BURNOUT AND PTSD IN WORKERS IN THE HOMELESS SECTOR IN CALGARY
January 30, 2016

JEANNETTE WAEGEMAKERS SCHIFF, PHD. UNIVERSITY OF CALGARY,
FACULTY OF SOCIAL WORK,
ANNETTE LANE, PHD. ATHABASCA UNIVERSITY,
FACULTY OF HEALTH DISCIPLINES

UNIVERSITY OF CALGARY

Calgary Homeless Foundation

Athabasca University
open. online. everywhere.

Contents

Acknowledgements

Summary

This report presents on the findings of a study examining symptoms of burnout, vicarious traumatization and PTSD among workers in the homeless-serving sector. The challenges of working with homeless individuals, including the psychological stressors of working with clients who have/are experiencing trauma, addictions and mental illness, as well as the physical/environmental challenges of the work are discussed. Within this discussion, the risks and protective factors experienced by workers are addressed, as well as organizational aspects that may help or hinder workers in coping with employment stress.

We noted at the onset that a disproportionately number of frontline workers have minimal education and training for dealing with people who have multi-problems and live in complex environments. Even when those with a university degree are factored into this picture, most do not come to their positions with training in interview, counselling or intervention skills. Further, while addictions is a major issue for homeless persons, there are virtually no addictions counsellors among our respondents and thus there appears to be a serious lack of attention to the special interventions that are required for many homeless persons who also struggle with addictions.

Two hundred and forty five workers across 13 agencies participated in this study. These individuals include frontline workers, outreach workers, counsellors, clinicians and case managers, as well as receptionists. Participants were surveyed about their work (roles and responsibilities, educational level, length of time working in homeless sector), as well as screened for burnout, vicarious traumatization and compassion fatigue using the PROQOL. The PCL-6 was used to screen for symptoms of PTSD.

Of the 245 participants in this study, one third have worked in the homeless sector for 2 years or less, and another third for 2 to 5 years. Results from this study reveal that about 25% of workers in the homeless-serving sector in Calgary suffer from burnout and compassion fatigue to the point

where job performance, as well as quality of life is decreased. Most noteworthy, approximately 36% of workers reported symptoms of PTSD that very likely would result in a diagnosis of PTSD.

As the workers are experiences symptoms of direct trauma, rather vicarious traumatization, we speculate that the very high levels of PTSD might be related to a combination of prior traumatic experiences, traumatic work events, as well as client trauma. Recommendations include education and support in the areas of interviewing, counselling, intervention and addictions, as a large number serving the homeless sector have little or no education in working with this population and have worked with this population for relatively short periods of time.

Introduction

This study aims to understand the impact of the complex challenges that frontline workers in the homeless sector face. It also explores some of the risks and protective factors that workers encounter in the work place and looks at aspects of organizational function that help and hinder those who cope with the stressors of working with multi-challenged clients.

Frontline workers in the homeless-serving sector face many challenges relating to their work environment, such as dealing with complex and challenging clients and continually dealing with trauma. These challenges can result in high levels of burnout, secondary traumatic stress, compassion fatigue, and staff turnover. In turn, these consequences impact the individual, team, organization and system levels of the homeless sector.

Background

The topics of vicarious trauma or secondary trauma, compassion fatigue, and turnover have been examined in various human services fields, including psychology, mental health, social work, emergency services, nursing and child welfare. However, there is virtually no discourse on the causes and impacts of trauma and burnout in the homeless-serving sector. Furthermore, little research has been conducted on effective prevention efforts to address stress and burnout and the extent to which this impairs job performance, satisfaction and retention. Within the studies that have explored the psychosocial needs among frontline service providers, it has been suggested that workers lack appropriate training and supervision (Olivet, McGraw, Grandin, & Bassuk, 2010) and opportunities for self-care   While employees often feel tension between these negative outcomes and the positive aspects of their job (Kidd, 2003), anecdotally, members of the homeless population in Calgary who form the Calgary Homeless Foundation's Client Advisory Committee have noted that their experiences with caseworkers are lacking instrumental support, effective communication, and the development of positive relationships.

Homelessness in Calgary

Homelessness is a multi-faceted and complex social problem, influenced by a wide range of systemic and personal factors such as poverty, inequality, local economy, labour market, affordable housing stock, addictions, mental health, disability, and a lack of social support. The Calgary Homerless Foundation (CHF, 2016) reports that in Calgary, 23,165 households live in poverty, with an income of less than $20 000 per year and shelter costing more than 50% of their income. Risk factors for homelessness include (Tutty et al., 2009): childhood factors such as abuse, parental drug use, having a single parent, being on long-term social assistance, or being in the foster care system; interpersonal/family factors such as divorce, domestic violence, poor social support, and young parenting; mental health issues or addictions; health problems; housing transitions such as recent immigration or migration, eviction, institutionalization; and/or being a member of a minority group. These multiple psychosocial factors are often complicated by histories of trauma in people who have experienced domestic violence, childhood abuse, or the impact of living on the streets (Coates & McKenzie-Mohr, 2010) . It is this complex array of personal and interpersonal issues that confront frontline workers on a daily basis. In the following section we present a brief overview of salient issues facing this work force.

The Role of Frontline Workers in the Homeless-Serving Sector

The homeless-serving workforce is essential for supporting the needs and addressing the multiple psychosocial, legal, financial, employment and child welfare concerns of Calgary's most vulnerable. Staff fill a variety of roles, including case manager, case worker, support worker, and, in shelters, relief workers. In many instances, overlap in duties exists. These frontline workers provide a wide range of indispensable services, activities, and programs to homeless individuals and families, in which their primary task is to affect change, whether it is psychologically, physically, and/or socially. They are responsible for providing quality services, while being accountable to their clients, supervisors, and organizations (Roman & Travis, 2006). Together, the knowledge, skills, and

motivation of workers, their organizational background and working conditions, and the expectations and behaviour of clients comprise the service delivery process (Hazenfeld, 1992).

