Gains and losses within the homeless service, supportive housing, and harm reduction sectors during the COVID-19 pandemic: A qualitative study of what matters to the workforce

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Abstract

The COVID-19 pandemic has had deleterious effects on individuals experiencing homelessness; yet, less is known about how this global health crisis is impacting service providers that support the homeless population. This qualitative study examined the perceived impacts of the COVID-19 pandemic on the lives and work experiences of service providers in the homeless service, supportive housing, and harm reduction sectors in Canada. Further analyses were conducted to identify the occupational values that were represented in the work-related changes experienced by providers. A stratified purposive sample of 40 participants (30 direct service providers and 10 providers in leadership roles) were drawn from a pan-Canadian study of the mental health of service providers working with individuals experiencing homelessness. Reflexive thematic analysis was used to identify five themes of the work-related changes experienced by service providers during the pandemic: [1] “Everything was changing every day”: Work role and responsibility instability; [2] “How on Earth do we do our job?”: Challenges to working relationships with service users; [3] “It used to be a social environment”: Transitions to impersonal and isolating workspaces; [4] “It all comes down the chute”: Lack of organisational support and hierarchical conflict; and [5] “We've been supported as well as we could have”: Positive organisational support and communication. The findings underscored how many of the occupational changes during the pandemic did not align with service providers’ occupational values for collaboration, control, effective and safe service provision, and the importance of human relationships, among other values. As pre-existing sectoral problems were exacerbated by the pandemic, recovery efforts need to address these long-standing issues in ways that are aligned with service providers’ values. Future research is warranted on how organisational approaches can promote supportive workplaces for service providers and improve outcomes for individuals experiencing homelessness.

KEYWORDS
COVID-19 pandemic, harm reduction, homeless services, occupational values, service provision, supportive housing, workplace mental health
1 | INTRODUCTION

The COVID-19 pandemic is an unprecedented global health crisis that has had devastating effects on healthcare systems and economies around the world, and resulted in millions of deaths. The inequitable effects of the pandemic have become evident over time, with marginalised and low-income populations being disproportionately harmed (Persaud et al., 2021). Individuals experiencing homelessness are one group that has suffered the pandemic’s deleterious effects, including worse health outcomes associated with COVID-19 and reduced access to community supports (Baggett et al., 2020; Kiran et al., 2022; Richard et al., 2021). Enduring the pandemic alongside individuals experiencing homelessness are the individuals who support them. This sizeable and diverse workforce has been largely overlooked in pandemic-related social policy (Mental Health Commission of Canada, 2021). However, this omission has the potential to undermine post-pandemic efforts to prevent and end homelessness. Accordingly, it is beneficial to understand the pandemic’s impacts on service providers working with the homeless population and how these experiences shape the workforce’s support needs throughout and following the pandemic.

Pre-pandemic research demonstrated that work in the homeless service sector, as well as related community health and housing workforces, is stressful and demanding (Wirth et al., 2019). Service providers in this workforce are often first-responders to the crises of service users, increasing their risk of secondary traumatisation (Peters et al., 2022; Petrovich et al., 2021). Furthermore, direct exposure to chronic stressors are common in the workplace and can have insidious effects on the mental health of service providers (Kerman, Ecker, Tiderington, et al., 2022). Systemic problems present additional challenges for service providers that can exacerbate work-related stress. For example, limited funding for community services and a high demand for supports can contribute to larger caseloads for providers and greater difficulties meeting the long-term needs of service users (Kerman et al., 2017; Kidd et al., 2007; Wirth et al., 2019). Furthermore, due to limited funding, homeless service organisations may offer low wages and insufficient supports for their staff (Olivet et al., 2010).

