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Workplace trauma on the social housing and homelessness frontline

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Acronyms and abbreviations used in this report

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AHURI	Australian Housing and Urban Research Institute
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and other drugs
CHIA	Community Housing Industry Association
CHP	Community housing provider
CF	Compassion fatigue
CoP	Code of Practice
CRA	Commonwealth Rent Assistance
DFV	Domestic and family violence
EAP	Employee assistance program
ICH	Indigenous community housing
NASHH	National Agreement on Social Housing and Homelessness
NSW	New South Wales
NT	Northern Territory
PCBU	Person conducting a business or undertaking
PTSD	Post-traumatic stress disorder
Qld	Queensland
SCRGSP	Steering Committee for the Review of Government Service Provision
SHS	Specialist Homelessness Services
SOMIH	State owned and managed Indigenous housing
STHAs	State and territory housing authorities
STS	Secondary traumatic stress
Tas	Tasmania
US	United States
VT	Vicarious trauma
WA	Western Australia
WHS	Workplace Health and Safety

Glossary

A list of definitions for terms commonly used by AHURI is available on the AHURI website ahuri.edu.au/glossary.

Trigger warning for distressing content

This research responds to the need to understand more about the trauma experienced by frontline workers in homelessness and social housing services in their day-to-day work.

Throughout our report, but particularly in Chapter 2, we provide anonymised details of traumatic experiences that workers shared with us. Given the lack of documentation on the difficult experiences that workers in these sectors navigate on an ongoing basis, we felt it was important to share these experiences with some granularity.

However, these experiences may be distressing to readers, particularly those who have been exposed to trauma themselves. The report includes harrowing descriptions of the realities of clients' and tenants' lives, including physical and sexual assault, suicide and attempted suicide, deaths, use of weapons, medical emergencies, child abuse and family violence, all of which impact on workers. The report also includes quotes and descriptions of workers' distress and experiences of direct trauma—including physical assault and threats to kill.

Many of the workers we spoke with in interviews and workshops reflected that it was validating to see the extent of these distressing events documented. They wanted senior managers, CEOs, executives of organisations and policy makers to understand this element of their work. On behalf of our participants, we ask that you honour what they have shared by bearing witness and walking alongside them for a short while as you read this report.

Before doing so, we suggest you take a moment to consider signs that you may be feeling distressed—for example, feeling agitated or teary. If so, reflect on things you could do to help manage your distress and to remain grounded, such as going for a walk, having something to eat and drink, or playing with a pet. You may wish to read the report in sections over a period of time. But please do read it in full.

While workers shared details on their experiences of workplace trauma, they also provided us with detailed insights into the following:

1. The drivers of such experiences
2. The impacts on themselves, clients or tenants, and organisations—and on the sector more broadly
3. Current practices and persistent gaps in supports
4. A detailed list of how their work can be made safer.

We present these findings alongside existing evidence from frontline workers in homelessness and social housing services and allied sectors.

We are hopeful that reading through the detail of what workers experience will underscore the importance and urgency of efforts to reduce workplace trauma. We hope these findings will motivate you to work toward creating safer workplaces in the homelessness and social housing sectors.

Executive summary

Key points

- Workplace trauma can arise when someone is directly or indirectly exposed to traumatic events, information or experiences in the course of their work.
- For our research, we surveyed 578 frontline staff in the housing and homelessness sectors; interviewed frontline staff and stakeholders in New South Wales, Tasmania and Victoria; and facilitated workshops to investigate workplace trauma in the homelessness and social housing sectors.
- The report's findings reveal that exposure to workplace trauma is frequent and cumulative, and is embedded in frontline housing and homelessness work.
- These frontline workers navigate uniquely difficult challenges as they support clients/tenants. They experience moral distress when systemic factors prevent them from addressing clients' unmet needs, and they bear witness to clients' lived experiences of trauma.
- Frontline workers also experience direct trauma in the form of verbal aggression, threats and physical assault from clients and tenants. They are confronted with highly distressing events—including client deaths by suicide and overdose.
- Drivers of workplace trauma—which combine to cause cumulative harm—include daily trauma exposure, inadequate and unsupportive processes, poor work design and supports, chronic underfunding and poor conditions, and systemic barriers to supporting clients and tenants.

- **The impacts of workplace trauma are widespread and significant—and they affect many aspects of workers' lives. Many frontline staff—more than 40%, according to our survey—reported symptoms of post-traumatic stress that warranted further assessment. The great majority (90%) reported moderate-to-high vicarious trauma, while 61% reported one or more symptoms of burnout.**

- **A range of measures are currently in place to address workplace trauma—however, these practices are applied inconsistently within and between workplaces and are at times experienced as burdensome and tokenistic. Urgent further action is needed to address workers' health and safety.**

- **Sector-wide improvements to frontline workers' pay and conditions, work design and supports, are needed to reduce and mitigate workplace trauma.**

- **Addressing systemic issues is also critical. These include increasing the supply of social and affordable housing; increasing crisis accommodation options; and providing better client responses in allied systems.**

This research provides policy makers, peak bodies, service providers and workers with an evidence-base about the nature and extent of workplace trauma in social housing and homelessness services in Australia—including its causes and impacts and current practices to address it. The report outlines a suite of options to help mitigate workplace trauma in these sectors, as well as guiding principles for responding to this issue.

There is an urgent need to understand what is required to minimise the impact of workplace trauma and to create safer working environments for frontline staff, while ensuring that quality services are provided. The research presented in this report addresses the following questions:

RQ1: What events and experiences do frontline staff in social housing and homelessness services encounter at work that may lead to workplace trauma?

RQ2: What are the drivers of workplace trauma in housing and homelessness service delivery?

RQ3: What are the impacts of workplace trauma on housing and homelessness workers, organisations and service delivery?

RQ4: What is currently being done to address this issue in workplaces and what are the gaps?

RQ5: What can organisations and policy makers do to reduce workplace trauma and mitigate its impacts?

Key findings

Frontline staff in social housing and homelessness services may be directly exposed to trauma at work, through experiencing and responding to traumatic events, and indirectly, through ongoing exposure to the emotional distress and trauma of others.

Workplace trauma can be exacerbated by operational contexts, such as high caseloads and lack of supervision, and also by systemic factors, such as managing emergency situations that arise due to the failures and limitations of other services systems.

Workplace trauma can impact motivation, productivity and the ability to connect empathically with clients.

At an organisational level, the negative impacts of workplace trauma can lead to increased staff turnover and staffing costs, and recruitment and retention difficulties. Staff turnover and staff illness can affect the consistency and quality of services provided to clients/tenants. Together, these issues place considerable strain on social housing and homelessness organisations and have implications for the effectiveness and sustainability of the sector.

Negative events and experiences that may lead to workplace trauma

Frontline housing and homelessness workers are routinely exposed to challenging client and tenant interactions that result from unmet need.

In our national survey of 578 workers in the housing and homelessness sector, the great majority of participants (92%) observed hoarding and squalor, and clients/tenants under the influence of alcohol or other drugs (98%).

Hearing details of trauma and abuse that clients have survived and witnessing their distress are almost universal experiences (99%) among workers in the housing and homelessness sectors. For example:

- 95% of participants had spoken with clients/tenants about suicidal ideation
- 91% of participants had supported clients/tenants with experiences of family violence
- 88% of participants had clients/tenants who had engaged in self-harm.

In addition, more than three-quarters (78%) of participants had a client or tenant who had died, had supported a client or tenant who had survived a suicide attempt (or attempts), or who died by suicide (78%) or overdose (71%).

In the course of their work, frontline workers experience direct trauma through verbal aggression (96%) and threats against them or their families (85%), and through physical (59%) and sexual assault (28%) from clients/tenants. Many reported experiencing the presence of a weapon (including guns, knives and machetes) at work (60%).

Unsurprisingly, the majority of frontline workers (86%) had been concerned for their physical safety while at work. Most had reported a family violence incident to police (83%) or made a mandatory child protection report (77%). Many also have their own personal histories of trauma exposure. While these lived experiences were a source of strength, they can also be a source of vulnerability for frontline workers unless appropriate supports are in place.

Exposure to workplace trauma was frequent, cumulative and structurally embedded in frontline housing and homelessness work. Indeed, the housing and homelessness sector is uniquely exposed to trauma due to its role as the last resort for individuals with complex, high-risk needs, who are often without adequate support in other service systems.