Programs serving clients who are chronically homeless and with complex behavioural, health, social service, and medical needs often face staffing challenges (Olivet et al., 2010), including finding an appropriately skilled workforce, staff training and supervision, to ensure effective services delivery and prevent burnout and turnover. While it is necessary to make certain that staff have the necessary skills to serve clients with complex mental health, substance use, and housing needs, a systemic issue in the homeless sector is the combination of offering of relatively low salaries, and a lack of training around homelessness.

Challenges of Working in the Homeless-Serving Sector

Working in the homeless-serving sector can be difficult for a myriad of reasons. These challenges may stifle the employees' abilities to provide optimal care to clients. Without proper training, support, and resources, the issues faced in their everyday work experiences may lead the worker to burnout, secondary trauma, compassion fatigue or other negative outcomes.

Working with the homeless population can be extremely challenging for a variety of reasons. Frontline workers may feel overwhelmed, hopeless, and lose their sense of self-efficacy. Faced with highly stressful events, staff are challenged to maintain professional boundaries with their clients. Furthermore, as personal change in life-style, habits and coping mechanisms in clients may take time and incremental progress is hard to perceive, the constant striving to improvement can be emotionally draining on staff (Kidd, Miner, Walker, & Davidson, 2007). These issues are complicated by positions that have low salaries, limited resources, and lack of a "glamour profile" in the work force. These factors can negatively impact an organization's culture, lead to staff demoralization, and potentially to burnout. The following section explores some of these dynamics.

1) Dealing with clients with high levels of trauma

Frontline workers in the homeless sector deal with a unique population that includes marginalized individuals (Lakeman, 2011) and clients with high levels of mental health problems and addictions (Bride, 2007; Howell, 2012; Karabanow, 1999; Kosny & Eakin, 2008; Mullen & Leginski, 2010). Homeless clients often have experienced high levels of trauma, (Taylor & Sharpe, 2008) with histories of child abuse, domestic violence, violent crime, and war (Bride, 2007; Mullen & Leginski, 2010); these stories are often disclosed to frontline workers. Being homeless itself is a source of trauma – homeless individuals face multi-faceted, complex, and chronic issues that are compounded by a lack of adequate resources (e.g., food and shelter), a lack of access to health care, mental health issues, and substance abuse issues (Buhrich, Hodder, & Teesson, 2000; Hopper, Bassuk, & Olivet, 2009) . Constant exposure to trauma can lead to a normalization of the trauma in frontline workers and can reduce their empathy for their clients and others. As well, frontline workers' personal experiences of trauma can be compounded or heightened by dealing with the trauma of their clients (Howell, 2012).

2) Dealing with clients who have complex needs

In order to assist clients with complex issues, frontline workers need to listen, reflect, provide support, and assist in problem solving and behavioural change while maintaining an attitude of hope, respect and optimism. However, maintaining a positive approach can be difficult as progress is often slow, may involve relapses, especially where addictions play a role. These challenges can lead to feelings of a lack of accomplishment (Miller, Birkholt, Scott, & Stage, 1995), compassion fatigue, or emotional exhaustion and motivation to leave their position (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2011). For individuals new to the homeless-serving sector, working with complex clients often leads to disillusionment, erodes their idealism and diminishes their sense of self-efficacy and accomplishment (Collins & Long, 2003). This in turn can lead to high turnover, burnout, and less effective work (Lloyd, King, & Chenoweth, 2002).

3) Dealing with relapse or death of clients

In comparison to the general population, homeless individuals experience disproportionally high rates of injury and illness, often with greater severity (Song et al., 2007). Research studies have highlighted that homeless individuals have the highest mortality rates amongst developed nations; homeless people die at rates 3 to 10 times that of the general population (Barrow, Herman, Cordova, & Struening, 1999; Frankish, Hwang, & Quantz, 2005; Hwang, 2001). Homeless individuals also have an increased risk of dying at a younger age. For example, Cheung and Hwang (2004) found that younger women aged 18 to 44 have from 4 to 31 times the risk of dying when compared to housed women. Similar trends have been found amongst male homeless populations living in Toronto shelters (Hwang, 2001), and street youth living in Montreal (Roy et al., 2004). People who work in the homeless sector are likely to work with individuals who are at high risk of death and to be frequently exposed to the deaths of service users (Lakeman, 2011), thus presenting yet another challenge and source of trauma for these frontline workers. Death in the workplace can be exceedingly traumatic for service providers.

4) Inadequate job preparation, poor pay and difficult work environments

Many workers have inadequate training for effectively addressing the issues of their clients (Hopper et al., 2009; Olivet et al., 2010). Hopper et al. (2009) explored the challenges that face staff working for a multi-site US Federal program designed to serve the chronic homeless. Participants identified a number of training needs such as training in mental health and substance use, homelessness, criminal justice, and assessment that presented challenges to the effectiveness of service provision. These findings were also reported by Olivet et al. (2010) who go on to note that frontline workers in the homeless sector experience a lack of adequate supervision and support. In addition, poor pay, limited resources for training, and a lack of opportunity for promotion lead to high rates of emotional exhaustion and motivation to leave the job.

Homeless shelters and programs usually do not have the resources for adequate supplies, working equipment, and furnishings to provide more than minimal tools and equipment for staff. Compared to those who are employed in business and industry, these workers are placed in difficult and at times dangerous situations in dealing with people who have complex needs, some of whom may be intoxicated or under the influence of drugs, and many of whom have personal hygiene deficits. Further, frontline staff in homeless shelters work directly with clients who have communicable diseases, such as Hepatitis B and C, as well as HIV/AIDS. All of these issues contribute to job-relates stress.

5) Job Dissatisfaction

As a result of these challenges, many homeless sector frontline workers may feel constrained in providing the best care for their clients (Travis, Lizano, & Barak, 2015), and may therefore feel dissatisfied with their jobs (Mullen & Leginski, 2010). Frontline work in the homeless sector has been characterized as a stressful and highly demanding occupation (Mullen & Leginski, 2010; Olivet et al., 2010). Burnout can lead to frequent turnover or a lack of longevity in the field as organizational effects include increased absenteeism, turnover, low morale, inefficiency, increased number of sick days taken, more frequent tardiness, and early retirement (Wright & Cropanzano, 1998; Yaniv, 1995).