The pandemic has had further deleterious effects on the mental health of the workforce that serves individuals experiencing homelessness in many countries. In Canada, a national survey of direct service providers found that 79.5% reported deteriorations in their mental health during the pandemic, for whom 31.6% indicated substantial declines (Kerman, Ecker, Gaetz, et al., 2022). Further, in a US study of emergency shelter providers in Texas, most were worried about being exposed to and contracting COVID-19 at work, which had a negative impact on burnout levels (Aykanian, 2022). Factors that may have exacerbated the stress levels of service providers during the pandemic included changes to how supports were delivered, increased demand for services due to closure of other programmes, and a heightened need to effectively balance risks and benefits in work-related decisions (Carver et al., 2022; Kaur et al., 2022; Parkes et al., 2021; Pixley et al., 2022). Yet, as organisations serving individuals experiencing homelessness were forced to adapt to the pandemic, this also yielded workplace innovations that had benefits for providers. For example, use of hotels as temporary accommodations in the United Kingdom facilitated rapport building with service users and the provision of more support (Kaur et al., 2022). Thus, despite emergent evidence of pervasive ill effects of the pandemic on service providers to individuals experiencing homelessness, it is necessary to also identify occupational improvements and innovations, so that these can be leveraged moving forward.

The objective of this qualitative study was to explore the perceived impacts of the COVID-19 pandemic on the lives and work experiences of service providers in the homeless service, supportive housing, and harm reduction sectors in Canada. Broadly informed by a critical realist perspective, we sought to understand the central gains and losses of the COVID-19 pandemic for providers, with a focus on what they identify as important work-related factors and the occupational values that are represented in these changes. Critical realism posits that knowledge is subjective and socially constructed within an independent objective reality (Houston, 2001). This approach pairs well with reflexive thematic analysis, which recognises the centrality of the researcher in data interpretation (Braun & Clarke, 2019). The study’s primary research question was: How do service providers experience changes in the workplace during the COVID-19 pandemic in relation to their occupational values? For this study, occupational values were defined as the beliefs, principles, and needs that underlie and guide the work of service providers.

2 | METHODS

2.1 | Participants and recruitment

The study had two phases to recruitment. First, an online survey was disseminated to over 300 homeless service, housing, and harm reduction agencies and networks across Canada in November 2020. What is known about this topic?

- Service delivery to individuals experiencing homelessness can be demanding and stressful.
- The COVID-19 pandemic has worsened the mental health of service providers working with individuals experiencing homelessness.

What this paper adds?

- The pandemic has exacerbated long-standing sectoral issues, though there has also been increased recognition of workplace mental health within some organisations.
- Many of the work-related changes experienced by service providers during the pandemic were misaligned with their occupational values.
- Service providers’ occupational values could be used to inform workplace mental health promotion strategies in the homeless service, supportive housing, and harm reduction sectors.
Individuals were eligible to participate in the survey if they: [1] were 18 years of age or older; [2] worked in Canada; [3] provided direct services to individuals experiencing homelessness; and [4] worked in the homeless service, supportive housing, or harm reduction sectors. At the end of the survey, providers were invited to give their contact information if they wished to participate in a follow-up, in-depth interview. Of the 701 survey participants, 244 provided contact information for a follow-up interview.

The second phase of recruitment involved stratified purposive sampling of 30 survey participants by region of Canada (British Columbia, the Prairies, Ontario, and Eastern Canada) and sector (homeless services, supportive housing, and harm reduction) for an in-depth interview. An additional 10 service providers in leadership roles (e.g. organisational directors, programme managers) were also recruited to participate in an in-depth interview to understand how the COVID-19 pandemic had impacted organisations and workers more broadly. Service leaders were identified during the dissemination of the online survey in the first phase of recruitment. Service leaders were purposively sampled using the same criteria as the other participants. Data for this study are drawn from these 40 qualitative interviews (see Table 1 for sample characteristics).

### 2.2 | Data collection

Qualitative interviews were conducted virtually using semi-structured guides. There were three parts to the interview: [1] role identification and history in the sector, [2] work experiences and their perceived impacts on mental health, and [3] recommendations for improving the workplace mental health. Interview questions were framed in a way that participants could discuss their experiences during or before the COVID-19 pandemic. However, clarifying, open-ended prompts were used to understand how the pandemic impacted their reported experiences. Semi-structured interview questions were similar for direct service providers and service leaders; however, the former group was asked about their own experiences, whereas service leaders were asked about workers’ experiences within their programme and organisation. Interviews were conducted between January and April 2021. All interviews were recorded and participants provided written consent.

