-housed. Currently, the definition of homelessness continues to evolve. With the introduction of Canada's National Housing Strategy in 2019, many advocates and

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policymakers continue to draw on the report outlined by the Canadian Observatory on Homelessness (COH): "homelessness describes the situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means, and ability to acquire it". It results from systemic or societal barriers, a lack of affordable and suitable accommodation, the individual or household's financial, mental, cognitive, behavioural, or physical challenges, and racism and discrimination. "Most people do not choose to be homeless, and the experience is generally negative, unpleasant, stressful, and distressing" (Echenberg and Jensen, 2012, p. 7). To clarify and define homelessness within Canada, COH acknowledges the complexities of homelessness that range beyond individuals sleeping rough (living on the streets) but include those couch surfing, those in temporary shelter accommodations, and those who lack access to affordable housing. Within these complexities are the added variables of lack of income, mental health and substance addiction issues, lack of family or societal support, and discrimination related to many challenges (Echenberg and Jensen, 2012).

Homelessness is not having a home or permanent place to live. It can be seen as the result of varied circumstances impacting individuals and, by extension, their families, neighbourhoods, cities, and countries. In working with homeless individuals daily, as a frontline worker and director, I have come to accept that anyone who does not have an address is deemed homeless. There is a great need for society to acknowledge that hidden homelessness is as significant as the more visible homelessness of those accessing shelter, hospitals, and other institutions without the arrangement for housing after being discharged. This assertion then brings to the surface the fluidity of homelessness and how homeless individuals interact with the homeless sector.

Understanding the Intersection of Addiction and Mental Health in the Homelessness Environment

According to Canavan et al. (2012), many homeless individuals are experiencing some form of addiction as well as mental health issues. This is often referred to as a *concurrent disorder*, and it can be defined as "co-occurring addiction and mental health problems."

Many marginalized individuals may experience barriers such as limited income support, stigma, and lack of appropriate health care. These barriers are of significant importance, given that many individuals will avoid seeking help or accessing the resources needed to exit homelessness.

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These experiences can also lead to many having limited access to employment, given they may have untreated mental health or physical injuries (Clement et al., 2015). For example, discrimination and stigma mean that people with concurrent disorders regularly encounter significant barriers to adequate housing. "It covers a wide array of problems, such as anxiety disorder and alcohol problem, schizophrenia and cannabis dependence, borderline personality disorder and heroin dependence and bipolar disorder and problem gambling" (Skinner et al., 2004). For instance, many landlords discriminate against individuals who may be social assistance recipients or identify as having mental health issues.

[Understanding the Role of Frontline Workers with Lived Experience in the Homelessness Sector](#)

The inclusion of frontline workers with lived experience (FWLEs) in the homelessness sector has become increasingly visible in Canadian communities. At the 2014 Canadian Alliance to End Homelessness Conference in Vancouver, individuals with lived experience called for more intentional platforms that contributed to policies and decisions that impacted them the most (Paradis, 2016). It is important to note that the activism mentioned above was taken by peers having a voice at the table in the homelessness discourse. However, there is a distinction between peers and FWLEs, with evident intersectionality. The intersection between these two groups of individuals lies within the need for "nothing for us without us" and makes solid recommendations for employment opportunities to prioritize those who have lived experiences. The request for equitable pay is notable, as peers are often paid less and seen as an add-on to services, rather than service providers in their own right (Lived Experience Advisory Council, 2016). Peer workers are hired with the knowledge of their lived experience of homelessness. On the other hand, FWLEs are often employed by employers who are not aware of their previous or current lived experience of homelessness. They are usually hired on the merit of education, work experience, as entry-level employees.

Magwood et al. (2019) opine that the inclusion of FWLEs in the development and delivery of programs can increase the effectiveness of care, thus resulting in a higher success rate among homeless individuals seeking support. Furthermore, the involvement of Indigenous, LGBTQ, newcomers, individuals with concurrent disorders, women, and people with physical and mental disabilities who are also FWLEs can add tremendous value to organizations (Magwood et al., 2019). While there is a strong need to ensure FWLEs have a role in ending homelessness, it is

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essential to discuss the challenges they may face due to their experiences. Firstly, they may be at risk of other physical and mental health challenges due to being homeless. These are often classified as tri-morbidities, including former or current substance abuse issues. In addition, they are also at significant risk of having meaningful support and relationships (Miler et al., 2020).

One of the limitations of this review process has been the lack of information on the role of FWLEs in the homelessness sector. While there continue to be emerging studies and research papers, many continue to be situated in the lived experiences of those with addiction, mental health issues, and substance use. Another area where I have found a large volume of research related to FWLEs has been in the Human Immunodeficiency Viruses (HIV) / Acquired Immunodeficiency Syndrome (AIDS) and other infectious illnesses.

Section 3

Behind the Frontline – Life through the Lens of a Frontline Worker with Lived Experience

In 2019, I authored a book called *Behind the Frontline*, which allowed me to explore the recent experiences of FWLEs and how they navigate the homelessness sector as frontline workers while also accessing services themselves. *Behind the Frontline* takes inspiration from the lives of those individuals providing support on the frontlines and the individuals who access their support. It gives an insight into the sacrifices made by frontline workers and the connection made to the oppressed through the inherent human spirit. Hopper et al. (2009) opined that organizations serving homeless individuals are often chaotic and render a platform for many frontline workers to be significantly impacted by individuals who have a long history of trauma. Inevitably, FWLEs can be triggered by and within such environments.

To place some perspective on the environments in which frontline staff in the homelessness sector work, I will share a few excerpts in the words of FWLEs, from *Behind the Frontline*. These excerpts outline the challenges of service providers and consumers.

Behind the Frontline Excerpts

Frontline Worker with Lived Experience 1

"Vlad", Harm Reduction Worker

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Sharing my experience is not necessarily an easy one for me. I have lost friends to the opioid crisis. I have seen clients die at my location of work. I started my work at L.C.T. and then moved to Street to Homes. This program is a flagship program in the City of Toronto. My role requires me to provide hands-on harm reduction tools and skills to individuals struggling with substance abuse.

I am angered by the pressure to save lives and the burden if the clients do not survive. This work has changed me.

My emotions are gone.

No one told me that my resume would one day have a B.S.W. in Traumatic Events and Complexed Stories.

I function as a wall.

I have lost too many clients that I have stopped counting.