The drivers of workplace trauma in housing and homelessness services

While client/tenant interactions were a source of trauma for frontline workers, we found evidence of numerous other drivers. Organisational factors exacerbated and, in some cases, outweighed the effects of challenging client/tenant interactions. These factors include:

- high workloads
- poor or absent supervision
- poor responses from organisations.

Many of these issues were sector-wide—for example, high case/tenant loads and lack of resources to meaningfully assist clients/tenants.

Systemic issues such as underfunding and services gaps also drive workplace trauma. Workers in this study grappled with feelings of hopelessness and moral distress due to system failures—including a lack of housing options, and gaps in the mental health system.

These findings were consistent with our review of the literature in homelessness and allied fields. Addressing workplace trauma in these sectors requires understanding and addressing the various drivers of the problem. Structural reforms are needed alongside improved individual and organisational supports.

The impacts of workplace trauma on workers, organisations and service delivery

Frontline staff in our national survey and our interviews identified a range of negative physical, emotional and mental health impacts of working in the social housing and homelessness sectors. Negative events and experiences create cumulative harm, with impacts compounding over time.

An alarming number of frontline staff in our national survey reported symptoms of post-traumatic stress that warranted further assessment (43%), high (47%) or moderate (44%) vicarious trauma, or one or more symptoms of burnout (61%).

Participants in both the national survey and interviews also described impacts suggestive of compassion fatigue and moral injury. Service delivery to clients/tenants was negatively impacted as distressed workers struggled to manage desensitisation to trauma, felt increasingly reactive and sometimes even dehumanising toward clients/tenants.

When staff took leave to care for themselves, this inadvertently increased workloads for other member of their teams, further exacerbating gaps in service delivery. Unplanned staff leave, high (and increasing) turnover and resultant increases in staffing costs made the difficult work of organisations in the sector more challenging.

Current practices for preventing and responding to workplace trauma

A range of measures currently in place to address workplace trauma in the housing and homelessness sectors include:

- incident-reporting systems
- employee assistance programs (EAPs)
- training
- reflective practice
- supervision.

However, there are significant gaps. Incident-reporting processes were often described as burdensome and disconnected from meaningful action to address staff concerns. EAPs were commonly viewed as inadequate and insufficiently tailored to the specific challenges of the sector. While training is widely available, participants identified substantial barriers to accessing it in a timely and consistent manner.

Stakeholders identified time pressures, under-resourced teams, and a lack of trained supervisors as factors that undermine services' ability to implement effective strategies to prevent and respond to traumatic incidents and support staff wellbeing. Conversely, when reflective supervision, peer support, and team-based wellbeing practices were available, they were highly valued, especially where managers promoted open communication and encouraged help-seeking.

However, despite participants acknowledging organisational efforts to manage workplace trauma, current practices were widely described as inadequate in preventing significant and widespread harm in these sectors.

Policy development options

Frontline workers and stakeholders suggested a range of changes that would reduce and mitigate workplace trauma in the social housing and homelessness sectors. Sector-wide reform is necessary, and additional government resourcing is essential to support sustainable change.

Changes included improvements in conditions such as pay, leave entitlements, flexibility, and improvements to recruitment and onboarding processes. Improving the skills and expertise of managers was suggested, along with dedicated funding for safety measures.

Improvements to work design included:

- fixed case/tenant loads
- adequate staffing levels and backfill
- an end to lone-worker models
- job or task rotation to give breaks from trauma exposure
- dedicated administration and decompression time built into daily schedules.

Suggested improvements for staff support included:

- provision of supervision—including clinical supervision (separate from line management)
- incorporating psychological first aid into services.

Participants also described improvements about how to manage critical incidents and requested EAPs where staff understood the work and had clinical skills in trauma. More support for after-hours and casual staff is needed, along with additional training on working with trauma, and time and space to embed learnings from training.

Frontline workers in social housing and homelessness sectors are impacted by a range of systemic issues. The biggest issue is the lack of affordable rental housing options for clients/tenants. This:

- impacts the ability of homelessness services to resolve people's homelessness—which increases the distress of both clients and workers
- limits the ability to move or evict tenants who pose safety risks.

Both frontline workers and stakeholders called for increased investment in homelessness services, a greater supply of social and affordable housing, improved responses for clients/tenants in allied sectors—especially mental health—and better collaboration and information-sharing between homelessness, social housing and allied sectors.

Increasing funding for homelessness and social housing services will be necessary to action the range of pragmatic suggestions outlined above.

Drawing on our findings, we developed a set of six principles to guide action on workplace trauma at the organisational and policy maker level:

1. Acknowledgement: Recognise that exposure to workplace trauma is frequent, cumulative and structurally embedded in frontline housing and homelessness work.
2. Holistic system investment: Social housing and homelessness services are part of a broader health and social care system that require increased investment.
3. Worker agency: Because workers understand their work deeply, change must be worker-led.
4. Commissioning safety: Program funding must include staffing and infrastructure to deliver services safely.
5. Culture of safety: It is not enough to have controls and responses in place—they must be effective.
6. Trauma-informed organisations: Trauma reduction will enhance organisational effectiveness and improve both worker and client/tenant wellbeing.

The study

The research used a mixed-methods design that incorporated four integrated components:

- a review of the national and international grey and academic literature on workplace trauma in homelessness, housing and allied sectors
- a national online survey of frontline staff in housing and homelessness sectors
- interviews with frontline staff in housing and homelessness services (in New South Wales, Tasmania and Victoria) and interviews with key stakeholders
- workshops with frontline staff and key stakeholders to stress-test findings and develop guiding principles for change.

1. Introduction

This research focussed on workplace trauma in social housing and homelessness services in Australia. While exposure to trauma may be unavoidable when working with marginalised client groups, there is limited understanding of what is needed within these workplaces to prevent trauma exposure, minimise the consequences of trauma when it occurs, and provide a safe working environment, while also ensuring that high quality and accessible services continue to be provided.

In this research 'workplace trauma' refers to the exposure, direct or indirect, to traumatic events or information that people may experience as a result of their work, and the consequences of this exposure. As Worksafe Victoria (2023: 54) explains:

> Work-related violent or traumatic events are incidents that can cause fear and distress and involve exposure to abuse, the threat of harm or actual harm. The fear and distress from violent or traumatic events can lead to work-related stress, psychological injury and physical injury. The impact of traumatic experiences can arise from a single distressing event, or from the cumulative impact of many events over time, including direct or indirect exposure.

To address this serious issue, the research was guided by the following questions:

1. What events and experiences do frontline staff in social housing and homelessness services encounter at work that may lead to workplace trauma?
2. What are the drivers of workplace trauma in housing and homelessness service delivery?
3. What are the impacts of workplace trauma on housing and homelessness workers, organisations and service delivery?
4. What is currently being done to address this issue in workplaces and what are the gaps?
5. What can organisations and policy makers do to reduce workplace trauma and mitigate its impacts?

This introductory chapter:

- provides an overview of the literature on trauma and prior research on workplace trauma exposure, with a focus on the social housing and homelessness sector
- reviews the legislative environment for workplace safety, including psychosocial safety, and the structural and policy context for social housing and homelessness services in Australia
- explains our research methodology
- outlines the structure of the report.

1.1 What is trauma?

Trauma has been defined in a variety of ways. We define it as an experience that engenders feelings of fear, helplessness or horror, ultimately overwhelming a person's coping mechanisms (Herman 1992; Hopper, Bassuk et al. 2009).

Psychological or emotional responses to traumatic events that involve real or threatened harm can occur in response to:

- a one-off event such as a natural disaster, car accident or witnessing someone be seriously harmed or killed
- distressing events and experiences that occur over a longer period of time—in other words, complex trauma—such as family violence, childhood abuse and neglect, and military conflict (O'Donnell, Varker et al. 2014).

People can develop trauma symptoms in response to direct involvement in a distressing event, such as being a victim of or witnessing violence. People can also experience trauma symptoms in response to indirect involvement, such as through hearing another person describe a traumatic event.

Trauma is cumulative, its effect compounding over time. While the negative effects of trauma exposure include psychological symptoms, trauma has a strong somatic component and is very much an embodied experience (Rothschild 2000). While most people will experience a traumatic event in their lifetime (Australian Institute of Health and Welfare [AIHW] 2022), such events are disproportionately borne by marginalised groups and inextricably linked to social problems including gender inequality, racism and poverty (Salter and Hall 2022).