Sociodemographic and occupational characteristics of direct service providers were drawn from online survey data. Only data on work role were collected for service leaders. The study was reviewed and approved by the research ethics board at the last author’s institution.

### 2.3 | Data analysis

Qualitative data were analysed using reflexive thematic analysis, with iterative processes informed by Braun and Clarke (2006).

| TABLE 1 | Characteristics of service providers (N = 30, unless otherwise noted) |
|----------|----------------------------------------------------------------------------------|
| Characteristic | n/M | %/SD |
| Gender | | |
| Woman | 22 | 73.3 |
| Man | 6 | 20.0 |
| Non-binary | 2 | 6.7 |
| Age | 36.20 | 10.43 |
| Ethnicity, White | 23 | 76.7 |
| Region of Canada | | |
| British Columbia | 10 | 25.0 |
| The Prairies | 9 | 22.5 |
| Ontario | 10 | 25.0 |
| Eastern Canada | 11 | 27.5 |
| Level of education, postsecondary degree/diploma | 29 | 96.7 |
| Work role | | |
| Direct service | 18 | 45.0 |
| Team lead/coordinator | 9 | 22.5 |
| Programme manager | 7 | 17.5 |
| Senior leadership | 6 | 15.0 |
| Primary service sector | | |
| Harm reduction | 12 | 30.0 |
| Homeless services | 16 | 40.0 |
| Supportive housing | 12 | 30.0 |
| Lived experience of behavioural health problems | 21 | 70.0 |
| Lived experience of homelessness | 4 | 13.3 |
| Direct contact with service users (percentage of work) | | |
| ≤25% | 3 | 10.0 |
| 26–50% | 8 | 26.7 |
| 51–75% | 9 | 30.0 |
| ≥76% | 10 | 33.3 |
| Full-time work (≥40 h/week) | 26 | 86.7 |
| Small/remote community service delivery | 7 | 23.3 |
| Intention to be in same job in 12 months | 23 | 76.7 |
| Intention to be in same sector in 12 months | 29 | 96.7 |
| COVID-19 pandemic impacts | | |
| Worsened mental health and wellness | 26 | 86.7 |
| Increased alcohol use | 10 | 33.3 |
| Increased cannabis us | 9 | 30.0 |
| Less effective at work | 20 | 66.7 |
| Reduced work hours | 5 | 16.7 |
| Financial problems (any) | 20 | 66.7 |

\(^a\)N = 40.

\(^b\)Small is defined as communities under 30,000 people; remote is defined as permanent settlements with at least 10 dwellings without year-round road access or rely on third party for transportation to large centre.

\(^c\)Includes slight, moderate, and extreme financial problems.
Thematic analysis comprised six steps. First, interviews were transcribed verbatim by the last author, providing a familiarisation of the full data set. Second, line-by-line analysis of interview transcripts was then completed in NVivo (Release 1.0) using codes “grounded in” the data (Braun & Clarke, 2021). Third, coded data on experiences and impacts of the COVID-19 pandemic were analysed to form initial themes and subthemes, according to the active meaning-making of the first author. Codes were assembled into initial candidate themes and depicted in a thematic map. Fourth, potential themes were reviewed according to key questions identified by Braun and Clarke (2012) on two levels: [1] the relationships among the items and codes were initially reviewed within each theme and subtheme and [2] candidate themes were then reviewed in relation to the full data set and the primary research question. Fifth, a detailed thematic framework was created wherein individual themes and subthemes meeting dual criteria were displayed (i.e. a coherent and internally consistent account of the data that is untold by other themes; Patton, 1990). Sixth, the order of theme presentation was established and subsequently written. Repeated iterations of coding analyses and the evolution of codes were tracked to aid in transparency (Byrne, 2022). Throughout this iterative analytic process, the first and last authors met regularly to discuss the emergent themes and collaboratively refined analyses to develop thematic consensus.