The short-term disability is not enough.

My supervisor is so detached from the work.

He never worked a day on the frontlines.

He proudly boasts of all the funding he has secured for the agency.

Look at my arms...

These are scars from me harming myself. At times I think if I bleed, the pain would one day subside.

"I am frontline."

Frontline Worker with Lived Experience 2

"Sal"

Two-Spirited Social Worker

Miigwech

I am humbled and moved by where we are all coming from to do this incredible work.

My name is Sal, and I am two-spirited.

I've been involved in the homelessness movement from birth, I would say.

I was born on a reserve in southern Alberta, where many resources are limited, and my community is always struggling.

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Access to clean, drinkable water, adequate housing, and sustainable options for our overall growth has made me feel homeless.

I was left in the care of my grandparents from three months old.

I am lucky not to be a part of the sixties scoop; my siblings are not so lucky.

After high school, I hitched my way across Canada, finally settling in Brandon, Manitoba, for a few years, became restless again, and made the eastern journey to Toronto.

I experienced homelessness as an adult for three years and decided I wanted to make a difference by becoming a social worker.

Building trust is an essential aspect of this work, and over my career, clients have shared their stories with me.

From addiction, family breaks down, and mental health intellectual disabilities to loss of employment, there were so many gut-wrenching stories, some replicating my own.

Shelter worker does their best to support clients; conflict is always present. Varied personalities and experiences cobbled together with confined spaces with rules, offensive odors, noises, violence, and conflicting expectations are perfect for chaos. Having lived experience has shaped my ability to connect with everyone I work with.

It gives me a different perspective.

With it, though, are challenges of boundaries.

My friends, as homeless individuals, often do not understand or respect my role as a social worker. In their eyes, I am seen as another authoritative figure telling them what choices to make, etc.

At 45, I am looking forward to retirement and reflecting on the last 23 years on the front line. As an elder, I have much to offer young workers; that is what I think.

Frontline Worker with Lived experience 3

"J B", Former Social Worker

Currently Homeless at the Lakeshore Justice Brand is the name. Call me J.B. for short.

Sitting here at this coffee shop waiting for my caseworker is a regular occurrence. Today I am going to determine how he can help me get ready for the winter. I live in a warm encampment on the Lakeshore. I have food and water; lights come from the highway. No meds, however. Water I have. Did I say that already? I am not homeless but can certainly

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relate. Workers repeatedly ask for my address, and my response does not change. The postman will bring my emails for me! The postman not only knows my address; he brings me a treat with each delivery. Like most who meet me, you are wondering what does J.B. stands for? J.B. stands for Justice Brand.

They are trying to convince me to live the way they want or the way society thinks I should. Why should I believe that they would not abandon the cause just like most people do? Workers go into deep thought when I ask them what makes them different. They all hope to make a difference, two separate issues if you ask me. Some do not even know what motivates them beyond a paycheck.

What makes them different from all the bureaucrats? "Safe and affordable housing is not a choice; it is a right regardless of who you are. I believe everyone has the right to housing regardless of gender, class, race, or economic status." This is their scripted response.

Workers were taught well in school; they knew all the terms. I know them too. I used to be a social worker. Told people what they needed, how they felt, what medication was good for them, what they should eat when to be outside, what was best for them, and why they needed a therapist. "Thanks for sharing," Another scripted response. I said that too! No one cares where I came from and the struggles and sacrifices made for me to become Canadian.

My parents would have loved to hear my vivid recollection of our journey, their determination, except they are afraid to come outside, but maybe call them yourself and say that I am doing well. I have failed them. I did not carry on their legacy. I came to Canada, and instead of rising, I fell. Maybe I am not Canadian. I have failed. Am I not Canadian? Besides, how does a former worker access services where they sent their clients? A shame to see my clients in the same space I referred them. Moreover, yeah, we can meet but not here. Maybe at your office.

Frontline Worker with Lived Experience 4

"Luigi", Former Bank Employee Former Housing Worker Currently Homeless

I came forward to share my story because workers' voices are seldom heard. I was 24 years old when I decided to become a frontline worker. I come from the average Canadian Italian family having no interaction with poverty or homelessness. I would say my immigrant

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family was living the 'Canadian Dream.' After working as a financial advisor at a financial institution, I was ready to give real meaning to my life. Life in the bank was becoming increasingly difficult.

In retrospect, we were leaving one frontline position for another. For six months, we learned the language of the social service sector. We became confident in providing life skills training, budgeting- which we excelled in as this was a real transferable skill, and informal counseling for grocery shopping. We enjoyed the rewarding work. As time went by, we were offered many training opportunities and were even offered contract jobs. Due to increased homelessness and the opioid crisis, the impact on frontline workers has been tremendous. I want the public to know that homeless clients died in large numbers before the opioid crisis was called.

Currently, agencies have found a loophole to somehow build exposure to aggressive and unpredictable behaviors as part of the job. This disclaimer prevents frontline workers from stepping forward and talking about the impact of this environment. It is part of our job! Trying to seek support, having re-read my job description, I recognized that I had signed up for ongoing exposure to the crisis, verbal, emotional, and physical abuse by default. The revelation was crippling, which would later determine the length of time to find the courage to access the support I desperately needed. Working solely with men with mental issues presented many challenges as my career progressed. Therefore I decided to work with another agency whose focus was broader and included youth homelessness. This would be my first encounter with the issues related to homelessness and vicarious trauma. My banking colleagues and I supported each other, despite working with different nonprofit organizations across the city of Toronto and the Employment Assistance Program (E.A.P.) offered at our respective workplaces. E.A.P. supports staff to access telephone counseling and in-person counseling. However, the onus is left to the staff to connect themselves to these options. It is hard to access support when you are in denial of the impact, fearful to admit you are no longer mentally and emotionally stable to do your job.

Standing in the hallways of my sunny apartment on January 12, 2015, I finally admitted to myself that I NEEDED professional help. I was afraid to share my experience with anyone.