The high incidence of trauma among people accessing homelessness and social housing services can have significant consequences for the health and wellbeing of frontline staff in these sectors (Lemieux-Cumberlege, Griffiths et al. 2023; Peters, Hobson et al. 2021; Robinson 2022; Waegemakers Schiff and Lane 2019), as well as for the community services sector more broadly (Louth, Mackay et al. 2019).

Frontline staff may experience trauma both directly and indirectly (Kerman, Ecker et al. 2023a; Lemieux-Cumberlege, Griffiths et al. 2023).

Direct exposure can occur through witnessing, responding to, or being involved in incidents of violence, physical or sexual assault or medical emergencies (Kerman, Ecker et al. 2023a). For example, recent research has drawn attention to the high risk of exposure to verbal and physical abuse faced by workers in homelessness service settings (Peters, Hobson et al. 2021).

Indirect exposure—which is sometimes referred to as 'vicarious trauma' or 'secondary traumatic stress'—arises through cumulative physical, emotional and psychological distress resulting from working with individuals who themselves have experienced traumatic events, or who are suffering from emotional and psychological distress (Bransford and Cole 2019).

1.1.1 Key trauma-related terms

The research relevant to workplace trauma, in and beyond the housing and homelessness sector, uses a range of concepts and terms. These terms include post-traumatic stress disorder (PTSD), vicarious trauma (VT), secondary traumatic stress (STS), burnout, compassion fatigue (CF), moral injury, and work-related stress. To contextualise this research and to illustrate the nature and extent of workplace trauma, these concepts and terms are reviewed below.

Post-traumatic stress disorder

PTSD is a mental health disorder that develops in the aftermath of surviving a traumatic event that involves 'actual or threatened death, serious injury, or sexual violence' (American Psychiatric Association 2022: n.p.). Individuals may develop PTSD due to experiencing the event directly, experiencing or witnessing the event in person, learning the trauma occurred to someone close to them, or by being exposed repeatedly to details of the event—for example, first responders.

To meet the criteria for a diagnosis of PTSD according to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR)* (American Psychiatric Association 2022), an individual must be exposed to a traumatic event and subsequently experience, for at least one month, a combination of:

- intrusive symptoms (e.g. nightmares)
- avoidance (e.g. of people or places or distressing feelings)
- negative changes in cognition and mood (e.g. fear or shame)
- changes in arousal and reactivity (e.g. angry outbursts or difficulty concentrating).

Certain types of traumatic events—for example, sexual assault—are more likely to lead to PTSD and tend to be experienced disproportionately by certain groups. For example, sexual violence disproportionately impacts cis-women and people who are gender diverse—in other words, trans and nonbinary people (Australian Bureau of Statistics [ABS] 2023a; Callander, Wiggins et al., 2019)—which helps to explain why women experience higher rates of PTSD than men (see Kimerling, Allen et al. 2018).

Vicarious trauma

VT is a constellation of negative psychological effects that occur among people in helping professions, as a result of both:

- ongoing exposure to others' lived experiences of traumatic events
- the past and ongoing distress associated with these traumas (Devilly, Wright et al. 2009; Steenkamp and Barket 2024).

According to Leung, Schmidt et al. (2023), VT leads to a change in the helper's cognitive schema. Relatedly, Devilly, Wright et al. (2009: 375) argue that VT refers specifically to changes in the helper's 'identity, world view, psychological needs, beliefs and memory system'.

VT is not acute; rather, it is a cumulative transformation with long-lasting effects (Leung, Schmidt et al. 2023). The term is sometimes used interchangeably with secondary traumatic stress (see for example Petrovich, Twis et al. 2021; Waegemakers Schiff and Lane 2019). Some argue that the development of VT is also influenced by the helper's empathic ability and personal trauma history (Devilly, Wright et al. 2009; Leung, Schmidt et al. 2023). VT is acknowledged as a risk inherent in the core work of community services organisations (Louth, Mackay et al. 2019).

Secondary traumatic stress

Similar to VT, STS develops in response to the details shared by trauma survivors and their distress and emotional reactions. The condition is characterised by symptoms akin to those of PTSD (Leung, Schmidt et al. 2023; Petrovic, Twis et al. 2021), including intrusion, avoidance, and changes to cognition and arousal (Devilly, Wright et al. 2009; Leung, Schmidt et al. 2023; Petrovic, Twis et al. 2021).

Where the concept of VT focusses on the changed psychology and worldview of the helper, the concept of STS relates to behavioural and emotional impacts (Ogińska-Bulik, Gurowiec et al. 2021).

However, there is an overlap between both concepts, and measures of VT and STS are moderately correlated (see for example Cao 2022). Cocker and Joss (2016) argue that STS is caused by the guilt and distress a helper feels when they perceive they cannot save or protect someone from harm. A systematic review of studies investigating STS and the personal trauma history of therapists found that having lived experience of personal trauma made the development of STS more likely (Leung, Schmidt et al. 2023).

Burnout

Burnout is a related but distinct concept that has three main dimensions: emotional and/or physical exhaustion, depersonalisation (e.g. detachment from clients and colleagues), and feelings of ineffectiveness and lack of accomplishment (Devilly, Wright et al. 2009; Scanlan and Still 2019; Waegemakers Schiff and Lane 2019).

Unlike STS and VT, burnout can occur in any work context where someone is overworked and experiences chronic workplace stress, not just in frontline or direct client-facing work (Henderson, Jewell et al. 2024; Scanlan and Still 2019; Steenekamp and Barker 2024). It is linked to workload and staff shortages (Henderson, Jewell et al. 2024). Cocker and Joss (2016) argue that burnout starts to occur when a staff member cannot achieve their goals or complete their work, leading to a loss of morale, a diminished sense of control, and frustration.

Compassion fatigue

CF was originally conceived as a type of burnout specific to care-giving work, arising from prolonged exposure to trauma and distress (Marshman, Hansen et al. 2022).

CF is often cited as a consequence of working in human services (Steenekamp and Barker 2024). It involves feelings of physical and mental exhaustion, reduced ability to feel empathy or sympathy for clients or patients, reduced job satisfaction, and development of maladaptive coping behaviours (Cocker and Joss 2016).

CF can also include difficulty concentrating and sleeping (Cocker and Joss 2016) and affects a worker's ability to build trusting connections with clients or patients (Steenekamp and Barker 2024). It has been linked with decreased quality of care or support for patients (Cocker and Joss 2016) and high staff turnover (Marshman, Hansen et al. 2022). A systematic review of CF among mental health nurses identified a number of protective factors, including leadership that is supportive and consistent over time, clinical supervision and reflective practice (Marshman, Hansen et al. 2022).

Moral injury

Although there is no consensus definition of moral injury (Griffin, Purcell et al. 2019), it is generally understood to arise from perpetrating or witnessing acts that violate a person's core moral beliefs (Litz, Stein et al. 2009; Shay 2014).

The concept of moral injury originated with the experiences of military personnel who faced moral and ethical dilemmas during combat (Litz, Stein et al. 2009), but it has since been recognised in various professions, including healthcare and social services (Thibodeau, Arena et al. 2024; Williamson, Stevelink et al. 2018).

In care settings, moral injuries may result from experiences such as being unable to provide necessary care due to resource constraints, witnessing malpractice, or failing to prevent patient mistreatment (Čartolovni, Stolt et al. 2021).

Moral injury can lead to profound feelings of guilt, shame and betrayal, with significant consequences for mental health and increased risk of depression, anxiety and PTSD (Griffin, Purcell et al. 2019).

Work-related stress

Work-related stress is a physical and psychological reaction that occurs when a person 'perceives the demands of their work exceed their ability or resources to cope' (Safe Work Australia 2022). A worker may become stressed by direct exposure to stressors (such as verbal abuse) or by the risk of direct stressors not being properly managed or controlled. While stress can occur in any job or workplace, prolonged exposure to stress can cause physical and emotional harm (Safe Work Australia 2022) and constitutes a hazard according to the National Model Code of Practice (discussed in Section 1.3).

1.1.2 Workplace trauma in the housing and homelessness sector

Workplace trauma can reduce workers' motivation, productivity and their ability to connect empathically with clients (Kerman, Ecker et al. 2023a; Louth, Mackay et al. 2019). Prolonged exposure to critical events and chronic stressors at work is related to increased risk of post-traumatic stress and general psychological distress (Kerman, Ecker et al. 2023a).

At an organisational level, the negative consequences of workplace trauma include:

- workplace injuries
- increased staff turnover and associated costs
- recruitment and retention difficulties
- workers' compensation claims.