Burnout, secondary traumatic stress and compassion fatigue

Research on the psychosocial impacts of human services work have focused more broadly on human services workers as a whole, and include health and mental health professionals, nurses, EMTs, counsellors, social workers, and teachers. Burnout, secondary traumatic stress and compassion fatigue have been identified as particularly serious outcomes of the nature of frontline work in the homeless sector (Baker, Billhardt, Warren, Rollins, & Glass, 2010; Bride, 2007; Howell, 2012; Mullen & Leginski, 2010).

In many instances, homeless persons have had contact with social services agencies before losing their housing. This prior contact reflects the multiple psychosocial problems that lead to homelessness (Tutty et al., 2009). Once housing is lost, this group of people become even more vulnerable to stress and trauma. Resultantly, those who work with homeless people are continually confronted by those with multiple problems and prior traumatic experiences. Thus, it is logical to extend research exploring burnout, secondary traumatic stress, and compassion fatigue generally amongst human service professionals to the experience of the homeless sector workforce.

Burnout

In general, burnout is characterized by three dimensions: emotional exhaustion, depersonalization, and diminished feelings of personal accomplishment (Baker, O'Brien, & Salahuddin, 2007; Maslach, Schaufeli, & Leiter, 2001; Stamm, 1995). The dimension of emotional exhaustion includes feelings of depletion of physical and emotional resources, being over-extended and no longer being able to give of themselves. Depersonalization, in this context, refers to development of excessively detached attitudes and feelings towards work and clients. Diminished feelings of personal accomplishment and self-efficacy is the last dimension of burnout. Workers feel that they no longer have a meaningful role in helping others (Demerouti, Karina Mostert, & Bakker, 2010; Maslach et al., 2001).

Burnout consists of multiple symptoms, both physical and psychological: physical exhaustion, fatigue and insomnia; feelings of helplessness and hopelessness; a negative attitude towards work, life, and other people; ineffective coping though alcohol and drug abuse; and the psychosocial complications of marital discord and family problems. In some instances, suicide has been reported (Maslach et al., 2001; Yaniv, 1995).

At the organizational level, burnout impacts operations, performance and productivity, characterized by increased absenteeism, staff turnover, low morale, inefficiency, increased sick days reported, more frequent tardiness, and early retirement (Acker, 2012; Morse et al., 2011). Burnout may work in conjunction with secondary trauma and compassion fatigue to lead to negative impacts (Stamm, 2009) for frontline workers, the clients they serve and the organizations that employ them.

Secondary/vicarious trauma and compassion fatigue

Secondary traumatic stress (also known as vicarious trauma) has been identified as a specific phenomenon that occurs in helping professions. Secondary traumatic stress is described as a constellation of physical and emotional reactions that occur in response to exposure to the stories and emotions of victims of trauma. It is termed secondary as the helper does not directly witness or experience the trauma but is emotionally impacted through working with victims (Figley, 1995). Vicarious trauma can include symptoms of post-traumatic stress such as dissociation and flashbacks, while varying in duration, severity, intensity and duration, resulting from a worker's secondary and empathic engagement with clients' traumatic experiences (Stamm, 2009; Van Hook & Rothenberg, 2009). Feelings of anger, caution, sadness, vigilance, irritability, intolerance, denial and sensitivity, as well as sleeplessness and nightmares have also been established as symptoms of secondary traumatic stress (Crothers, 1995).

Compassion fatigue, although associated with burnout, is a distinct construct (Howell, 2012). Burnout is typically understood as being externally directed where workers focus on challenges and troubles in their external environment. In contrast, compassion fatigue is understood as being internally directed, where negative changes to workers' views of themselves and the world occur, and these individuals experience feelings of hopelessness and helplessness in regards to their capacity to provide assistance to their clients.

Study Design and Methodology

The Calgary Homeless Foundation research staff identified the lead agencies that provide significant numbers and different types of services to individuals facing homelessness. These included shelters, day programs and drop-in services, and family support programs. Participating organizations agreed to allow the researchers to meet at a staff meeting with all staff. At that time, research aims and

protocols were explained, the surveys were distributed and staff was asked to return to their usual place of work or a private location to complete the survey. They were then asked to return to the meeting room and return the survey in a sealed envelope, regardless of whether they chose to complete it or not. At shelters where staff work on shift basis, several meeting were arranged to correspond with the availability of evening and night staff. This method of data collection allowed for the least staff burden, opportunity to decline to participate, and a rapid and relatively complete return of surveys. Of the entire recruited cohort in Calgary, three not completed surveys were returned. This signified that some staff did exercise a choice not to participate. It also assured that we had over 90% participation by front-line workers (excluding those absent due to illness or vacation). Thus we can be assured that the results are representative of the workforce in the homeless sector.

The PROQOL is the measure most commonly used to assess the quality of professional life of people who work with those experiencing extremely stressful events (Stamm, 1995). It has excellent construct validity and consists of three scales: compassion satisfaction, compassion fatigue and burnout. The PROQOL is a 30 item instrument that asks people to indicate how much they have experienced each item in the previous 30 days and uses a 5 point Likert scale. The three scales (10 items each) have internal validity and consistency as follows: compassion satisfaction, .87, compassion fatigue .80 and burnout .72 (Bride, Radey, & Figley, 2007), which is in line with what are considered strong scales. It has been used in over 47 of one hundred studies on burnout (Stamm, 2009).

Data Analysis

All surveys were coded and entered into a data base that used SPSS-22 for statistical analysis. In the case of missing data, cases were excluded from the final results. Importantly, most respondents completed the entire survey and only nine did not complete the PCL related questions. Thus this

report presents a reliable cross-section of responses from frontline workers in major organizations serving homeless individuals and families in Calgary.