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I was experiencing flashbacks from my time at the bank and was uncertain why this was happening. The complexities of my clients were tangible. It was more than the abuse; the lack of resources required for their unique needs and the high caseloads impeded meaningful progress. The evidence was clear. We needed more affordable housing, and wrap-around supports to keep people housed. Not finding suitable housing options for my clients had taken a toll on my mental health. How does one keep showing up for work, knowing they cannot adequately provide what the client is seeking? By the time I got to my doctor, I could not work after 3 hours without nausea. There were days I wished I owned a large housing complex to place all my clients and take them out of the “cycle of homelessness”. Today, I no longer work as a housing advocate as I have become homeless after being unable to work and qualify for long-term disability support. I currently live in a shelter outside Toronto's downtown core to avoid my old clients and co-workers. Hopefully, in the next three months, I will have secured housing and regained stability. I want to return to my old workplace and share the challenges frontline workers face and how organizations can support staff more effectively. There needs to be education for clients too. No one wants to admit that, but clients must understand how their abusive language/ actions impact workers. Our job is to support, not to be exposed to ongoing acts of violence. I wonder what age of the client on worker violence in the city of Toronto and surrounding areas? No one tracks those! The client is always right. Housing is a right! No matter what. We have to get the job done! And I did....

Frontline Worker with Lived Experience 5

"Zain", Mental Health and Justice Worker

I am Zain, a recent migrant from the Caribbean. My path to homelessness is an interesting one. I was encouraged to participate in a focus group that engaged residents around homelessness, youth violence, and an aging population in 2016. At the focus group, the counselor started by saying he wanted to hear from constituents/ residents about concerns they had regarding these issues and sought input to identify the gaps and identify areas of

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improvement. Being new to the country and my Parkside neighborhood meant I had limited insight, as I was too new to make such observations and suggestions.

Individuals who were new to the shelter system opted to live outdoors under bridges, their cars, and encampments. This experience was very challenging for me.

The chaos was beyond my understanding. Where did all these people come from?

Justifying the need for this new response to homelessness in the City of Toronto, local politicians indicated in their various news conferences that the spike being experienced by city shelters was from the increased illegal border crossing. They argued that this new phenomenon had stretched an already burdened system. However, as I completed Intake after Intake, there were three newcomers for every 30 intakes in a week. The statistical picture painted in the news was untrue and exaggerated, but the public sucked it up. The clients were abusive to staff, and if ever we reacted, we were disciplined.

Management failed to address the clients' complex needs, and our capacity to address the needs of the homeless was limited. We needed more specialized services on site. Clients were demanding, and some even requested support the programs were not funded to provide. I tried to be patient, but the abuse was too much. I do not want to paint a picture that all homeless and impoverished clients as aggressive. Many used the support they were presented with and moved into shared housing or other housing options. Where are the moms, dads, siblings, and extended family? The least they could do was help them get back on their feet. Too many broken families in Canada."

Section 4

Theoretical Approaches

The theoretical framework is situated in Trauma-Informed Practices (TIP) and People with Lived Experience (PWLEs). These frameworks were chosen as the most relevant to individuals with lived experience in the homelessness sector and lend validation and credibility to the unique experience. Early theorists such as Pearlman and Saakvitne (1995) situated their work in constructivist self-development theory in the early introduction of vicarious trauma and PTSD in the workplace. They also utilized psychoanalytic and cognition approaches that provided a developmental framework for viewing vicarious traumatization. These early developments were

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instrumental in further developing and understanding how support for traumatized individuals impacted the service provider. However, there was no emphasis on isolating the research data set to indicate those with traumatic histories while providing service during these early developments. Today, this unique data set is referred to as having "lived experience." For this research, I define individuals with "lived experiences" as people who have experienced homelessness.

Trauma-Informed Care

TIC first appeared as an approach to change how professionals provided services to those experiencing trauma. The researchers of this study examined professionals in the helping profession after the World Trade Center attacks on September 11, 2001 Substance Abuse and Mental Health Services Administration (SAMHSA, 2014). The change they noticed was psychological instability, among others. Since then, there has been a great emphasis on organizations grounding their TIC policies and procedures. The examination demonstrated the need to better support the service provider and further recognized that trauma is prevalent in the general population.

In situating TIC principles within the homelessness sector, we assume that all individuals and families who are homeless or seeking support have experienced some form of trauma (Hopper et al., 2010). This knowledge serves as the optimum guide for organizations and service providers to align their responses to eliminate further re-traumatization and emotional harm.

Trauma-informed practice bases its approach on the assumption that most clients will have suffered trauma at some point. The response to trauma is highly individual, and the psychological and emotional impact continues long past the experience itself (SAMHSA, 2014). While there is a consensus on TIC as a recommended principle, there appear to be varied definitions of its foundational pillars (Hopper et al., 2010).

Despite these varied definitions, practitioners working with individuals who have experienced or have exposure to traumatic incidents should incorporate a trauma-informed approach in their work in supporting clients. It is essential to realize the prevalence of trauma, recognize how trauma affects all individuals, and respond by putting that knowledge into practice. TIC offers a

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framework for health care providers and institutions in helping to avert persistent traumatic stress responses while providing an opportunity for improved client care (Bruce et al., 2018).

The Substance Abuse and Mental Health Services Administration (SAMHSA) has led the trauma-informed model's research and development. According to SAMHSA, the concept of trauma is as follows: "Individual trauma results from an event, series of events, or set of circumstances that individual experiences as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (SAMHSA, 2014, p. 12).

Having a clear understanding of trauma allows practitioners to ground their practice in realizing that trauma occurs with the individuals with whom they work, acknowledging a vast majority are impacted by post-traumatic stress disorder (PTSD), secondary trauma, and burnout. This acknowledgment is a critical conduit for identifying the need for recovery. It recognizes the signs of trauma that clients, their support networks, and those providing services can all see.

TIC follows and adheres to six fundamental principles that ensure a strong coalition between recovery and resilience. TIC does not track a particular order of significance. However, the need for safety while providing service remains paramount. Therefore, the six principles listed in this paper follow a strength-based and resilience model. By its very nature, trauma, especially that perpetrated by humans (as opposed to natural events), evokes feelings of lack of psychological and physical safety. It destroys one's trust in others as the victim has been violated (Muskett, 2013).

Safety sets the tone for trust and the ongoing success of those seeking support and those providing support. Therefore, physical and psychological safety should be paramount within the TIC model. Safety promotes confidentiality and free expression in a non-judgmental environment while respecting resistance. Failing to provide a safe environment for clients can negatively impact client care.