Further, staff turnover and staff illness can affect the consistency and quality of services provided to people in marginalised communities (Kerman, Ecker et al. 2023a). Together, these issues can have a significant impact beyond individual workers, including on clients, housing and homelessness service organisations, and the sector more broadly.

When workplace trauma occurs, broader factors mediate the consequences for staff and organisations. Operational factors, including high caseloads, lack of training around trauma, lack of supervision, and lack of time for self-care heighten the effect of trauma exposure (Kerman, Ecker et al. 2023a; Louth, Mackay et al. 2019). In contrast, there are factors that can mitigate these effects. Work satisfaction, informal support from colleagues, and being able to celebrate small wins with clients are factors that have been found to play a protective role (Louth, Mackay et al. 2019). Professional supervision is also critically important, although on its own is an inadequate strategy for managing trauma symptoms (Kerman, Ecker et al. 2023a).

People experiencing homelessness and accessing social housing are some of the most disadvantaged members of our community and are disproportionately likely to have experienced trauma (Buhrich, Hodder et al. 2000; Louth, Mackay et al. 2019). Many have PTSD (O'Donnell, Varker et al. 2014; Taylor, Thielking et al. 2022) or have survived complex trauma in childhood (Keane, Magee et al. 2016). Traumatic injuries, such as traumatic brain injury, are also common (Hartanto and Mackelprang 2019). Even homelessness itself is considered a traumatic experience (Hopper, Bassuk et al. 2009; Robinson 2014). Working with people experiencing homelessness can therefore be a source of indirect trauma. Workers in these sectors can also experience direct trauma via critical incidents, such as client/tenant death or overdose, as well as verbal, physical and sexual aggression (Kerman, Ecker, et al. 2023a).

Research also suggests that workplace trauma in the housing and homelessness sector has systemic drivers. Accessing homelessness services is often the last resort when complex mental health, substance use and trauma supports are unavailable or access is restricted (Kerman, Ecker et al. 2023b; Robinson 2022). In such situations, frontline staff must manage clients who require complex, multidisciplinary support in service models that have not been designed for this task, and who lack the necessary specialist training (Robinson 2022).

The housing and homelessness sector also increasingly recognises the importance of having staff with lived experience of homelessness or social housing (Black 2014; FEANTSA 2015). Alongside the benefits of this for organisations and clients, it is important to acknowledge these workers themselves live with the effects of trauma. We need to better understand how such workers can be safe at work and ensure that the systems, supports and workplace cultures that enable them to do so are understood and resourced.

Cultural safety is particularly important for Aboriginal and Torres Strait Islander workers (Aboriginal Housing Victoria 2020; Tually, Tedmanson et al. 2022). According to the Community Housing Industry Association (CHIA) of Victoria, 43% of the Victorian community housing sector workforce have lived experience of housing insecurity, and this increases to 58% in frontline tenancy management roles (CHIA Victoria 2023). A survey by Cortis and Blaxland (2024: 47) found that community sector workers employed because of their cultural knowledge or lived experience 'faced unique challenges compared to other workers in the sector', *i*ncluding stigmatisation, discrimination, and a greater need for self-care. Indigenous Australian workers in the community sector faced racism, a lack of recognition and understanding of culture, and complex dynamics within their own communities.

There has been limited research into the prevalence and impact of trauma among frontline workers in these services. This is despite the pervasive nature of workplace trauma, its impact on the wellbeing of those exposed, and the nature of work in the housing and homelessness sector. While a handful of studies have been published internationally (see for example, Kerman, Ecker et al. 2023a; Petrovich, Twis et al. 2021; Waegemakers Schiff and Lane 2019), there is only one study to date investigating workplace trauma in the housing and homelessness sector in Australia (Cao 2022).

However, the limited evidence that does exist suggests that trauma is a significant and pressing issue for the sector. One international study found that nine in 10 homelessness services staff have experienced direct trauma exposure in the course of their work—which is a rate comparable to that of staff working in inpatient psychiatric settings (Kerman, Ecker et al. 2023a). Another study on the mental health of emergency shelter workers in Canada found that more than one-third of the 400 participants screened positive for symptoms of PTSD (Waegemakers Schiff and Lane 2019). Other recent research examining STS levels among homelessness workers in Texas (Petrovich, Twis et al. 2021) highlighted the gendered dimension to trauma exposure in homelessness services because of the predominance of women workers.

1.2 The social housing and homelessness sector

The following sections provide an overview of the social housing and homelessness sector in Australia and outline the policy and service context that shapes workplace experiences for those working in the sector—including exposure to trauma.

The 'social housing and homelessness sector' is a term that encapsulates the range of services and support provided to Australians in need of assistance with housing. 'Social housing' is an umbrella term for public housing, which is owned and managed by state and territory housing authorities (STHAs), and community housing, which is managed by community housing providers (CHPs), but owned by either CHPs or the applicable STHA. State owned and managed Indigenous housing (SOMIH) is a form of public housing available only to Aboriginal and/or Torres Strait Islander people. Indigenous community housing (ICH) is a form of community housing operated by Indigenous community organisations (Steering Committee for the Review of Government Service Provision [SCRGSP] 2025).

Support for people who are homelessness or at risk of homelessness is provided through Specialist Homelessness Services (SHS). These services offer a range of support, including providing or facilitating access to emergency or crisis accommodation, medium-term or transitional housing and long-term housing. SHSs also provide advice and information, advocacy, material aid, family violence support, financial information, transport, help with living skills and personal development, meals, assistance with trauma (for clients who have experienced or witnessed a traumatic event including family violence and physical and sexual assault) and family and relationship assistance (AIHW 2025).

1.2.1 Funding

As of July 2024, the primary housing and homelessness assistance funding agreement between the Australian Government and the states and territories is the National Agreement on Social Housing and Homelessness (NASHH), supported by bilateral agreements between the Commonwealth and each state and territory. This agreement provides funding for social housing and for SHS. It also requires all states and territories to develop a publicly available housing and homelessness strategy. The NASHH replaces the previous National Housing and Homelessness Agreement (NHHA), although its provisions are largely consistent with that agreement.

Funding for homelessness services is provided by the two levels of government on a matched basis. However, state and territory governments are responsible for service delivery (SCRGSP 2025) and directly commission SHS services from not-for-profit providers. State and territory governments are responsible for issuing service guidelines for practice within their jurisdiction, and for monitoring quality standards. Government funding is the primary revenue stream for the SHS system (James, Dunlop et al. 2023).

Funding for social housing services is complex. Both CHPs and STHAs receive income from rent paid by tenants—but as these rents need to be within the range deemed affordable to tenants, they are constrained by the very low incomes of most tenants. CHPs can leverage additional rental revenue by setting rents to capture the maximum available Commonwealth Rent Assistance (CRA). However, STHA tenants are not entitled to CRA, so STHAs bridge the gap between operating costs and rental income largely through revenue forgone or by reducing other costs, such as expenditure on maintenance.

1.2.2 Social housing: homes and households

Under the reporting framework used by the Productivity Commission to assess the performance of government services (SCRGSP 2025), social housing stock comprises public housing, community housing, SOMIH and ICH, although public and community housing are the two dominant types.

For well-documented reasons (see for example Lawson, Denham et al. 2019), public housing stock numbers are in steady decline. This decline has been offset by growth in community housing, although the net outcome has largely been stagnation. Between 2015–2024, the number of:

- public housing dwellings fell from 321,627 to 297,684
- community housing dwellings rose from 76,620 to 118,817
- SOMIH and ICH dwellings increased from 25,678 to 33,401 (SCRGSP 2025).

This represented a net increase in social housing stock of 28,977 across the decade.

However, research based on 2016 Census data estimated that 727,300 new dwellings would be needed by 2036 to meet demand—with 433,400 of those dwellings needed to meet immediate (i.e. then-current) need (Lawson, Denham et al. 2019). Therefore, growth over the past decade has represented just 6.7% of what would have been required to meet existing additional need in 2016. It should be noted that the National Housing Accord (Australian Government 2022: 1) and the Housing Australia Future Fund provide avenues for increasing social housing stock over time.

Community need for social housing is reflected in the long waiting times for a dwelling. For example, the median wait time for new public housing tenants nationally is nine months (SCRGSP 2025). Strict eligibility and targeting to need—and widespread awareness of these factors among potential tenants—means that waiting lists are a conservative measure of existing demand. But even with these caveats, the number of households on the waiting list is high: in 2023–24, 71,652 households categorised as in greatest need were waiting. This figure represents 42.5% of the entire waiting list of 168,552 households (SCRGSP 2025).