Following the development of a working map of themes and subthemes, the first and last authors independently identified possible occupational values that underlay the findings. This analytical process began with the identification of three research and practice frameworks related to service provision values among health and social service professionals: [1] the National Association of Social Workers’ Code of Ethics (National Association of Social Workers, 2017); [2] an international Delphi study of values in integrated health services (Zonneveld et al., 2020); and [3] a systematic review of quality improvement frameworks in health, education, and social services (Klassen et al., 2010). The themes and subthemes were then independently coded by the two authors according to the full set of values included in the three frameworks. Overlapping values among the three frameworks were multiply coded during this stage of analysis. The two authors then met to review their independent assessments, pare down overlapping codes, and reach consensus on a final list of corresponding occupational values for the qualitative findings. This process also involved adapting the language of values to be more applicable to the study sample and thematic findings.

The research team members involved in qualitative data analysis had graduate degrees (social work or clinical psychology), and research backgrounds in homelessness and qualitative methods. Multiple strategies were used for establishing rigour in qualitative research, including multiple coders to sense-check ideas (i.e. analytic triangulation), peer debriefing, and maintaining an audit trail (Padgett, 2017).

Quantitative data from the online survey were analysed to describe the characteristics of direct service provider participants using descriptive statistics in SPSS 25. These data were not available for the 10 participants in leadership roles who were recruited separately from the online survey.

### 3 | RESULTS

Five themes were identified that described how service providers experienced COVID-19 pandemic work-related changes, with each theme having associated occupational values (Table 2). The five themes were: [1] “Everything was changing every day”: Work role and responsibility instability; [2] “How on Earth do we do our job?”: Challenges to working relationships with service users; [3] “It used to be a social environment”: Transitions to impersonal and isolating workspaces; [4] “It all comes down the chute”: Lack of organisational support and hierarchical conflict; and [5] “We’ve been supported as well as we could have”: Positive organisational support and communication. As implied by the latter two themes, experiences varied across participants and their organisations based on contextual and individual conditions. The themes and associated occupational values are described in detail below. A total of 15 unique participants are represented in the 25 presented quotes, with no more than three quotes from any single participant.

#### 3.1 | “Everything was changing every day”: Work role and responsibility instability

Service providers described major and minor changes to their daily responsibilities, workloads, and level of collaboration due to the pandemic. As the pandemic changed rapidly, so did the expectations of providers. Occupational values challenged by these work-related changes included maintaining a sense of control at work, professionally collaborating with others to accomplish goals, and maintaining work-life boundaries.

#### 3.1.1 | Unexpected changes to work role and workload

Substantial challenges arose due to understaffing, quarantine mandates, on-call and overnight shift requirements, and overtime. New role expectations and responsibilities were common during the pandemic: “Slowly over time, they started to build up extra things that we have to do, right? Like new COVID protocols that we would have to follow ... there’s 50 new things that we have to do”. Providers in leadership positions also acknowledged the challenges around enacting pandemic policies to keep programmes safe, while also recognising how challenging this was for staff: “I drafted up a 20-page pandemic policy, that’s a lot of learning. A lot of new policies, a lot of pressure”. These work role and workload changes underscored the importance of providers having a sense of control over their work and work environment, which was undermined due to changing pandemic circumstances, and unexpected and shifting supervisory mandates.

#### 3.1.2 | Blurred work-life boundaries

The pandemic challenged providers’ capacity to set and maintain healthy work-life boundaries. This was due to changes in work...
responsibilities, new modes of interacting with service users, and less accessible support outside of work. Others described feelings of guilt for holding boundaries, given service users’ dire needs: “The need is never-ending and to say ‘no,’ you feel like a bad person … the pandemic has come with saying a lot of ‘yes,’ which has created such ridiculous work-life balance flux. You’re just always thinking about work”. The narrative of the subtheme reflects occupational values held by providers on the importance of maintaining a psychologically safe work environment, and having the capacity and organisational support to have healthy work-life boundaries.