The strength of a scale is normally reported as an alpha score which ranges from 0 to 1.0. In our sample we found, for the PROQOL, scale (Cronbach's) alphas of .738 on the burnout scale, .828 on the secondary traumatic stress (vicarious traumatization) scale, and .884 on the compassion satisfaction scale. These concur with norms reported by others (Bride et al., 2007; Stamm, 2009). The PCL, also known as the PTSD Check List, is the most commonly used instrument to assess PTSD symptoms in various populations, including the military and civilian populations. A scale reliability analysis of the PCL with this group of respondents indicated a Cronbach's alpha of .835, with strong internal consistency and each item contributing significantly to overall scale score and strength. These results support those reported in the literature (Wilkins, Lang, & Norman, 2011), and thus we can be confident about the validity of the results in this study.

We also examined the correlations among the PCL and three PROQOL scales, to determine if we were measuring similar or different constructs. The research literature reports that these are related but not the same and indeed, we found the same indicators. We used the t scores developed for each PROQOL scale to assess these relationship, but found, additionally, that when the raw scores were used the correlations were almost identical. The PCL and burnout scales have a correlation coefficient of .580 and the burnout scale of .611, both at a significance level of p> .000. The satisfaction scale was, as would be expected given its positive indicators of work satisfaction, negatively correlated to burnout   (.r = -.502) and PTSD (r= -.288).   Thus we are measuring related but not identical constructs, as relationships are measure on a scale from 0 as no relationship to 1.000 as a perfect relationship. Thus this allows for further inquiry into the reported results of burnout, vicarious traumatization and PTSD symptoms as separate and distinct issues.

Survey Results

A total of 13 different agencies in Calgary were invited and eleven participated in this survey. Scheduling problems arose in one instance and one organization declined to be part of the study. This resulted in a total of 245 participants.   As the size of the individual organizations varied, there was a wide range of responses with 53 in the largest agency and 6 in the smallest. In most response categories there was minimal missing information, thus most respondents answered all of the questions in the survey. This ensures a robust analysis and indicates that results are reliable and valid as descriptions of the experiences of frontline workers in Calgary. Except where there is a significant instance of missing information, results reported here are on complete responses from 245 individuals.

One of the first important observations is that is the first overview of the demographics of those who are employed in the homeless sector, in Calgary, in Alberta, and probably in all of Canada. Thus this study makes an important contribution to what we know about these workers. Because the intent of the survey was to ascertain the psychosocial stresses that workers encounter, and to maximize anonymity and reduce respondent burden, we did not obtain all aspects of the demographic profile but report on those issues that are most salient.

Respondent Characteristics

Employment roles

Respondents reported a variety of primary roles, ranging from intake worker to case manager and frontline shelter staff. However, 32.7% reported other roles. Most often these roles could be described as a more specific aspect of the major categories, such as addictions counsellor, and family counsellor, which could be subsumed under counsellor. The self-reporting of multiple job titles and roles may reflect confusion, lack of uniformity or the fact that many in this work force are new to the

field and lack role clarity. No specific role was over-represented, thus the survey reached a broad spectrum of those who work in the sector.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Intake Worker	7	2.9	2.9	2.9
	Outreach Worker	14	5.7	5.9	8.8
	Counsellor	9	3.7	3.8	12.6
	Shelter Staff	64	26.1	26.8	39.3
	Clinician/Clinical Staff	7	2.9	2.9	42.3
	Case Manager/Care Coordinator	51	20.8	21.3	63.6
	Receptionist/Front Desk	7	2.9	2.9	66.5
	Other	80	32.7	33.5	100.0
	Total	239	97.6	100.0	
Missing	System	6	2.4		
Total		245	100.0		

Primary role of Respondents

By prior agreement with the participating agencies, we assigned each organization an identifying code but did not record their identities. Thus all outcomes are reported without organizational identification. However, coding allowed us to retain organizational level data which proved to be valuable in determining the extent to which results were common across all the participating agencies.

Employment Status

The majority of people reported that they held full-time permanent positions (78.5%) and a further 8.3% had full-time contract positions. This left 12.4% employed part-time, either permanently or by contract. Many fulltime workers (30%) also hold a part time job and those who work part-time, generally hold more than one job. However, few (6) report holding more than one part-time job in addition to full-time employment and three report holding two full-time jobs.

Respondent Employment Status: permanent or by contract		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	2	.8	.8	.8
	Permanent/Full-Time	190	77.6	78.5	79.3
	Contract/Full-Time	20	8.2	8.3	87.6
	Permanent/Part-Time	18	7.3	7.4	95.0
	Contract/Part-Time	12	4.9	5.0	100.0
	Total	242	98.8	100.0	
Missing	System	3	1.2		
Total		245	100.0		

Across all incomes brackets people reported working part-time in addition to fulltime. The proportion ranges from 26.5% to 37% of workers in each income category and the lower income levels were not disproportionately represented.

Approximate Gross Annual Income		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than $20,000	14	5.7	5.9	5.9
	$20,000 to $29,000	19	7.8	8.0	13.9
	$30,000 to $39,000	40	16.3	16.8	30.7
	$40,000 to $49,000	71	29.0	29.8	60.5
	$50,000 to $59,000	58	23.7	24.4	84.9
	$60,000 to $69,000	18	7.3	7.6	92.4
	Greater than $70,000	18	7.3	7.6	100.0
	Total	238	97.1	100.0	
Missing	System	7	2.9		
Total		245	100.0		

Over one third have been employed in the homeless sector for less than two years, and 20% less than a year. A further 33% have been employed for between two and five years and a final third over five years.

Length Of Time Employed In The Homeless-Serving Sector (In Years)		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than 1 year	48	19.6	19.7	19.7
	1-2 years	42	17.1	17.2	36.9
	2-5 years	82	33.5	33.6	70.5
	5-10 years	39	15.9	16.0	86.5
	Greater than 10 years	33	13.5	13.5	100.0
	Total	244	99.6	100.0	
Missing	System	1	.4		
Total		245	100.0		

Although there is a relatively even distribution across length of employment, 71% of the workforce reports less than five years' experience in the sector. We do not know how much prior work experience these individuals may have had in other human services organizations thus it is not possible to determine how young and inexperienced this group of newcomers to the field may be.

Education and training

The educational and prior background of workers revealed that 22% had a college diploma and a further 24% had some post-secondary education. Thus 46.5% of respondents had a college-level of education and only 37% had a university degree.