Households defined as 'in greatest need' are those who are homeless or in housing that is inappropriate to their needs, adversely affecting their health, or placing their life and safety at risk, or those who have very high rental costs (SCRGSP 2025). The proportion of allocations to households deemed in greatest need has increased steadily over the past three years. Although eligibility and tenure are managed differently according to jurisdiction, effectively all the households in public housing are on low incomes—with a national average of 99.9%. The proportion of households in community housing and SOMIH on low incomes are only fractions of a percentage point less (99.6%) than for public housing (SCRGSP 2025).

The disparity between demand and supply means that access to social housing is triaged, and frequently households must demonstrate urgent need across multiple dimensions of their lives in order to be allocated a home (Morris, Robinson et al. 2024). The level of exposure to trauma among successful applicants means that social housing tenants are disproportionately likely to carry substantial trauma of their own. Many of these tenants will also have been supported into social housing through the SHS sector.

1.2.3 Homelessness services: client needs and service responses

According to estimates based on the 2021 census, the rate of homelessness in Australia on a given night is 48.2 people per 10,000 in the population—or 122,494 people in total. The rate is much higher in the Northern Territory (564 per 10,000, compared to Victoria, which has the next highest rate of 47 per 10,000). This is connected to the disproportionately high rates of homelessness among Aboriginal and Torres Strait Islander peoples; over a fifth (20.4%) of all people experiencing homelessness are Indigenous (ABS 2023b).

SHS services are the primary means of support for people experiencing homelessness, but SHS also support people who are deemed at risk of homelessness. There are around 1,800 SHS providers across Australia, and they vary widely in size and scale (AIHW 2025). In 2023–24, SHS services supported 280,100 people (AIHW 2025). Most people needed help with accommodation, but access to this is constrained. In 2023–24, 58% of clients reported a need for accommodation, but around a third (31%) of these clients were neither provided with accommodation nor referred to an accommodation provider (AIHW 2025). The issues are particularly acute in relation to finding long-term accommodation. In 2023–24, 70% of clients needing long-term accommodation were neither provided with it, nor referred to a service that could provide it (AIHW 2025).

People experiencing homelessness have a diverse range of needs, and this is reflected in SHS data. As well as needing support with imminent risks to their housing and homelessness, clients may also be experiencing:

- poverty
- mental health issues
- family violence
- relationship breakdown
- health problems
- disability
- unemployment
- problematic substance use
- sexual abuse
- criminal justice system involvement
- challenges with immigration services
- involvement with child protection
- disengagement from education (AIHW 2025).

The complexity of need is illustrated by the results of a community sector survey conducted in 2024, which asked participants to identify which of a list of issues affected the clients they served. The options included mental health issues, trauma, disability, health issues, isolation, domestic and family violence, and poverty. Participants working in the social housing and homelessness sector identified a mean number of 11.2 issues per client, which was the highest for all the sectors surveyed (Cortis and Blaxland 2024).

1.2.4 The workforce

The Australian community sector workforce is composed predominantly of women, and this has contributed to the skills and experience present in the sector being less acknowledged and valued, with consequences for pay and working conditions (Cortis and Blaxland 2024). This gender imbalance is mirrored in the housing and homelessness sector workforce—in one survey, 72.6% of participants from the housing and homelessness sector were women, compared to 73.4% for the community sector overall (Cortis and Blaxland 2024).

There are no minimum entry-level qualifications to work in the homelessness sector (James, Dunlop et al. 2023), nor, in most cases, in the social housing sector. In one state, an advertisement for a tenancy services team-leader position listed no essential requirements other than standard pre-employment checks.[1] However, this does not mean that the workforce is unskilled. Cortis and Blaxland (2024) emphasise the complex and nuanced nature of community services work, and the extensive skills and capabilities that workers need to possess. However, a lack of required qualifications does imply that some workers are likely to be entering these roles with limited prior knowledge regarding the complex needs of clients who are served by community services organisations. Throughout the social housing sector, there is significant reliance on on-the-job training (CHIA Victoria 2023).

It is difficult to quantify the size of the social housing and homelessness workforce. Data about the frontline public housing workforce is obscure, as most reporting on the public sector workforce profile is at a headline level only, and it is similarly challenging to identify the number of frontline workers in the community housing sector or the SHS sector. The AIHW welfare-workforce data is not broken down sufficiently by sector (see AIHW 2023). Although the size of the workforce is unclear, it is generally acknowledged to be under pressure.

The data documenting these pressures is fragmented, but consistent. Difficulties with recruitment and retention may be higher in the housing and homelessness sector than in the community sector in general, if results from one New South Wales study (Cortis and Blaxland 2017) hold true across jurisdictions. In the Victorian community housing sector, staff turnover was at 25.6% in 2017–18, and although this fell to 17.5% during 2020—which was a period of significant COVID-19 controls in Victoria—it was back up to 24.7% by 2021–22 (CHIA Victoria 2023). This turnover was attributed primarily to lack of career progression within the sector, but workload may also have been an important factor, as it was a source of job dissatisfaction for 55% of surveyed workers (CHIA Victoria 2023).

Previous research has found that operation of the SHS workforce is heavily influenced by the SHS funding model, which does not support the full cost of safe service delivery (James, Dunlop et al. 2023). This reflects a wider concern: the 2023 Australian Community Sector Survey identified that only 9% of organisational leaders reported that funding covered the full cost of service delivery, down from 20% the previous year (Cortis and Blaxland 2023).

In social housing, revenue is constrained by the limited capacity for people on very low incomes to pay rent. While CHPs can use CRA to bridge at least some of the gap between the cost of delivering the service (which includes staffing costs) and the rents tenants can afford to pay, this option is not available to the public housing system—a feature that is unusual by global standards (McNelis 2006). Under-resourcing may contribute to the observed staff turnover in the sector, because it adds to the pressure people are working under.

1 This example is taken from a Homes Tasmania recruitment advertisement. The position has now, presumably, been filled, so the advertisement has been taken down, but a copy of the position description is available from the authors on request.

James, Dunlop et al. (2023) found that job design in the SHS sector was diverse enough to be almost entirely individualised. In social housing, the main frontline roles are divided into tenancy management and asset management, although these are not necessarily discrete roles, and many frontline workers perform aspects of both. Both types of work require more intensive knowledge of and interaction with clients, sometimes in a compliance-focussed context (CHIA Victoria 2023).

1.3 Workplace trauma as a health and safety issue: legislative context

The effects of workplace trauma are a form of psychosocial harm, which is increasingly and rightly recognised as a workplace health and safety (WHS) issue. Provisions on managing psychosocial risk, which would include the risk of workplace trauma, were added to model WHS regulations at the start of 2023, and Safe Work Australia (2022) has produced a Model Code of Practice, which has already been enacted in New South Wales, Queensland, Western Australia and Tasmania. These changes increase the expectation that workplaces, including in the housing and homelessness sector, must respond effectively to psychosocial hazards such as workplace trauma.

While a comprehensive description of WHS legislation and associated duties can be found in the relevant Acts (e.g. *Model Work Health and Safety Act 2011*) and regulator websites (e.g. Safe Work Australia), what follows is a brief overview of legislation in Australia, including:

- who is responsible for WHS
- what those people are required to do
- how WHS legislation is enforced
- specific information about WHS provisions on psychosocial safety.

1.3.1 General health and safety

Everyone in a place of work has a legislative responsibility for WHS, though certain individuals—such as managers and senior executives—have more responsibility than others. In addition to their own employees, organisations also have responsibilities for WHS in their supply chain.

WHS legislation is set and enforced at the state and territory level. In response to concern about variation across jurisdictions, a national Model Workplace Health and Safety Act (the Model Act) was developed in 2011. Most jurisdictions have adopted this Model Act in part or in its entirety. WHS legislation in all jurisdictions sets out the responsibility of all persons in a workplace, including employers, managers, workers, visitors, customers and patients, to contribute to the health and safety of themselves and others to some extent. However, the primary duty holder is the person conducting the business or undertaking (PCBU). A PCBU can be an individual (e.g. a sole trader) or an organisation (e.g. a private company or a government department). In the context of housing and homelessness services, PCBUs will typically be a government agency or community services organisation. These organisations have a legislative duty to eliminate or minimise the risks to health and safety of their workers and any others affected by the work being carried out.