Trust is another critical ingredient in the application of TIC. Trust supports the maintenance of boundaries, building respect, and keeping their word as a practitioner. More importantly, forming an initial trusting relationship between practitioner and client allows for a smoother pathway

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when there comes a need for more intrusive questions or assessments (Briere & Scott, 2014). Also, consistent communication will support trust that is built. Like safety, trust remains essential to the service provider and service user's relationship with ongoing support. It identifies abilities and boundaries within the service provision.

Acknowledgment recognizes the need for timely intervention while considering the need to enter into a therapeutic relationship that is not rushed. More importantly, it fosters validation, coping skills, and ongoing contact to reinforce T.I.C.'s other principles. This also ensures there is recognition that traumatic events have a significant impact. Without this recognition, interventions are of more limited value.

Choice and control support transparency, open communication, and informed consent. Service providers understand the impacts of trauma and recognize the balance of power between themselves and the service recipient.

Collaboration ensures that judgment is flexible and recognizes that service providers and recipients have a role in trauma-informed care. The path of healing remains at the core of the collaborative therapeutic relationship. Recognition of culture, gender, and spiritual uniqueness is also necessary to explore in the journey of healing.

The **Strengths-Based** principle works on emotional management skills as a foundation for developing other skills. Thus, there is no focus on deficits or problems, rather on current "haves"—using person-focused language (e.g., persons who have experienced trauma). As designed and listed above, the TIC model application ensures individuals understand trauma and develop strategies to maintain a solid sense of safety (de Arellano et al., 2014). Trauma-informed care may lack empirical data on its efficacy; however, a commitment to sharing best practices and progress can propel the model's further development (Cutuli et al., 2019).

The etiology of vicarious trauma on service providers was first acknowledged around the end of the Second World War when practitioners providing clinical support to veterans experienced traumatization feelings (McCann and Pearlman, 1990). Since then, several studies have involved first responders, social workers, and other professionals supporting individuals who may or may not have trauma histories. McCann and Pearlman (1995) focus their efforts on professionals

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within health settings such as nurses, psychotherapists, social workers, or psychiatrists. This group measured trust safety, self-esteem, self-trust, and others. The section listed as "other" can be deemed subjective and cannot always be quantified in research.

At the same time, McCann and Pearlman's (1995) study revealed that participants without trauma histories were most impacted by their role in providing support for traumatized individuals. Some of the significant variables in this research were attributed to the length of employment, income, level of education, attention to their self-care, or accessing therapy for themselves. Their study concluded that professionals were doing emotionally well in their roles despite their histories. This study is essential for the current research because it appears to be one of the closest comparisons to the current research that has been mounted. Its tools are the same ones used for the present research.

Two studies, Schiff and Lane (2016) and Kerman et al. (2021) appear to be the only two situated within the homelessness setting in Canada, to have specifically asked participants to identify their lived experience status or history of trauma. However, more studies are emerging.

Early reviews have shown extensive data on inclusion and participation with lived experience in ending homelessness (Turner et al., 2017; Norman et al., 2015). However, there is limited research on the psychological impact of individuals with lived experiences and past trauma while conducting their duties as service providers. As noted before, several studies have looked at the effects of trauma on frontline staff in other sectors (Baird & Kracen, 2006); however, based on an initial review of various literature reviews, there appears to be limited research regarding frontline staff in the homeless sector with lived experience.

Other pertinent variables that would guide my research and support a healthy comparative review are management support, access to health supports, peer support, and role within the organization and function. These variables are essential given many positions where staff who identified as having lived experience lacked pay equity, had limited access to resources and opportunities for intentional inclusion compared to their counterparts, or remained at risk for experiencing burnout.

Section 5

Research Design and Methodology

Psychosocial Impact During COVID-19 on Staff in Organizations Serving Homeless People

This research focuses on analyzing a subset of an ongoing study, which examines the psychological impact of COVID-19 on frontline workers within the homelessness sector across seven cities in five provinces in Canada (I describe my direct involvement in this ongoing study below). The subset from this research provides me with an excellent platform to critically examine the stress of FWLEs working in the homelessness sector. My research builds on past research on frontline staff within the homelessness sector and the reported incidence of traumatic stressors (Waegemakers Schiff & Lane, 2019; Waegemakers Schiff & Lane, 2016). Both previous studies applied the same measurement tools, including some additions that allowed for the identification of reported stressors experienced by frontline workers in the homelessness sector.

The significance of this data allows me to compare the results against the current research where it is possible to isolate data being collected related to FWLEs. There are necessarily some limitations within the secondary review in this work, given there is little research in this area. Nonetheless, I endeavour to study similar data from other sectors, such as frontline workers within addictions and mental health sectors or highly traumatized environments.

Direct Project Involvement

In conjunction with the research team, I reviewed the survey used in previous studies (Waegemakers Schiff & Lane, 2019). In discussions with the team, I proposed gathering data related to FWLEs and the impact the working environment was having on their psychological wellbeing. These discussions led me to develop an enhanced list of questions that was added to the current national survey distribution, in addition to the existing questions for FWLEs and administrators.

As a result of this participation in the design of the enhanced questions for FWLEs, the statistical analysis of the results included examination of the experiences of frontline workers with lived

experience. These results were prepared by the project statisticians and made available to me for this paper. I performed the interpretation of the results.

As a knowledge disseminator for the project, I was responsible for: agency recruitment; providing information sessions to leading homelessness organizations; conducting survey distribution; contacting key policy and political individuals; disseminating early findings; presenting at conferences and workshops; and coordinating Greater Toronto Area data collection.

Understanding the Methodology

The current research uses a mixture of qualitative and quantitative methods that aim to gather critical data that explicitly captures the experiences of frontline staff and administrators while comparing the baseline data from previous research. These combined methods were chosen as they are often used by social service researchers in a comprehensive data collection process. Furthermore, Waegemakers Schiff, on July 22nd, 2021 in an informal conversation, noted, "convenience sampling often results in getting to those most available for the surveys, but not always the most impacted or rather what one can say is the crème of the crop."

Like the past research conducted by Waegemakers Schiff et al. (2016), the data collection approach for the current study is unique. It is not a convenience sample but a combination of purposive and theoretical sampling and quantitative data gathering through survey administration. Purposive sampling seeks to recruit participants with a preselected criterion, allowing researchers to collect robust data for their respective studies (Lopez & Whitehead, 2013). In the context of this study, the preselected criterion would be all frontline staff working in the homelessness sector. In addition, the subset I am most curious about is that of frontline workers in the homelessness sector who have lived experience.