3.1.3 | Worsened relationships and reduced collaboration with community organisations

A common frustration reported by participants was a lack of perceived community collaborator support in achieving their shared missions during the pandemic. Some providers experienced this as “system dumping”, wherein other agencies that had reduced their services due to the pandemic would refer their service users to participants’ organisations that remained open with in-person supports. The lack of shared responsibility and “dumping” of service users hindered providers’ occupational value for respectful professional relationships and systems collaboration:

Other systems dumping really impacts people’s mental health and well-being. I do not think it makes us feel like we are part of a larger team and that has been worse during COVID … a whole bunch of these stay-at-home providers knew that we were working in-person and so they just referred, and they did not actually want our services, they just wanted one of our workers to go see the person and then report back.

Others described challenges in connecting service users to external community resources, including delays due to other organisations operating with a limited capacity and staff working from home: “One of the things that really stressed staff out a lot was a lot of the systems were working from home … there’s less support coming from that end, so then staff found themselves probably doing a little more”.

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**TABLE 2** Themes and subthemes with corresponding occupational values

| Theme | Subtheme | Occupational value |
|-------|----------|--------------------|
| "Everything was changing every day": Work role and responsibility instability | Unexpected changes to work role and workload | • Sense of control over work and environment |
| | Blurred work-life boundaries | • Safe work environment (psychological) |
| | Worsened relationships and reduced collaboration with community organisations | • Capacity and support for healthy work-life boundaries |
| "How on Earth do we do our job?": Challenges to working relationships with service users | Unable to help service users to the extent providers would like | • Systems integration and collaboration |
| | Toll of enforcement of COVID-19 pandemic rules | • Respectful professional relationships |
| "It used to be a social environment": Transitions to impersonal and isolating workspaces | Changes in how providers operate and feel in their workspace | • Effectiveness in service provision |
| | Transactional coming and going, and community lost | • Importance of human relationships |
| "It all comes down the chute": Lack of organisational support and hierarchical conflict | Poor organisational communication | • Equitable care and support |
| | Lack of inclusion and staff recognition in decision-making | • Safe work environment |
| | Increased organisational focus on workplace mental health | • Service user safety |
| "We’ve been supported as well as we could have": Positive organisational support and communication | Stronger leadership collaboration and communication | • Safe work environment |
| | | • Sense of control over work and environment |

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3.2 | “How on Earth do we do our job”? Challenges to working relationships with service users

Many participants described new pandemic-related barriers to connecting with service users, which impeded building and sustaining meaningful working relationships. Operating in the pandemic led providers to feel unable to deliver services in the way they wanted while concurrently having to balance the enforcement of new COVID-19 rules and rapport building with service users. These challenges took a toll on several occupational values, including the service provision effectiveness, the importance of fostering and maintaining supportive human relationships, and the need to maintain safe work environments.

3.2.1 | Unable to help service users to the extent providers would like

Participants reported that the pandemic had limited what they could safely offer to service users. Said one, “The entire role with our [intensive case management] clients changed dramatically, and it’s moved from doing case management to just making sure the clients are okay through the pandemic”. Others described feeling guilty because they perceived that they were not providing enough for their clients: “There’s a real sense of staff not feeling like they can do their job and feeling very like that they’re not helping”. Having to turn people away who were seeking services due to capacity limits was also emotionally burdensome, especially for direct service providers who had to communicate this message.

Restrictions on in-person service delivery also complicated the development and maintenance of meaningful connections with service users: “We’re all talking through computer screens these days ... it is lacking that personal aspect of face-to-face connection, which really allows you to have, in my opinion, some more impactful conversations”. This subtheme underscores the challenges that providers experienced in upholding occupational values for effective service provision, the importance of human relationships, equitable care and support, and a safe work environment for service users and staff.