In addition to these primary duties for risk management at the organisational level, some individual office-holders can be personally liable for WHS if they make significant decisions affecting health and safety, such as a CEO or financial manager. Workers, including contractors and volunteers, have a responsibility to contribute to compliance with WHS legislation and WHS policy in their organisation. Other persons such as visitors and customers are required to take reasonable care of their own health and safety and to comply with instructions (Safe Work Australia 2024a).

In larger organisations, WHS is managed by a specific WHS or human resources manager or team. Workers also have a right to be represented in matters relating to WHS, and this right is often reflected by an employee acting as an elected WHS representative within an organisation. WHS managers—in some cases with input from WHS representatives—design and implement WHS systems to manage WHS risks in their organisation, including identifying hazards, designing and implementing risk controls, and reporting WHS incidents.

Compliance with WHS legislation is formally monitored and enforced by government regulators. Regulators have both educational and compliance functions, providing information and advice to duty holders about how to comply with their WHS obligations, and enforcing compliance through inspectors who conduct audits and issue penalties and improvement notices (Safe Work Australia2024c). Trade unions are also authorised under WHS legislation to monitor WHS compliance, including by entering worksites to inspect potential breaches (Safe Work Australia 2024d). Individuals can also report non-compliance to the regulator, a union, or a WHS representative.

1.3.2 Psychosocial health and safety

WHS legislation has always prescribed responsibilities to manage risks to both physical and psychological health and safety. However, a major review of the Model Act in 2018 (Bollard 2018) found that the duty to manage psychosocial risks had been inadequately acknowledged and implemented. As a result, the Model Act was amended in 2023 to explicitly articulate a responsibility for all duty holders to protect workers from psychosocial risk (Safe Work Australia 2023).

Such psychosocial risk can stem from a wide range of work factors, including:

- lack of worker support or supervision
- interpersonal relationships—such as interpersonal conflict, harassment and bullying
- work design—such as time pressure, excessive workload or work pace, role conflict, poor job control or procedural and relational injustice
- work content—such as processing traumatic material, working with traumatised clients, exposure to violence.

All these factors have the potential to harm the psychological health of workers (Safe Work Australia 2022).

Most jurisdictions have adopted the amended Model Act to explicitly nominate a duty of care for psychological health. Yet even without adopting the amendments, existing WHS Acts still include a duty of care for psychological health and safety.

While legislation defines key duties and principles, specific guidance on employer duties is articulated through Codes of Practice (CoP). Although these are not laws, they can be used in compliance and prosecution as evidence of feasible risk-management practice (Safe Work Australia 2024). There are CoPs on psychosocial risk management nationally (Safe Work Australia 2022) and in most jurisdictions (e.g. Safe Work NSW 2021). Many of these CoPs pre-date amendments to the Model Act and associated state and territory legislation, again reinforcing the prevailing duty of care for psychological health that exists regardless of recent amendments. Table 1 summarises which jurisdictions have adopted the Model Act, and which have a specific CoP for psychosocial risk management.

Table 1: Legislative and Codes of Practice provisions on psychosocial risk management in states and territories

Jurisdiction	Legislation	Code of Practice
ACT	Adopted Model Act provisions	ACT Code of Practice
NSW	Adopted Model Act provisions	New South Wales Code of Practice
NT	Adopted Model Act provisions	Adopted Model Code
Qld	Adopted Model Act provisions	Queensland Code of Practice
SA	Adopted Model Act provisions	No; Safe Work SA provides a psychological health safety checklist and a psychosocial risk assessment tool
Tas	Adopted Model Act provisions	Adopted Model Code
Vic	Victoria has not yet adopted Model Act provisions, however, the *Victorian Occupational Health and Safety Act 2004* includes psychological safety in its definition of health and safety. Victoria also recently passed the Occupational Health and Safety (Psychological Health) Regulations 2025	No; Victorian Code of Practice under development
WA	Adopted Model WHS provisions	Adopted Model Code

Source: Authors' summary of WHS legislation and Codes of Practice.

Under the national CoP (Safe Work Australia 2022), practical guidance is provided on the identification and management of risk. Trauma is referenced 40 times in the Model Code, both as a form of psychological harm arising from severe hazard exposure, and in relation to hazards with potential to be traumatic—such as traumatic events or traumatic material. As hazards with the potential to cause trauma are identified as severe, the CoP emphasises the importance of proactive risk management.

The first stage in risk-management guidance under the CoP is to identify hazards by consulting with workers. Surveys, observation, and analysis of administrative records—for example, incident reports and workers' compensation claims—are also nominated as potentially useful risk-identification activities. Assessment of risk requires consideration of the duration, frequency and severity of workers' exposure to hazards, with higher levels of hazard exposure requiring more proactive risk-management strategies. Examples of hazards are provided to illustrate risk assessment in practice. For example:

> A worker exposed to aggressive customer behaviour is more likely to be harmed if at that time they do not have other workers present to support them and do not have the control to alter the way they work to de-escalate the situation. (Safe Work Australia 2022: 23).

One section of the CoP (pp. 45–46) outlines a range of practical examples for controlling exposure to traumatic events or material. Some examples include:

- designing work to minimise the number of workers exposed
- scheduling tasks associated with these risks to limit exposure
- establishing safe work systems to record, respond to and review incidents
- training supervisors and staff on responding to trauma
- ensuring recruitment practices incorporate realistic job information so that workers are aware of trauma-related risks.

1.4 How did we do the research?

There were four integrated components in this study:

1. A review of national and international grey and academic literature.
2. A national online survey of frontline staff in social housing and homelessness services.
3. Interviews with key stakeholders and frontline staff in social housing and homelessness services.
4. Workshops with selected interviewees and those who expressed interest via our online survey.

Ethics approval for the research was obtained through the Swinburne University of Technology Human Research Ethics Committee and ratified by the University of Tasmania and the University of New South Wales Human Research Ethics Committees. A trauma-informed approach to data collection was used throughout the study, including through the development of distress protocols to support participants (and researchers) during and after data collection.

1.4.1 Literature review

As noted earlier, there is limited Australian literature on workplace trauma specific to the housing and homelessness context. As a result, the literature review drew on national and international grey and academic literature on workplace trauma, including in the community sector and allied fields, such as mental health, nursing, child protection, family violence, and social work. We also mapped the WHS legislation and CoP in each state and territory and reviewed sector workforce development strategies to understand the legislative and policy context that shapes responses to workplace trauma. Some findings from the literature review are included in this chapter, while other relevant literature is discussed in later chapters alongside data and study findings.

1.4.2 National online survey

An online survey tool was developed for the purpose of this research. It included a suite of demographic questions—including questions about participants' current and past roles—as well as questions about the sort of negative events and experiences participants encounter at work. The survey also included questions about the impacts of these experiences, with three sets of questions to screen for VT symptoms, PTSD symptoms, and burnout. A set of questions was included about the sorts of training workers were provided in their roles, as well as existing supports. Some of these items were taken from the trauma-informed organisations toolkit (Guarino, Soares et al. 2009). Further questions were developed based on the idea of 'systems trauma' (Kerman, Ecker et al. 2022b) in the Australian context. Finally, several short-answer questions asked what participants felt was currently working well to prevent and reduce workplace trauma, and what else needed to be done.

The four-item version of the PTSD Checklist-5 was used to screen for PTSD symptoms (Zuromski, Ustun et al. 2019). Although PTSD can only be diagnosed by a qualified health or mental health professional, this brief screening tool can identify individuals whose symptoms warrant further assessment. Each item corresponds to one of the PTSD symptom clusters, as per the DSM-5-TR. Respondents were asked to indicate how much each symptom had bothered them in the past month on a scale from 0 (not at all) to 4 (extremely). Scores are summed across the four items, with possible totals ranging from 0 to 16. Following the recommendation of Portillo-Van Diest, Vilagut et al. (2023), a score of seven or above indicates a positive screen for post-traumatic stress symptoms and indicates a need for further assessment by a qualified mental health professional. Within our sample, scores ranged from 0 to 16, with a mean of 5.82 and a standard deviation of 4.39. Internal consistency using Cronbach's alpha was good ($\alpha = 0.86$). This suggests that results from the scale are reliable in this study.