Theoretical sampling utilizes the similarities and differences among participants along previously researched data while using comparisons amongst participants to reveal any patterns. It relies on once-used data to guide the data needed in subsequent data collection, thus creating a platform for rich data sets (Utriainen et al., 2009). In the context of this study, the research team has been

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able to identify participants in the homelessness sector and those providing services to the population. Specifically, the present study used comparative data from previous work to determine the change in psychological stressors being experienced by frontline staff in the homelessness sector. The qualitative analysis used a grounded theory approach within a substantive theory to assess the psychological impact on frontline workers working in the homelessness sector.

The recommendation resulting from this research will highlight the intersectionality of having lived experience, employment in the homelessness sector, and exposure to stressors in the workplace related to gender, mental and emotional wellness, and/or issues related to substance abuse. More importantly, these findings may inform the extent to which attention should be placed on this issue and start a more in-depth dialogue on recommendations of support, environmental improvements, and other unidentified findings to uncover.

Quantitative Data Collection

The proposed research occurs based on the availability of a unique baseline data set from surveys of work-related stress in homelessness services organizations and an extensive network of organizations committed to participating in this project. Specifically, the study is mounted in Calgary, Edmonton, St. John, Toronto, Thunder Bay, Moncton, and Fredericton across 29 organizations nationally.

The survey offers a singular opportunity to compare workplace mental health and stressors before and after the onset of the COVID-19 crisis and examine mitigating factors. Together, this data will present important information on staff traumatic stress, the impact of the COVID-19 virus, resultant disabilities, possible mitigating factors resulting from organizational changes, and the efficacy of a novel data collection approach. Critical health authorities predict subsequent waves of infections that would seriously deplete an already highly stressed group of essential workers.

To ensure the effectiveness of this approach, administrators were asked to provide dedicated time for staff to complete the surveys, with the impetus participating and providing feedback would not represent additional work but would rather be a part of the staff's working day. The research

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team recognizes that COVID-19 has significantly impacted frontline line staff, service users, and organizations. A collaborative effort in data collection was necessary for this research study.

This approach utilizes knowledge users and research assistants who introduce the study to participating frontline staff. Given the limitation imposed by COVID-19, staff met with the research team virtually and was given dedicated time to complete the online survey. The survey was developed in tandem with the previously designed survey, with one change: the research team felt that to best capture the extent to which frontline workers are being impacted, stressors in the workplaces needed to include the Adverse Childhood Experiences (ACE) measurement tool along with the Resiliency tool. This will be discussed in greater detail later in this paper. Listed below is an excerpt of questions used in the current research.

Example 2: Excerpt sample of survey questions developed for Psychological Impact of COVID 19 on frontline workers in the homelessness sector

- Do you self-identify as Female Male These options are not relevant to me. I prefer to identify as _____
- How old are you? 18 – 21 22 - 29 30 - 39 40 - 49 50 - 59 60+
- With what background do you identify? Check ALL that apply Indigenous Canadian Central/South American Caribbean European Middle Eastern Asian Indian (S.E. Asian) Other

- What is the highest level of education that you've achieved? High School Some university/college BSc/B.S.N. College Diploma B.A. B.S.W. M.S., MSc. MSW Other _____
- During your highest level of education, what was your area of concentration? Social Work Psychology Health Sciences Social Sciences Business Other

- What is your approximate gross income bracket per year? Less than \$20,000 \$20,000 to \$29,000 \$30,000 to \$39,000 \$40,000 to \$49,000 \$50,000 to \$59,000 \$60,000 to \$69,000 Greater than \$70,000 Your Job:

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- How long have you been employed in your current position? Less than 1 year 1-2 years 2-5 years 5-10 years Greater than 10 years.
- To what extent do you feel psychologically/emotionally safe in the work that you do?
 Never Sometimes About half of the time Mostly Always
- What is your primary role? Intake Worker Outreach Worker Counsellor Shelter Staff Clinician/Clinical Staff Case Manager/care coordinator Receptionist/Front Desk Other – please specify: _____
- To what extent have you received training in trauma-informed care? None Some Training A Considerable Amount of Training

The unique data is obtained from the survey is that of FWLEs in the homelessness sector. This data has been analyzed through specific questions within the more extensive survey. To isolate the required data set to answer my research question, several questions were specific to FWLEs.

Example 3: Excerpt sample of survey questions developed for Psychological Impact of COVID 19 on FWLE in the homelessness sector

- have identified as having lived experience with homelessness
- have identified as being concerned for psychological and emotional safety
- have received trauma-informed training
- have a history of trauma
- have reported work stressors while on and off the job
- have reported indicators for a PTSD diagnosis
- have witnessed or been experienced a traumatic event
- have reported adverse childhood trauma.
- Age

- Level of education

Quantitative Data Collection Measurement Tools

This research attempts to determine the extent to which frontline staff in the homelessness sector with lived experience are experiencing stress due to their current working environment. To determine their psychological wellness, the PTSD Checklist for Civilians (PCL-C) was used to measure work stressors. Specifically, it looks at the respondents' problems and complaints while working. The PCL-C is the most commonly used instrument to assess PTSD symptoms in various populations. Another standard tool used in this study was the Professional Quality of Life (PRO-QoL), which measures compassion satisfaction and compassion fatigue, burnout, secondary traumatic stress, vicarious traumatization, and vicarious transformation (Stamm, 2010). The PRO-QoL will assist in identifying work-related stressors experienced by FWLEs as listed above.

In addition, the Life Events Checklist for DSM-5 (LEC5) complements the above psychological instruments as it allows respondents to self-report lifetime events and experiences that may have contributed to PTSD or any other work-related traumatic stress. Furthermore, it captures what respondents have witnessed, learned about at work, or experienced while at work. The Adverse Childhood Experiences (ACE) measurement tool captures traumatic events and experiences of one's childhood. The Resiliency tool also captures the respondent's ability to cope with events and experiences at work—their level of resilience. In summary, these series of questions focused on respondents' ability to cope while working in a stressful environment.