Highest Level Of Education		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Some High School	4	1.6	1.6	1.6
	High School	15	6.1	6.1	7.8
	Some University/College	41	16.7	16.7	24.5
	College Diploma	54	22.0	22.0	46.5
	B.A./B.S.	91	37.1	37.1	83.7
	Graduate Degree	40	16.3	16.3	100.0
	Total	245	100.0	100.0	

Of those with a university degree (BA), 22 reported social work as their area of concentration and 20 reported psychology. A further 13 reported an advanced degree in social work and 13 also reported an advanced degree in psychology. Also revealing was the areas of concentration reported by the 82 respondents (32% of the total) who indicated a background other than social work, psychology, business, rehabilitation studies or social sciences. One group of 10 reported a background in nursing. Beyond this cohort participants report a wide range of concentrations that cover most departments in arts and sciences faculties and included anthropology to sociology, theology/religious studies, health sciences, history, interior design, criminal justice, addictions, child care/development, to name but a few.   Further analysis showed that education levels and areas of concentration were dispersed throughout all of the represented organizations. These reports indicated that the overall workforce in the homeless sector is less well prepared, by way of educational achievement and specific background, than would be preferable for those working with complex needs in a difficult client population.

Primary Role of Respondents

Primary Role		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Intake Worker	7	3.2	3.3	3.3
	Outreach Worker	9	4.1	4.2	7.5
	Counsellor	9	4.1	4.2	11.7
	Shelter Staff	53	24.3	24.9	36.6
	Clinician/Clinicial Staff	7	3.2	3.3	39.9
	Case Manager/Care Coordinator	44	20.2	20.7	60.6
	Receptionist/Front Desk	7	3.2	3.3	63.8
	Other	77	35.3	36.2	100.0
	Total	213	97.7	100.0	
Missing	System	5	2.3		
Total		218	100.0		

The Work Environment: The Organizations.

We asked people to describe the organizations for which they worked in their primary role. We received multiple responses to this question and report these (total more than 100%). Of the largest cohorts, 32% worked in shelters, and 34% in permanent housing, while 14% were working in transitional housing, 29% provided supports and one small program (12 persons) provided residential treatment. In addition, 46% reported doing outreach work as well.

Within these organizations, using operating principles based on "housing first" was reported by 55%, while 49% indicated that they used a harm reduction approach. These differences suggest that it is unclear if respondents understood that housing first is a harm reduction approach. Only 39 (16%) report that their program uses an abstinence-based model.   A further examination of responses shows that in most organizations, there are diverse views as to whether the agency follows "housing first", abstinence- based or harm reduction approaches. That is, not everyone appears to understand or concur with whether their organization follows specific operating principles. Several programs work exclusively or primarily with specific groups. Single individuals were served by 52%, families only were served by 25% of respondents, and Aboriginal individuals by 26% of respondents.

Research suggests that certain aspects of the work environment are related to worker burnout and job dissatisfaction. In this context we asked questions about the extent to which people work in teams, receive support from supervisors and management and provide peer support to each other. There was considerable variation in whether or not participants reported working as a team or regularly meeting as a team. Over 38% report working all of the time in a team while another 36% report working primarily or all of the time alone. When critical incidents occur in the workplace, 24% rarely, if ever debrief as a team while 28% debrief all of the time. When clients are involved in critical incidents 23% rarely if ever debrief and 30% debrief all of the time.   It appears that staff do not perceive that in many instances they have adequate opportunity to process significant events that

occur on the job. On the whole, most people (68%) feel supported by senior management, while a much larger proportion (83%) felt supported by their immediate supervisor.

One note of caution: The response pattern across organizations was quite varied. That is, in each agency, some workers felt quite supported and others not so much. When we created a scale of all items measuring worker perceived support we found a lot of variation across organizations, but no significant differences. That is, most organizations are challenged when addressing support of workers. Additionally, it may be that some workers have higher support needs than others and that this is reflected in self-reports of on the job supports. However, the perceived support is not correlated with length of employment in the homeless sector, the present position, educational background, or primary role.

Work Related Stress: PROQOL and PCL

Burnout and Secondary Traumatic Stress

Professional quality of life has becomes the subject of concern in the workforce as its reports of burnout, compassion fatigue and vicarious traumatization are reported among health care and human services professionals. The measure used to assess these factors, the PROQOL (Stamm, 2009) has been widely employed to determine the extent of issues that impact the workforce. It has strong psychometric properties and is reported to be the most widely used measure of compassion satisfaction, fatigue and burnout for those who work with people who have experienced traumatic events (Stamm, 1995).

Compassion Satisfaction refers to the degree to which persons derive pleasure from being able to do their work well. Higher scores reflect the extent to which the work done is inherently satisfying. In this study, the majority of people report an average level of satisfaction. While some people report

high levels of satisfaction, 16% of our respondents indicated low levels of satisfaction to the extent that they should consider if their current job is an appropriate fit at the present time.

Compassion fatigue consists of two components: burnout and secondary traumatic stress (STS). Burnout is often associated with feelings of hopelessness, lack of feeling effective in one's job, and resultant physical and emotional fatigue. Burnout has become well-known as it has been the subject of numerous studies of those who work with people (nurses, social workers, psychologists, EMTs, teachers). STS refers to the problems than can develop as a result of second–hand exposure to the traumas that others have experienced. It can include difficulty sleeping, having intrusive thoughts of the trauma or avoiding reminders of the trauma. These behaviours, similar to symptoms of PTSD, are thus also referred to as vicarious traumatization. As with compassion satisfaction, many people reported average levels of burnout and STS. However, 24% of respondents reported high levels of both burnout and STS, levels at which they should be seeking professional help or consider stepping back from their stress-producing jobs.

Traumatic Stress and PTSD

The PCL-C, 6 item version was used to measure traumatic stress. This instrument is widely used to measure traumatic stress and as a screen for PTSD. The abbreviated version is 95% accurate for detection of a constellation of symptoms that indicates the presence of PTSD (Lang et al., 2012). The PCL correlates strongly with other measures of PTSD and the civilian version is not linked to a specific event, but refers to "stressful events". We chose this instrument for its brevity and well-documented validity and accuracy in detecting potential PTSD.