3.2.2 | Toll of enforcement of COVID-19 pandemic rules

Participants often described difficulties upholding new COVID-19 pandemic rules and protocols, as this work was a further strain on their working relationships with clients, as well as on their own mental health. Aligned with the previously described changes in work-related responsibilities, providers felt like rule “enforcers” in their new roles. Participants recognised that rule enforcement was also a source of frustration for service users, which likely reinforced the interpersonal connection difficulties: “People are frustrated as well, like they come in, especially with COVID, we have to ask all these questions, they have to wear a mask, sanitize their hands, they have to wait outside”. Service providers’ experiences reflect occupational values related to having a safe work environment and a sense of control over one’s work, which became more precarious during the pandemic.

3.3 | “It used to be a social environment”: Transitions to impersonal and isolating workspaces

Alterations to providers’ workspaces was a source of dissatisfaction and another challenge to occupational values. Environmental changes varied across organisations, with some transitioning from friendly and homey environments to more isolated and clinical spaces. This also restricted the ways in which staff and service users were able to use the workspaces, in addition to the types of programmes that organisations could provide.

3.3.1 | Changes in how providers operate and feel in their workspace

Changes to the physical workspaces impacted how providers perceived their environments and what they could do with service users. The locations where services were offered changed for some providers, leading to perceptions that the new settings were less hospitable and more institutional: “We’re in a clinical kind of setting now, which is really sad, because we were in a home before, like it was a sense of warm home”. Changed environments impacted organisational service offerings, which prevented service providers from delivering needed supports. There was also dissatisfaction among some providers who shared office space. This was related to a sense of impermanence in the workplace and anxiety about contracting or spreading COVID-19 to colleagues: “I’m in this rotating office ... I live out of my work bag”. Another spoke of the strain of ever-present uncertainty in shared workspaces: “You have to second guess just reaching for somebody else’s pen to borrow, and so I think that it’s just mentally wearing to be constantly thinking about the impact of your actions”. The uncertainty and programming disruptions precipitated by the physical workplace changes underscore occupational values for having a safe and dignified built environment at work, and sufficient supply of services to meet the needs of service users.

3.3.2 | Transactional coming and going, and community lost

Service providers described a loss of support and connection across different sets of working relationships. Participants in leadership positions described how the pandemic had led them to “police” the actions of staff, instead of promoting social support
between colleagues: “They can’t connect with their colleagues, all the informal kind of grab coffee together stuff. All the things that we would have been encouraging them to do, we’re now policing them around”. Capacity limits also made for more transactional spaces that prevented connection: “Our drop-in is a really limited number of people we can have inside of it now. So, that’s frustrating for people because it used to be a social environment for people ... well, that’s not there for them anymore”. The sub-theme underscores the importance that service providers place upon connection in human relationships, and teamwork and collaboration, which were restricted by pandemic-related workspace changes.

3.4 | “It all comes down the chute”: Lack of organisational support and hierarchical conflict

Inadequate organisational support was a salient narrative among service providers. This included perceptions of poor communication about COVID-19 pandemic policies, as well as their unequal application; strained direct service provider-leadership relationships; and the lack of inclusion in decision-making processes. The perceived lack of organisational support challenged team dynamics, relationships within organisational hierarchies, and providers’ sense of value in their roles.

3.4.1 | Poor organisational communication

Insufficient, inefficient, and unclear communication related to COVID-19 policies and procedures was a source of frustration for providers at all levels. Direct service providers described a need for clarifying information on their roles and responsibilities; however, this was not always available. Participants in leadership roles acknowledged staff’s need for this, but noted that, in some cases, they also did not have answers: “For a while, it was difficult because we didn’t know what was happening ... you’re giving your staff information and support, but you don’t really want to tell them, ‘Well, we’re not getting anything right now.’” There was also recognition by some that communication breakdowns were connected to all staff feeling more stressed:

Managers are stressed themselves because the directors are stressed because the CEO is stressed and it all comes down the chute. So, people are being less and less responsible for their own kind of like containment and letting it bleed out.

The subtheme underscores occupational values for consistent and equitable implementation of policies and procedures, and timely and open communication from leadership, both of which were strained by the pandemic.