Data Analysis and Current Data Sets

Waegemakers Schiff and Lane's (2019) research entitled *Traumatic Stress, and Mental Health Impacts of the COVID-19 Pandemic on Front-Line Workers in Homelessness Services* (which has received approval from the Board of Ethics at the University of Calgary, University of New Brunswick, and Lakehead University) looks at the psychological impact COVID-19 has on frontline workers in the homelessness sector. The project currently has over 350 respondents and

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anticipates 450 - 500 surveys returned via online submission or paper-based. All responses are kept confidential and are non-identifiable. Interviews were completed with the key administrator via a digital platform. The survey was not randomized but conducted through an inclusive process that included all participating organizations. This approach was consistent with previous studies where 31 different organizations in three cities participated and surveyed their entire staffing teams. The responses received accounted for 85% of the available workforce.

Early analysis of the received data, both qualitative and quantitative, indicated that 28% of the respondents identified as having lived experiences of homelessness. This is a critical revelation to determine other cohort characteristics for this paper. The demographic data that will be emphasized will be educational status, gender, lived experience of homelessness, and adverse childhood experiences to determine how these variables impact FWLEs in the homelessness sector. Furthermore, I am looking at whether these variables impact their experience of trauma in the workplace as frontline staff and the potential impact on their level of resiliency and job satisfaction. It is important to note that this is an exploratory analysis as there is no current research guiding this cohort of FWLEs in the homelessness sector.

Psychological Impacts on Frontline Staff



Current Data Analysis

This section will analyze the data sets specific to respondents participating in the current study who have identified themselves as frontline workers in the homelessness sector with lived experience. This isolation of data sets is unique to this present study and all previous studies on frontline staff in the homelessness sector. To this end, I hope that this current work will form the initial framework and contextual guidance for this subset of FWLEs providing care within the homelessness sector.

Upon commencement of this research, the initial hypothesis was to identify how FWLEs in the homelessness sector were impacted by the stressful environment in which they worked. The assumption that FWLEs would be at a greater risk than their non-lived experience peers seemed inevitable. My awareness validated this thought that many FWLEs were providing support in locations and environments they had previously accessed as homeless individuals, which had now rendered them more vulnerable to traumatic stress and psychological trauma. In addition, I hypothesized that FWLEs were experiencing higher incidents of burnout and compassion fatigue, all with the awareness of their past traumatic experiences and the complexities of coping in such environments.

Results

From 2020 to 2021, 574 unique respondents participated in this study. Frontline staff aged 40-49 accounted for 25%, and frontline staff aged 50-59 accounted for 22% of the workforce, respectively. Thus, staff aged 40 to 59 accounted for just under half of staff in the homelessness sector (see Table 3).

Of the 574 respondents, 387 were identified as females, with 23.7% of these indicating they have lived experience (LE). Additionally, 143 respondents identified as males, with 28.7% indicating they have LE (see Table 2). Respondents identified as non-binary accounted for less than 2%, and 13 respondents chose not to disclose their LE status.

Regarding education, 67% of the respondents indicated they had a college diploma, compared to 47% who have no lived experience (NoLE). 14% of respondents with LE possessed a Bachelor

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of Arts or higher level of education compared to their counterparts with NoLE accounting for 42%. Those with LE had markedly lower levels of education than those with NoLE (see Table 5).

The respondents' ethnic distribution ranged from 51% identifying as Caucasian and 25% identifying as Black, including those in the African, Haitian, Jamaican, and Somali diaspora. Indigenous respondents accounted for 11% of the study respondents and included individuals from Inuit/First Nations/Métis, while Asian respondents accounted for 8%. Latin American respondents accounted for 4%, Mid-Eastern accounted for 2%, and 5% identified as biracial.

Respondents with LE and NoLE reported having an average length of employment ranging from less than 1 year to 2 years. Staff with LE are more likely to be employed for a more extended period in the homelessness sector and account for over 29% of the respondents who worked for 3-5 years, while 22% reported being on the job for over ten years. In contrast, 25% of the staff with NoLE in the homelessness sector indicated their most extended term of employment ranged from 1 to 2 years (see Table 7).

The types of jobs frontline workers held ranged from intake workers, outreach staff, shelter staff, and case managers; however, there was no over-representation of the positions between LE and NoLE. Respondents with LE reported having a LEC score of 17.21935, compared to their counterparts without lived experience with 12.70945 (which is significant $P < .000$) (see Table 9).

In the Resiliency tool, the average reported resilience score for respondents with LE was 52.5362, while those with NoLE indicated a higher resilience of 57.5185 (which is significant $P < .000$) (see Table 11).

Respondents with LE reported having a compassion score of 40.3191, while respondents with NoLE reported a lower score of 37.8088. When we examine the average rate of burnout, respondents with LE reported a score of 21.5248 in contrast to those with NoLE at 23.3385. LE reported a PCL-C score of 14.2590, while the respondents with NoLE reported a lower score of 14.167. When it came to the ACE scores, LE reported a higher rate of 4.3066 than their NoLE counterparts, who reported 2.4763 (see Table 11).

Section 6 Discussion

In the last two years, with the introduction of the COVID-19 virus organizations and policy makers demonstrated an increased interest in FWLEs across the social service sector, given the heightened risk of stress and burnout. However, at the writing of this paper, as indicated previously, there are few publications related to FWLEs in the homelessness sector. Despite these discoveries, this research has been able to identify some critical findings related to the rate of burnout, ACE, PCL, secondary stress, compassion stress, resilience, and LEC among FWLEs. In addition, we looked at how some demographic data such as age, gender, ethnicity, employment status, and education interacted with some of the above-listed variables.

Firstly, 50% of the respondents were females ages 30-39 and 40-49. Of those female respondents, 23.7% identified as FWLE. These stats are also consistent with a recently concluded report that profiled who is working in the homelessness sector that identified "women led the way in the homelessness support sector," accounting for over 76.5% of the workforce (Toor, 2019, p.8). Male-identified FWLE respondents accounted for 28.7%. Furthermore, we are aware that the general population data highlights that male homelessness continues to be on the rise, as reported in a 2021 report that looked at the current trends of who is homeless, specifically in Ontario (Strobel et al., 2021).

When it came to the PCL-C score, there was a notable difference in the scores of FWLEs, who reported a higher score of 14.2590 on average. This higher score can be accounted for by their previous exposure to stress, which may make them more likely to meet the qualification of a PTSD score. It can also account for the current environment of homelessness services, which we know can be stressful and chaotic (Davidovitz & Cohen, 2022). The reported increased incidence of the trauma FWLEs experience in the homelessness sector should be cause for alarm to policymakers focused on ending homelessness. Based on this data, we can start acknowledging the current rates of trauma among staff in homelessness services and formulate ways to foster preventative measures and processes that support the team. Ideally, these measures would allow staff to address their wellness and self-care proactively.