Scores of 14 or greater are consistent with a positive screen for PTSD. Over 36% of respondents (N= 245) reported PTSD symptoms that would probably result in a diagnosis of PTSD. If we examine

those on the cusp, with a score of 13, we include another 9.7% of respondents. Those at risk then constitute 46% of all respondents. The following chart provides a graphic illustration.

PCL scores in Calgary
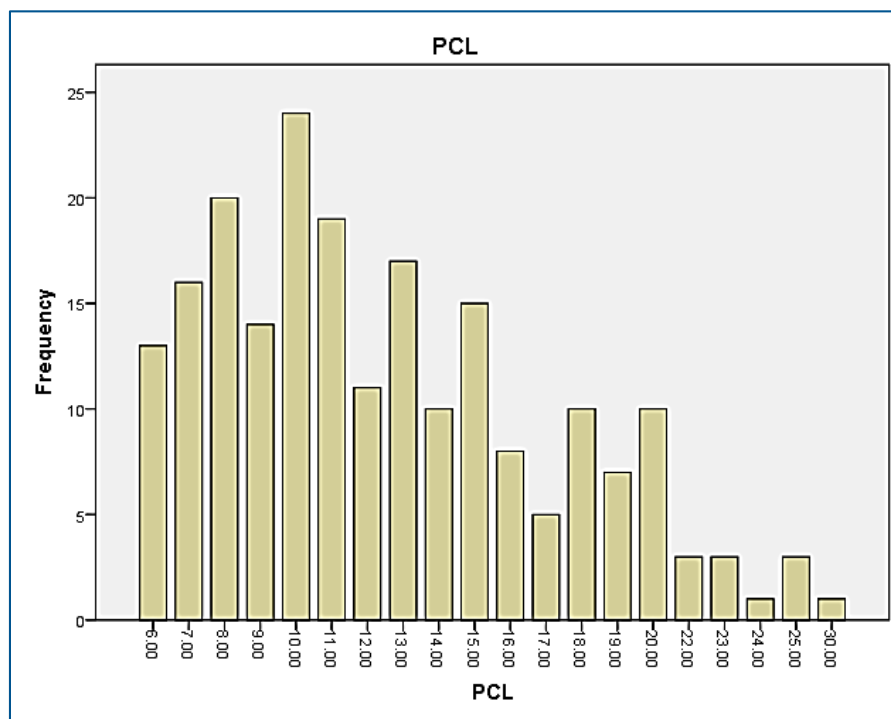
Epidemiological studies indicate that the one-month incidence of PTSD in the general population in Canada is approximately 2.4% (Van Ameringen, Mancini, Patterson, & Boyle, 2008). While the PCL is indicative of a possible diagnosis, it is not definitive. We can be certain over one third of all respondents screen positively for clinical criteria of PTSD. This compares with other populations, especially adults who have experienced rape, victims of domestic violence and abused children for which the incidence of PTSD has been reported as seen in the following chart:

Occurrence of PTSD in Different Groups

Adapted from : http://www.traumaline1.com/node/74
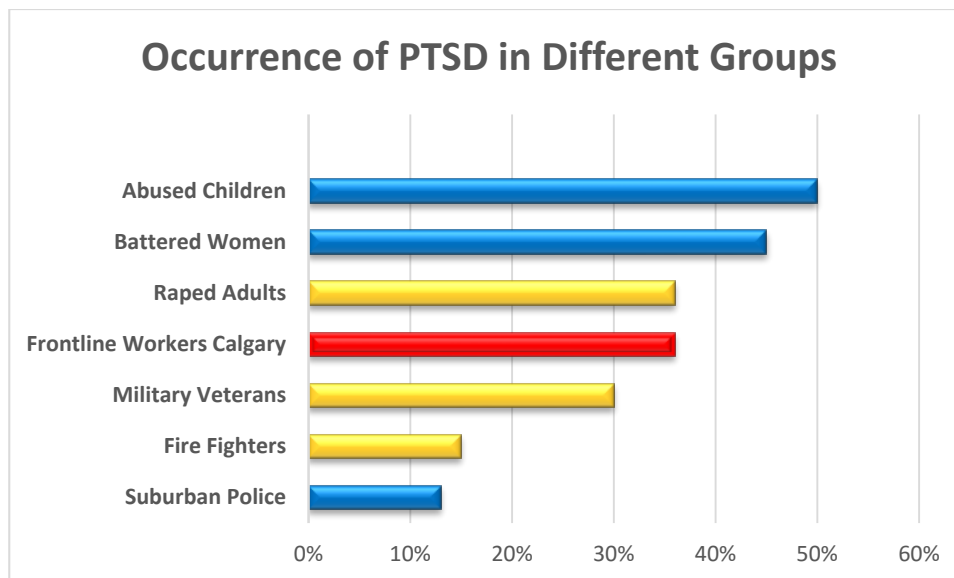
We also examined the extent of the relationships between scores on the PCL, and burnout, compassion fatigue and compassion satisfaction. As expected, there were very significant (p> .000) and had strong correlations with PCL (r= .580 for burnout and .611 for STS) between these constructs. What was more surprising was that reported PTSD symptoms were greater than the STS indicators. We continue to explore the precise nature of this finding.

Without doubt, the high rates of PTSD symptoms are the most significant finding of this study. While burnout and compassion fatigue affect about 25% of respondents at levels where their performance and quality of life is impeded, the extent to which PTSD symptoms prevail in homeless services sector employees is alarming. Furthermore, it is not concentrated in one or a few organizations but is randomly scattered throughout all of the participating agencies.

While the prevalence of trauma and potential PTSD is alarmingly high among homeless persons (Bassuk, Buckner, Perloff, & Bassuk, 1998; Buhrich et al., 2000; Taylor & Sharpe, 2008), the extent to which this may impact helpers, who are in turn traumatized, has not previously been documented

among a cohort as large as that in this study. Our data did not inquire about prior histories of trauma, so we do not know the extent to which persons with a prior history of trauma enter the workforce in the homeless-serving sector, or if they are initially traumatized by their work. What we do know from these results is that there is a very large cohort of workers who are impaired by serious symptoms of PTSD and yet work daily with a traumatized population. The mental health risks for both workers and clients cannot be ignored.