3.4.2 | Lack of inclusion and staff recognition in decision-making

Some direct service providers felt powerless to enact change and contribute to organisational decision-making during the pandemic. These participants felt unheard and devalued when they were not consulted prior to new policies that affected them being implemented: “I felt completely and utterly disrespected. It was just clear that like my work and the incredible hard work that I put into this job was not being recognized and was not being supported”. The lack of opportunity to provide input on organisational changes where some staff worked from home and others did not was a particular source of frustration that led to perceptions about policies being inequitably implemented. Participants in leadership positions described challenges in appeasing all staff due to differing views on the pandemic and appropriate courses of action, leading to tension among team members:

We have [staff] who are absolutely terrified and want every single health provision in place to protect them and then we have this group that are kind of the opinion that there’s other bigger problems in the pandemic ... so, the different managers are kind of not appealing either side because this group wants things that are unrealistic and this group is potentially jeopardising the health of the other.

Others described how the pandemic had put everyone into “crisis mode”, which contributed to reduced staff inclusion in organisational decision-making: “I think everybody is kind of in crisis mode, just trying to keep everything afloat”. The occupational values challenged in this subtheme are inclusion in organisation decision-making; consistent and equitable implementation of policies and procedures; and a sense of trust, recognition, and validation from organisational leadership.

3.5 | “We’ve been supported as well as we could have”: Positive organisational support and communication

In contrast to the previous theme, some participants reported feeling organisationally supported during the pandemic from which there were “silver linings”. These included greater awareness of workplace mental health, stronger leadership commitment to communication and collaboration, and prioritisation of worker safety.

3.5.1 | Increased organisational focus on workplace mental health

More recognition of the mental health of service providers was a commonly identified organisational change that had occurred during the pandemic. Said one provider, “I think COVID has brought up
the topic about mental health care quite a bit, so that’s opened up. I think people are more willing to dialogue about that stuff”. Others reported that their organisations had provided more support during the pandemic in response to increased stress among providers: “My organization particularly did start coming out with ways to support their staff and that was doing a lot of online webinars and check-ins and offering education and resources to do at home”. This subtheme reflected occupational values related to recognition of the support needs of workers by leadership.

3.5.2 | Stronger leadership collaboration and communication

A number of participants in leadership roles described efforts to foster supportiveness and openness at the team level. Some direct service providers also spoke about feeling supported as a result of receiving regular emails and virtual meetings with senior leadership that recognised the hard work of staff and provided needed information:

There's just this constant conversation around, 'How are you doing?’ And, in the early days, we used to get weekly updates from our CEO that would go out to every staff saying, 'You know, here's the new stuff. Again, thank you for all you're doing'. So, those really meant the world to people.

These collaboration and communication approaches addressed providers’ occupational values for timely and open communication, teamwork support and collaboration, and a sense of validation from organisational leadership.

4 | DISCUSSION

This qualitative study examined the occupational impacts of the COVID-19 pandemic on service providers who worked with individuals experiencing homelessness in Canada, and the underlying occupational values reflected in these work-related changes. The findings demonstrate that providers experienced significant changes during the first year of the pandemic, most of which did not align with their occupational values. A range of structural and organisational problems were exacerbated by the pandemic, with some of the identified “changes” being underacknowledged issues that existed in the sector prior to the onset of the pandemic. For example, professional boundary-setting, effectiveness in overcoming structural barriers, and collaboration with other community partners were described as being negatively impacted during the pandemic, yet pre-pandemic research has also found these to be issues (Kidd et al., 2007; Petrovich et al., 2021; Wirth et al., 2019). Accordingly, there is a need for the sector to attend to these long-standing issues within the workforce as part of pandemic recovery efforts in a way that is congruent with service providers’ values.