For VT, we used the Vicarious Trauma Scale (Vrklevski and Franklin 2008). This tool was developed in Australia to assess the impact of exposure to traumatic materials among solicitors and is a commonly used tool to assess for symptoms of VT, including among frontline workers in homelessness services (for example Cao 2022). Respondents are asked to rate their agreement with eight statements about things they experience at work and their emotional reaction to them on a Likert scale from 1 (strongly disagree) to 7 (strongly agree). Total scores range from 8 to 56 and can be grouped as low (8–27), moderate (28–42) and high (43–56) (Vrklevski and Franklin 2008). Within our sample, scores ranged from 8 to 56, with a mean of 40.91 and a standard deviation of 9.74. Cronbach's alpha indicates good internal consistency for the measure within our survey sample (0.87).

To measure the prevalence of burnout among our survey participants, we used the Single Item Measure of Burnout (Rohland, Kruse et al. 2004). This scale asks participants to provide a self-assessment of burnout by selecting one of five statements that best describes their current level of burnout. Statements are ranked from 1 through 5, with a score of 3 or more considered an indication of one or more symptoms of burnout. Dolan, Mohr et al. (2015) found this single-item measure was a reliable alternative to the Maslach Burnout Inventory Emotional Exhaustion subscale. We used this short-form item rather than the longer inventory to reduce the survey burden on participants.

The survey was distributed nationally through the researchers' professional networks, including through national and state/territory peak bodies, large SHS and CHP services with whom the authors had existing relationships, some STHAs, and an existing repository of frontline workers' email addresses from a prior study. The Australian Services Union also circulated an invitation to participate to members in Victoria and Tasmania.

The survey responses were collected from late October 2024 to early February 2025. In total, 910 individuals consented to the study. Some respondents started the survey but were screened out as ineligible—for example, they did not work in the SHS or social housing sector (n=102). Some responses only included answers to a few demographic questions and no further questions (n=227), and some respondents (n=3) had completed the survey but then requested to withdraw their answers from the study in a final survey question that reiterated participant consent.

After ineligible and incomplete data were excluded, a total of 578 survey responses were retained for data analysis. The valid number of responses varies slightly for each question and is therefore reported for each item throughout our report. Of the 578 responses, 93 were from people working for CHPs, 376 were from workers in SHS and 109 were from STHAs.

The survey had almost national coverage (there were no respondents from Northern Territory), with the majority of respondents in Victoria (265 responses), New South Wales (121 responses) and Queensland (109 responses).

It is important to note that lower survey participation in some regions, particularly remote and very remote contexts, means that the perspectives of workers in these settings may not be fully captured.

Tables 2 and 3 present the number of survey responses by sector and by state/territory respectively.

Table 2: Total number of survey participants by sector

Sector	Number of participants
Community housing provider	93
Specialist homelessness service	376
State and territory housing authority	109

Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

Table 3: Total number of survey participants by state or territory

State or territory	Number of participants
New South Wales	121
Victoria	265
Queensland	109
South Australia	23
Western Australia	33
Tasmania	23
Northern Territory	0
Australian Capital Territory	4

Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

Survey participants were predominately women (75.3% of responses), aged between 24 and 55 (78.1%), with a roughly even distribution across the decades in that range, and well educated (14.3% had a postgraduate qualification, 62.5% an undergraduate qualification, and 14.7% a vocational education and training qualification). Some 6.6% identified as Aboriginal, Torres Strait Islander, or both.

Most participants worked in a greater capital city (63.1%); only 2.6% worked in remote areas and the rest worked in regional locations. A large majority worked directly with clients and tenants (88.8%), and 36.3% were responsible for supervising other frontline workers. The most common cohorts with which participants worked were people experiencing or at risk of homelessness (84.4% of participants), Aboriginal and/or Torres Strait Islander peoples (73.8%) and women (72.8%). More than half (61.8%) of participants had been working in the sector for one to nine years; a quarter (25.8%) had worked in the sector for 10 to 20 years. Most (78.3%) said they intended to be in the same job in 12 months' time.

Detailed information about survey participants can be found in Appendix 1.

1.4.3 Interviews: frontline workers and stakeholders

Twenty-one frontline workers across the housing and homelessness sector were interviewed using a semi-structured approach. Interviewees were recruited from the online survey participants who expressed interested in participating in a follow-up interview. Of the interviews conducted, five were with workers in CHPs, nine with SHS workers, six with workers from STHAs, and one with a community service worker. There were 14 women and five men interviewed—three participants did not disclose their gender—and they ranged in age from their 30s to their 60s. None of the interviewees identified as Aboriginal or Torres Strait Islander. The interviewees had many years of experience in the housing and homelessness sector, and some also had experience in related sectors, such drug and alcohol services. The length of time they had worked in the homelessness, social housing and allied sectors varied from five to 35 years.

Frontline workers were asked about:

- their experiences of workplace trauma in general and specifically
- the responses to and drivers of workplace trauma in their workplace
- what needed to be done to address workplace trauma.

Stakeholders were people working in senior roles in SHS (four participants), CHPs and STHAs (two each), peak bodies (two), and unions representing housing and homelessness workers (four). Since only a smaller number of these interviews were conducted, sampling aimed for breadth rather than depth. In total, 14 stakeholders were interviewed, with some interviews including more than one participant. Stakeholders were asked about:

- how WHS—and particularly trauma risk—was managed in their organisations or the sector
- the nature, drivers and consequences of workplace trauma in their organisations/sector
- responses to workplace trauma.

Interviews with both groups were conducted either in person or through video-conferencing technology and were transcribed for analysis. Where quotes have been presented in the text, they have been edited for readability and clarity, while preserving meaning.

1.4.4 Workshops with stakeholders and frontline staff

Three online workshops were held—one with stakeholders and two with frontline workers—to discuss the emerging research findings and to identify any critical gaps or omissions. Frontline workers were engaged separately, as the findings indicated that organisational responses play a key role in mediating the impacts of workplace trauma. This separation aimed to ensure participants did not feel compromised or inhibited by the presence of senior managers, even if those individuals were from different services or organisations.

Workshop attendees were recruited from the pool of participants who were interviewed in the previous phase of the project. There were 12 participants in the workshops, four in the key stakeholder workshop and three and three respectively in the frontline worker workshops. Although attendance was limited due to the sector's intense workloads, the small group sizes supported full and frank discussions.

1.5 Structure of the report

This report is structured around our five research questions, with a chapter dedicated to each, followed by a concluding chapter.

Chapter 2 draws on our fieldwork to document the nature and extent of workplace trauma in the social housing and homelessness sectors, focussing on the range of negative events and experiences that workers deal with, as well as their frequency.

Chapter 3 explores the drivers of workplace trauma exposure, which are grouped as follows: individual (e.g. personal trauma), client/tenant interactions (e.g. exposure to distress and workplace violence and aggression), organisational (e.g. high workloads, poor supervision), and systemic (e.g. underfunding, service gaps).

Chapter 4 describes the impacts of workplace trauma for workers, for services delivery to clients, and for organisations.

Chapter 5 describes current practices to address workplace trauma and the gaps in or limitations of existing practices.

Chapter 6 presents a detailed suite of options collected in our fieldwork for improving prevention of, and responses to, workplace trauma.

Chapter 7 concludes our report and presents a set of guiding principles for addressing the problem of workplace trauma in the homelessness sector, and for implementing the suite of options outlined in Chapter 6. The results of our review of the literature are presented throughout the report, at the beginning of each chapter.

2. Working on the homelessness and social housing frontline

There is limited research on the types of negative events and experiences encountered by frontline workers in homelessness and social housing services. This chapter addresses this gap by presenting findings in the Australian context from our national survey, along with interviews with frontline workers and stakeholders. In doing so, the chapter addresses our first research question: What events and experiences do frontline staff in social housing and homelessness services encounter at work that may lead to workplace trauma?

The chapter begins with a summary of key research from national and international literature in the homelessness, social housing and related fields, before presenting data collected through this research. This data offers detailed insights into:

- the nature of frontline workers' experiences of workplace trauma
- how frequently these experiences occur
- the degree to which these experiences are unique to the housing and homelessness sector.

In the national online survey, participants were provided with a long list of experiences they may have had at work over the past 12 months and asked which had affected them or their colleagues. This list was developed based on our literature review, as well as the research team's direct experience conducting fieldwork in these sectors. Interviews with frontline staff and stakeholders included open-ended questions about the nature and extent of negative events and experiences at work. During the interviews, people were asked to provide examples of things they found challenging at work, including how frequently these events or experiences occurred.