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The reports of burnout in this study have been notable, with FWLEs reporting a lower burnout rate than burnout rates with lived experiences. While it may be challenging to ascertain the reason for this difference as more in-depth analysis would be required of the data. However, FWLEs have shared in informal discussions that their familiarity with the environments in which they work is not burdensome or chaotic but familiar to them based on past experiences of navigating these environments. Therefore, one can surmise that the FWLEs arrive at the workplace having a better fundamental understanding of the work and of the clients' experiencing homelessness. They may have greater compassion based on their shared experiences, and a developed resilience to navigating these chaotic environments. There may be a wide range of other variables to account for these differences; however, I can only seek to make inferences based on the presented data.

Similar to the rates of compassion satisfaction among respondents, FWLEs reported having a greater rate of satisfaction at 40.3191, compared to 37.8088 for those with NoLE. When experiencing burnout, staff no longer have the ability to care while doing the work, whereas compassion satisfaction reflects the joy they may experience from doing the work, despite its challenges. These findings were of particular interest to the research team. The original hypothesis was that FWLEs had higher rates of burnout and lower rates of compassion satisfaction based on their previous histories of homelessness. In fact, they had lower rates of burnout and higher levels of compassion satisfaction than their colleagues without lived experience.

Another meaningful relationship to note is that of resilience and the ACEs. FWLEs reported a significantly higher score in the ACEs at 4.3066, while those with NoLE reported 2.4763.

According to Briere and Scott (2015), early incidents of trauma place individuals at risk of traumatic stress in adulthood; moreover, the ongoing exposure to trauma can be cumulative and lead to depression and/or to PTSD. Notably, frontline staff with lived experience reported having a higher level of compassion satisfaction *and* higher adverse childhood traumatic experiences.

Interestingly, FWLEs reported a lower resilience of 52.5362 than NoLE staff, who reported a higher strength of 57.5185. The lower resilience score among FWLEs may be based on the increased incidences of ACEs and their PCL-C scores. This finding is noteworthy when we think

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about this cohort reporting high satisfaction in the work yet lower resilience. It creates another opportunity to discuss how support can be made available to increase their strength.

Consequently, we can make the connection here between education and resiliency in that we also found that FWLEs identified as having lower levels of education than their counterparts. While this may seem insignificant, the TIC model reminds us to provide trauma-informed care training to both the provider and service recipient, emphasizing reducing harm and increasing resiliency (Leitch, 2017).

Notably, both staff with LE and NoLE reported a high secondary trauma stress score which also correlates with the data and recent report in the *Globe and Mail* (Casey, 2021) that indicated there was a marked increase in violence in the shelter system in Toronto. The report stated in 2016, there were 120 violent incidents in a month, however by 2020, a reported 270 incidents per month occurred and in 2021, there were 368 incidence of violence. This increase can be attributed to many factors related to residents' poor mental health, overcrowding, and addictions to substances, however, regardless of the cause, it creates a chaotic environment for frontline staff to provide support and services. This article then draws attention to the intersectionality between the LEC while at work, the negative psychological impact these reported acts of violence can have on staff, and the potential for them to continue to be at risk of PTSD. As Neuner et al. (2004) opined, ongoing exposure to traumatic events increases the risk of PTSD in individuals in emergency service providers, whose routine work involves ongoing exposure to trauma, in addition to their own histories of trauma.

Another interesting observation between the stories shared is the presence of stigma for those who have experienced homelessness. While the data collection did not ask the question of stigma in the workplace, the literature review did reveal how stigma continues to play a role in FWLEs accessing support. This area is one that creates additional opportunity to be explored further to determine if there is a correlation between lack of access to support resources for FWLEs and decreased resilience, given their reported low scores of resilience. The question remains: can increased resilience amongst FWLEs be achieved by greater support? While this research paper is an inaugural exploration, many significant findings have been uncovered that can be used to build on future research regarding frontline staff with lived experience in the homelessness sector. I am not focused on making factual conclusions but instead highlighting the profile of a

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unique cohort within the more significant nonprofit sector and care providers. As a leader within the homelessness sector, I am more concerned with the lack of response organizations may have around tangible support for frontline workers and those with lived experience and the long-term implications these inactions can cause. This research's accuracy levels are essential, given this study has been mounted for the last five years with similar results across Canada. The limitations were that specific questions were not asked about how recent the homelessness experience was, and thus, this would need to be addressed in future research.

Conclusion

The trauma frontline staff experience has not been treated with much urgency until recently, specifically during COVID-19. The decibels have been turned down, and their reality minimized. The impact of their stress is not visible like a gaping wound, however, the question remains for me as a senior leader and researcher, what is the appropriate response for an emotional bleed? How can organization conduct better assessments that are often misread as a common cold, a headache, a stomach ache, or racing heart? Providing better tools and awareness can significantly reduce the risk of re-traumatizing. We know that many staff do not have the skills and resources, and do not have the necessary training to work with clients who have trauma (Briere & Scott, 2014). Therefore, we must ensure we combine training, education, and wellness principles to improve the outcomes for frontline workers. Stress identification tools should become a priority for organizations. Policy and funding must align to ensure staff is supported within the centre of the continuum of care spectrum.

A few critical findings have surfaced when observing the data against the stories presented in Section 3. Specifically, I would like to highlight how the data related to FWLEs have aligned with the narratives shared, such as education, work preparedness, compassion satisfaction, burnout, exposure to traumatized environments, and overall impact on psychological wellness.

In reflecting and analyzing the data, FWLEs identified that despite various trainings, they remained unprepared to deal with the complexities of the work. While the surveys did not explicitly ask respondents if they had been formally trained using the TIC model, we can assume a strong correlation between lack of appropriate training and education that may render service providers unprepared for supporting complex clients with trauma. Counsellors and administrators are advised (SAMHSA, 2014) to develop intra- and inter-agency collaborations

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for trauma-specific services that anticipate a proactive response to helping individuals impacted by trauma while equipping staff with intervention strategies. This approach emphasizes the necessity for appropriate training to be provided to the team and thus limits the incidence of a negative response from both client and team. Furthermore, the absence of a trauma-informed model results in harmful outcomes for both service providers and clients. When applied effectively, the TIC model reiterates that "both clients and providers can competently manage traumatic experiences and reactions" (SAMHSA, 2014, p.18).