An underlying narrative of service providers’ work experiences during the pandemic was the importance of mental health recognition. The research on secondary trauma among individuals working with highly traumatised populations demonstrates that the work can have a serious toll on mental health and wellness (Newell & MacNeil, 2010; Peters et al., 2022). Adequate supervisory and organisational supports are key to preventing turnover and addressing the support needs of staff and service users (Ashley-Binge & Cousins, 2020; Choy-Brown et al., 2016). A greater focus on workplace mental health, which was identified as a “silver lining” of the pandemic in our study, and the ways this aligned with provider’s occupational values, has important service delivery implications. Direct service staff report better personal and service user outcomes when they feel supported and respected by organisational leadership (Mullen & Leginski, 2010; Pearlman & Saakvitne, 1995). Given the high rates of burnout, compassion fatigue, and turnover among the workforce (Aykanian, 2022; Kerman, Ecker, Gaetz, et al., 2022; Kidd et al., 2007; Peters et al., 2022), attending to occupational values may be a beneficial workplace mental health promotion strategy.

Study findings highlight the importance of addressing the needs and preferences of service providers in the workplace. This is particularly critical as this sector grapples with increased pressures associated with the pandemic. Integrating the perspectives of direct service providers when developing and implementing policies and procedures may contribute to workers having a sense of agency and control over their environment. Furthermore, the inclusion of service providers in capacity- and partnership-building initiatives with other community organisations would offer opportunities to enact their occupational values for teamwork and collaboration through systems change. It is important that the needs of providers also be balanced with those of service users. For example, direct service providers experienced a diminished sense of control during the pandemic due to unexpected changes to their work roles and responsibilities, and requirements to enforce safety protocols. Addressing this issue by considering only the experience of providers risks worsening existing power imbalances between them and service users (Kerman & Sylvestre, 2020; Norman et al., 2015; Wen et al., 2007). Accordingly, it is essential that there are mechanisms in place so that both these essential stakeholder groups are able to meaningfully contribute to organisational decision-making.

This study had several limitations. First, from a critical realistic perspective, it is necessary to acknowledge that the knowledge produced from the study findings are fallible and transitive. As data were collected in early 2021 during the second wave of the COVID-19 pandemic in Canada, it is unknown how the findings will change during subsequent periods of the pandemic. Second, participants were recruited for the study following their completion of an online survey. Given that the online survey was disseminated to homeless, housing, and harm reduction service organisations and networks, individuals who were on leave from work due to the pandemic (e.g. childcare and homeschooling, mental health-related reasons) are likely under-represented in the sample. Third, the interview guides used open-ended questions to understand participants’
experiences during the COVID-19 pandemic, but did not include specific prompts about perceived gains and losses. Although this enabled participants to discuss experiences that were most salient, less impactful gains and losses may have been overlooked. Fourth, given the national scope of the study, it was not feasible to examine how local and provincial pandemic-related policies affected service providers’ experiences at work.

5 | CONCLUSION

Community-based service providers working with individuals who are homeless experienced occupational gains and losses during the COVID-19 pandemic. In particular, there was misalignment between service providers’ occupational values and how their work changed as a result of the pandemic, including their roles and responsibilities, physical workplace environments, and level of inclusion and acknowledgement in organisational decision-making. Although the pandemic challenged the occupational values of many service providers, it also yielded an opportunity for greater acknowledgement of the workplace mental health needs of this often-overlooked essential workforce. Overall, the findings underscore key occupational values held by service providers that can be targeted in approaches to improve service delivery and organisational operations for both staff and service users.

AUTHOR CONTRIBUTIONS

JMG and NK conceptualised the study, with input from ET, SAK, and JE. NK collected the data. NK led the first two steps of data analysis and JMG led the subsequent steps, with input from ET, SAK, and JE. JMG and NK drafted the manuscript. ET, SAK, and JE critically reviewed and edited the manuscript. All authors approved of the final version of the manuscript. NK and SAK acquired the funding.

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CONFLICT OF INTEREST

None declared.

DATA AVAILABILITY STATEMENT

Data will not be made available, as study participants did not provide consent for data to be used in this way.

ETHICS APPROVAL

Centre for Addiction and Mental Health (085/2020).

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