Relationship of PROQOL and PCL Scores with Organizational Components

The survey also asked a series of questions about the work and supervisory experiences that respondents experience regularly. The intent was to examine if any organizational components that have been reported in other research studies impact the burnout, compassion fatigue and PTSD symptoms reported by our respondents. Working alone, in a team, regular team meetings, and having individualized supervision were not significantly related to PCL scores. There were highly significant relationships, although mostly small   (r = .190 to r= .366), between reported traumatic stress symptoms and supports by supervisors and management, access to mental health supports, and having relief support available. These may be attributable to staff who are stressed having some supports that ameliorate their distress.   This is a potential explanation that would require further investigation.

Additional Comments from respondents

Over 28% of respondents added additional comments about supports that they would like to see added. While income is mentioned, especially by those who work jobs that provide the lowest income, it is not as frequent a theme as a variety of other supports: specific safety aspects of the work environment, the need for established "mental health days" that are separate from other sick leave, additional relief staff to decrease worker burden, additional supervisory support, further

education/training, more team development and a greater recognition for when additional supports are needed. While none are surprising, they all resonate with a workforce that is experiencing high rates of emotional and psychological stress in the work place.

Researcher Observations

There are several observations that are noteworthy. The overwhelming positive response and willingness to participate in this study by most organizations is a welcome aspect of any study. However, it is unusual to have respondents personally thank researchers for the opportunity to participate. We found, in many instances, that staff, upon returning their envelopes, stopped to express their thanks for this chance to voice their views. This reinforces the results of this study that many front-line people are in need of more opportunity to voice their concerns and have opportunities to explore ways to cope with the burdens of their jobs. We hope that this one aspect of workplace wellness will be readily adapted in routine practice within the participating agencies.

Recommendations and Conclusions

The aim of this study was to explore the extent of potential compassion fatigue, vicarious traumatization, burnout and potential risk for PTSD among support workers in the homeless sector. A second aim was to explore the extent to which some managerial and support factors may be related to reported work-related stress. The results indicated that while about 25% of frontline workers report high levels of burnout and vicarious traumatization, an even greater number (36%) report significant symptoms attributable to PTSD.   Since these same workers are reporting direct trauma symptoms rather than those acquired as a result of working with traumatized persons, we tentatively speculate that a combination of prior traumatic experiences, trauma- related events on the job and client traumas together contribute to trigger significantly elevated PTSD symptoms.

Trauma is an unavoidable consequence of various unforeseen and unavoidable serious negative events in peoples' lives. It can occur, among other reasons, through human acts of violence, because of accidents, or through acts of nature. While one event may produce PTSD in some individuals, others remain unaffected from serious emotional impacts. In other instances, multiple traumatic effects act cumulatively to produce a traumatic stress response. Additionally, in some instances, traumatic responses may be delayed by months or years, and in those who have recovered from PTSD, new reminders (triggers) can re-invoke traumatic reactions. There are no accurate predictors for those who may suffer a PTSD response versus those who remain unscathed by its impact. Thus, there are no effective prevention strategies that can be implemented to prevent PTSD in front-line workers. However, there are effective ways to cope with stress and to prevent re-occurrence in a person who has an understanding of the signs and symptoms of traumatic stress in themselves and others.   These strategies should be an integral part of worker training and support.

One additional outcome was the profiles of frontline workers that has not previously been documented. We find that a large group have two years or less of post-secondary education and that most do not come to their positions with training in interview, counselling or intervention skills. Further, we note that while addictions is a major issue for homeless persons, there are virtually no addictions counsellors among our respondents and thus they are severely lacking in the sector.

It is important to recognize that this report of workers in thirteen different organizations found no meaningful differences among these organizations, despite the fact that they represent various aspects of the types and ways services are delivered. This underscores the finding that the worker-related issues are systemic and not attributable to any organizational style or mission. This will hopefully permit organizations to collaborate to address issues of mutual concern. These findings underscore the importance of renewed attention to the training and on-the-job supports that workers in the homeless sector require in order to effectively help others wand also avoid compromise to their personal psychological safety. These needs extend to supervisory staff whop d

have no avenue for developing their own administrative and supervisory skills. We suggest that this has important implications for worker and client safety and should receive attention at all levels of the organization.

References

Acker, G. M. (2012). Burnout among mental health care providers. *Journal of Social Work, 12*(5), 475-490. doi:10.1177/1468017310392418

Baker, C. K., Billhardt, K. A., Warren, J., Rollins, C., & Glass, N. E. (2010). Domestic violence, housing instability, and homelessness: A review of housing policies and program practices for meeting the needs of survivors. *Aggression and Violent Behavior, 15*(6), 430-439.

Baker, L. M., O'Brien, K. M., & Salahuddin, N. M. (2007). Are shelter workers burned out?: An examination of stress, social support, and coping. *Journal of Family Violence, 22*(6), 465-474.

Barrow, S. M., Herman, D. B., Cordova, P., & Struening, E. L. (1999). Mortality among homeless shelter residents in New York City. *American Journal of Public Health, 89*(4), 529-534.

Bassuk, E. L., Buckner, J. C., Perloff, J. N., & Bassuk, S. S. (1998). Prevalence of mental health and substance use disorders among homeless and low-income housed mothers. *American Journal of Psychiatry,155*(11), 1561-1564..

Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social work, 52*(1), 63-70.

Buhrich, N., Hodder, T., & Teesson, M. (2000). Lifetime prevalence of trauma among homeless people in Sydney. *Australian and New Zealand Journal of Psychiatry, 34*(6), 963-966.

Calgary Homless Foundation (2016). http://calgaryhomeless.com/get-involved/learn-more/

Cheung, A. M., & Hwang, S. W. (2004). Risk of death among homeless women: a cohort study and review of the literature. *Canadian Medical Association Journal, 170*(8), 1243-1247.

Coates, J., & McKenzie-Mohr, S. (2010). Out of the frying pan, into the fire: Trauma in the lives of homeless youth prior to and during homelessness. *J. Soc. & Soc. Welfare, 37*, 65.