The ability to demonstrate compassion in the face of ongoing adversity remains a strong quality FWLEs bring to the workforce. Not only are they able to bring varied perspectives as articulated through the stories shared, but the data also confirmed that FWLEs reported having higher compassion for their work despite the many challenges. FWLEs may experience higher compassion for the clients given their personal histories in addition to perhaps having greater empathy and patience for an environment they previously navigated.

For those with lived experience, it is incumbent on us not only to acknowledge the expertise of their unique experiences, but to acknowledge that they bring exceptional skills to the workplace due to the ongoing stigmatization of homelessness, addiction, and mental health. Furthermore, if we can employ a trauma-informed framework like that outlined by SAMHSA (2014), it would provide concurrent trauma supports for both service user and service provider. Consequently, we can seek funding envelopes aligned with the service user and provider outcomes.

While there were limitations within this study, it is clear that more can be done to support staff. The secondary research and literature review may give rise to secondary questions around best practices related to training frontline staff to best support them while working. However, the intended outcome of the present work is ascertaining psychological implications. This research highlights the intersectionality of having lived experience, employment in the homelessness sector, and exposure to stressors in the workplace related to gender, mental and emotional wellness, and/or issues related to substance abuse. More importantly, these findings may inform the extent to which attention should be placed on this issue and start a more in-depth dialogue on recommendations of support, environmental improvements, and other as yet unidentified findings.

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Appendix
Data Tables

Table 1
Results of Age, Gender, Education and Employment

	Within Lived Experience	Without Lived Experience
Age Groups		
20 -29	22%	
30 – 39	25%	
40 – 49	25%	
50 -59%	22%	
60+	6%	
Gender		
Male	28%	
Female	14%	
Education		
High school/Some College	41%	12%
Diploma	34%	29%
BA/BSN/BSW	14%	42%
MA/MSc/MSW	18%	11%
Other	23%	6%
Employment Length of time in current job		
Less than 1 year	33%	32%
1 -2 years	28%	29%
3 – 5 years	19%	17%
6 – 10 years	9%	9%
Ø10 years	11%	13%
Length of time employed in homelessness sector		
Less than 1 year	13%	18%
1 – 2 years	20%	25%
3 – 5 years	29%	24%
6 – 10 years	7%	15%
10 years	32%	19%

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able 2

Do you have LE with homelessness?

Gender Cross tabulation

		Female	Male	Non-binary	Prefer not to say	Total
Do you have LE with homelessness	No	73%	25%	1.5%	0.5%	100
	Yes	68%	31%	0	1%	100

Table 3

Do you have LE with homelessness?

Age Crosstabulation

		18 – 29	30 – 39	40 – 49	50 – 59	60+
Do you have LE with homelessness	No	37%	28%	19%	10%	7%
	Yes	22%	25%	25%	22%	6%

Table 4

Do you have LE with homelessness?

Province Crosstabulation

		Alberta	Northern Ontario	Southern Ontario	New Brunswick
Do you have LE with homelessness	No				
	Yes	17%	34%	33%	20%

Note: Ontario organizations have significantly more staff with lived experience than Alberta or New Brunswick

Table 5

Do you have LE with homelessness?

Education Crosstabulation

		High school/some college	College Diploma	BA/BSc/BSW	MA/MSc/MSW	Other
Do you have LE with homelessness	No					
	Yes	24%	43%	20%	7%	6%

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Table 6

Do you have LE with homelessness?

Length of employment in homelessness services

		<1 year	1 – 2 years	3 – 5 years	6 – 10 years	> 10 years
Do you have LE with homelessness	No	80%	78%	70%	84%	62%
	Yes	20%	22%	30%	16%	38%

Table 7

Do you have LE with homelessness?

How long each group has worked in the sector

		<1 year	1 – 2 years	3 – 5 years	6 – 10 years	> 10 years	Total
Do you have LE with homelessness	No	18%	25%	24%	15%	19%	Of total of 400
	Yes	13%	20%	29%	7%	32%	Of total of 143

Table 8

Do you have LE with homelessness?

Length in current position

		<1 year	1 – 2 years	3 – 5 years	6 – 10 years	> 10 years	Total
Do you have LE with homelessness	No	32%	29%	17%	9%	13%	
	Yes	33%	28%	19%	9%	11%	

Table 9

Do you have LE with homelessness?

Primary Role

Percent of total in each role

		Intake Worker	Outreach Worker	Counsellor	Shelter Staff	Case Mgr/ Care Coordinator	Receptionist Front desk	Other
Do you have LE with homelessness	No	65%	78%	73%	71%	79%	88%	74%
	Yes	35%	12%	27%	29%	21%	12%	26%

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Table 10

Do you have LE with homelessness?

Report measuring Lived Events Checklist LEC

Do you have lived experience with homelessness		LEC – happened to me Witnessed it Learned about it Total score	LEC – part of my job Total score
No	Mean	11.7439	2.5537
	N	410	410
	Std. Deviation	9.30285	3.66485
Yes	Mean	13.8417	2.5899
	N	139	139
	Std. Deviation	9.04999	3.81229
Total	Mean	12.2750	2.5628
	N	549	549
	Std. Deviation	9.27632	3.69925

Note: people with lived experience report more traumatic experiences in their lifetime, but not as “part of my job”

Table 11

Do you have LE with homelessness?

Results of Key Measures: PROQoL, ACE and Resilience

Do you have lived experience with homelessness		PCL Total Score	Burnout	Secondary traumatic stress	Compassion Satisfaction	ACE Total Score	Resilience Total Score
No	Mean	14.1697	23.3385	22.7287	37.8088	2.4763	57.5185
	N	383	387	387	387	380	378
	Std. Deviation	5.55128	6.58910	6.98082	6.76126	2.34199	11.30414
Yes	Mean	14.2590	21.5248	22.2429	40.3191	4.3066	52.5362
	N	139	141	140	141	137	138
	Std. Deviation	6.51902	7.33152	7.82899	6.79739	2.88139	13.17161
Total	Mean	14.1935	22.8542	22.5996	38.4792	2.9613	56.1860
	N	522	528	527	528	517	516
	Std. Deviation	5.81834	6.83553	7.21143	6.85521	2.62118	12.02361

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