Collins, S., & Long, A. (2003). Working with the psychological effects of trauma: consequences for mental health-care workers–a literature review. *Journal of Psychiatric and Mental Health Nursing, 10*(4), 417-424.

Crothers, D. (1995). Vicarious traumatization in the work with survivors of childhood trauma. *Journal of Psychosocial Nursing and Mental Health Services, 33*(4), 9-9.

Demerouti, E., Karina Mostert, K., & Bakker, A. (2010). Burnout and work engagement: A thorough investigation of the independency of both constructs. *Journal of Occupational Health Psychology, 15*(3), 209-222.

Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*: Routledge.

Frankish, C. J., Hwang, S. W., & Quantz, D. (2005). Homelessness and health in Canada: Research lessons and priorities (Commentary). *Canadian Journal of Public Health, 96*(Supplement 2).

Hazenfeld, Y. (1992). *Human Services As Complex Organizations*. Newbury Park, CA: Sage Press.

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2009). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal., 2*, 131-151.

Howell, A. M. (2012). Working in the trenches: Compassion fatigue and job satisfaction among workers who serve homeless clients. MSW thesis. St. Catherine University. http: //sophia.stkate.edu/msw. _papers/116

Hwang, S. W. (2001). Homelessness and health. *Canadian Medical Association Journal, 164*(2), 229-233.

Karabanow, J. (1999). When caring is not enough: Emotional labor and youth shelter workers. *Social Service Review, 73*(3), 340-357.

Kidd, S. A. (2003). Street youth: Coping and interventions. *Child and Adolescent Social Work Journal, 20*(4), 235-261.

Kidd, S. A., Miner, S., Walker, D., & Davidson, L. (2007). Stories of working with homeless youth: On being "mind-boggling". *Children and Youth Services Review, 29*(1), 16-34.

Kosny, A. A., & Eakin, J. M. (2008). The hazards of helping: Work, mission and risk in non-profit social service organizations. *Health, Risk & Society, 10*(2), 149-166.

Lakeman, R. (2011). How homeless sector workers deal with the death of service users: a grounded theory study. *Death Studies, 35*(10), 925-948.

Lang, A. J., Wilkins, K., Roy-Byrne, P. P., Golinelli, D., Chavira, D., Sherbourne, C., . . . Craske, M. G. (2012). Abbreviated PTSD Checklist (PCL) as a guide to clinical response. *General Hospital Psychiatry, 34*(4), 332-338.

Lloyd, C., King, R., & Chenoweth, L. (2002). Social work, stress and burnout: A review. *Journal of Mental Health, 11*(3), 255-265.

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology, 52*, 379 - 422.

Miller, K., Birkholt, M., Scott, C., & Stage, C. (1995). Empathy and burnout in human service work an extension of a communication model. *Communication Research, 22*(2), 123-147.

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2011). Burnout in mental health services: a review of the problem and its remediation. *Administrative Policy in Mental Health, 39*, 341 - 352.

Mullen, J., & Leginski, W. (2010). Building the capacity of the homeless service workforce. *Open Health Services and Policy Journal, 3*, 101-110.

Olivet, J., McGraw, S., Grandin, M., & Bassuk, E. (2010). Staffing challenges and strategies for organizations serving individuals who have experienced chronic homelessness. *The Journal of Behavioral Health Services and Research, 37*(2), 226-238.

Roman, C. G., & Travis, J. (2006). Where will I sleep tomorrow? Housing, homelessness, and the returning prisoner. *Housing Policy Debate, 17*(2), 389-418.

Roy, É., Haley, N., Leclerc, P., Sochanski, B., Boudreau, J.-F., & Boivin, J.-F. (2004). Mortality in a cohort of street youth in Montreal. *JAMA: The Journal of the American Medical Association, 292*(5), 569-574.

Song, J., Bartels, D. M., Ratner, E. R., Alderton, L., Hudson, B., & Ahluwalia, J. S. (2007). Dying on the streets: Homeless persons' concerns and desires about end of life care. *Journal of General Internal Medicine, 22*(4), 435-441.

Stamm, B. H. (1995). *The ProQOL Manual: The Professional Quality of Life Scale Compassion Satisfaction, Burnout & Compassion Fatigue/Secondary Trauma Scales.* Baltimore, MD: Sidaren Press.

Stamm, B. H. (2009). Professional quality of life: Compassion satisfaction and fatigue version 5 (ProQOL).

Taylor, K. M., & Sharpe, L. (2008). Trauma and post-traumatic stress disorder among homeless adults in Sydney. *Australian and New Zealand Journal of Psychiatry, 42*(3), 206-213.

Travis, D. J., Lizano, E. L., & Barak, M. E. M. (2015). 'I'm So Stressed!': A Longitudinal Model of Stress, Burnout and Engagement among Social Workers in Child Welfare Settings. *British Journal of Social Work*, bct205.

Tutty, L., Bradshaw, C., Waegemakers Schiff, J., Worthington, C., McLaurin, B., Hewson, J., Dooley, D., Kean, S. & McLeod, H. (2009). *Risks and assets for homelessness prevention: A literature review for The Calgary Homeless Foundation*. Calgary Homeless Foundation, Calgary, AB.

Van Ameringen, M., Mancini, C., Patterson, B., & Boyle, M. H. (2008). Post-Traumatic Stress Disorder in Canada. *CNS Neuroscience & Therapeutics, 14*(3), 171-181. doi:10.1111/j.1755-5949.2008.00049.x

Van Hook, M. P., & Rothenberg, M. (2009). Quality of life and compassion satisfaction/fatigue and burnout in child welfare workers: A study of the child welfare workers in community based care organizations in central Florida. *Social Work and Christianity, 36*(1), 36.

Wright, T. A., & Cropanzano, R. (1998). Emotional exhaustion as a predictor of job performance and voluntary turnover. *Journal of Applied psychology, 83*(3), 486.

Yaniv, G. (1995). Burnout, absenteeism, and the overtime decision. *Journal of Economic Psychology, 16*(2), 297-309.