Please note that this chapter discusses examples of physical and sexual violence, family violence, child abuse, suicide and death including murder.

2.1 What does the literature tell us about the events and experiences frontline workers encounter?

Among workers in the homelessness and social housing sectors, negative events and experiences are diverse, likely widespread, and regularly experienced. The high incidence of trauma exposure among service users can significantly affect frontline staff (Lemieux-Cumberlege, Griffiths et al. 2023; Peters, Hobson et al. 2021; Robinson 2022; Tiderington 2019; Waegemakers Schiff and Lane 2019), although housing and homelessness services are not unique in this (see Cocker and Joss 2016; Louth, Mackay et al. 2019; Maheen, Dimov et al. 2021; Natalier, Cortis et al. 2021; Zhang, Zheng et al. 2021.

Workers' distress can arise from the frustration of seeing clients struggle to progress, despite the support provided (Mann 2023), and the severity of the traumatic content they are exposed to, especially when they have direct contact with survivors, or in cases involving graphic details (Cocker and Joss 2016). Recent research has found homelessness workers face a heightened risk of exposure to verbal and physical abuse in the workplace (Peters, Hobson et al. 2021).

To highlight just one study, Kerman, Ecker et al. (2023a) examined worker exposure to different chronic stressors and critical events with sobering results. Many participants (89%) had been directly exposed to one or more critical events during their working life, with an average of 3.5 critical events per worker. Most commonly these included:

- verbal aggression and threats: 80.7%
- overdose: 58.2%
- physical assaults by service users: 52.1%
- threats of death or serious injury to staff: 46.1%.

Other critical events directly experienced by staff included suicide of a client or a near-fatal attempt (27.8%), violent or accidental death (23%), and sexual assault by a service user (11.7%).

Chronic stressors, which were events that did not qualify as critical incidents but were nonetheless regular and difficult experiences, included biohazards, smeared faeces, property and housing damage, flooding, hoarding, physical resistance of support, constant screaming, self-harm, public sexual behaviour, various types of verbal abuse (i.e. racist, homophobic, anti-immigration) and having to ban clients from services.

2.2 What do frontline workers experience?

For reporting purposes, negative events and experiences reported by participants in the survey and interviews have been grouped thematically into the following categories:

- Responding to client/tenant behaviours resulting from unmet needs
- Sources of vicarious trauma
- Sources of direct trauma
- Reporting and emergency services
- Critical incidents
- Other

There were other ways that these events and experiences could have been grouped, and some events could be included in more than one category. For example, experiences included as direct trauma could also cause vicarious trauma to staff who witnessed them, while the circumstances leading to mandatory reporting could also be a source of vicarious trauma. Rather than find the perfect typology, our aim was to summarise our findings in an accessible format for senior service managers and policy makers.

In our survey, we presented participants with a detailed list of possible negative events and experiences and asked them to specify for each whether they had experienced it, witnessed it, or known of it occurring in their workplace. It was made explicit in the survey question that 'work' was not tied to location but happened anywhere that frontline workers had carried out tasks for their employer, including in an office, clients' or tenants' homes, or places where clients were sleeping. For simplicity, the categories of having experienced, witnessed, or having had an event occur in the workplace have been grouped together, while the category 'this did not occur in my workplace' is reported separately.[2]

Quotes from interviews are included throughout to illustrate relevant details and to add texture to our survey findings.

2 This response indicates that the event had not occurred in any setting where a participant carried out work duties, as defined above.

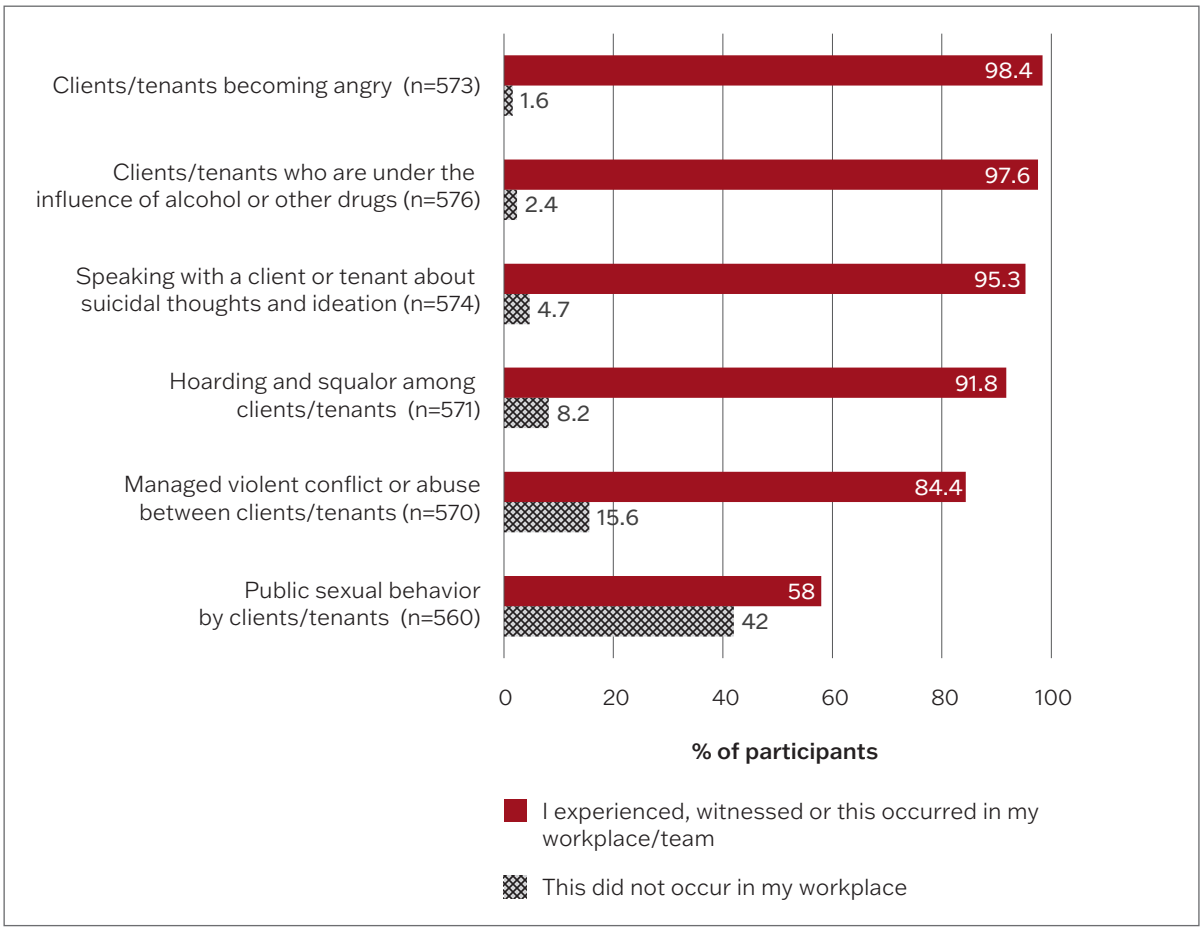
2.2.1 Behaviour arising from unmet need

Nearly all survey respondents reported exposure to client or tenant behaviours resulting from unmet needs (see Figure 1). Specifically, 98.4% had experienced, witnessed or had incidents occur in their workplace involving clients or tenants displaying anger. A similar proportion (97.6%) reported encounters with individuals under the influence of alcohol or drugs.

A high proportion of respondents (95.3%) indicated they had engaged in conversations with clients or tenants about suicidal thoughts and ideations, and 91.8% had encountered clients or tenants living in hoarding and squalor situations.

Violent conflict or abuse between clients or tenants had been experienced, witnessed, or known to have occurred in the workplace by 84.4% (n=481) of respondents. Over half (58%) reported exposure to public sexual behaviour from clients or tenants, although 42% reported that this did not occur in any settings where they performed their work duties.

Figure 1: Percentage of participants who had experienced, witnessed or had occur in their workplace: client/tenant behaviours resulting from unmet needs



Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

In relation to client/tenant anger and aggression, one tenancy worker said:

> What else is scary? Going into a tenant home and someone's in a really bad state of mind or drug-affected, and they're punching walls and stuff and you are just on your own. That can be really scary. (Frontline, STHA, I08)

Another frontline worker recounted an interaction with a client who told them of their parent giving them drugs at 12 years old. They described the emotional toll that arises from hearing these kinds of stories from clients:

> When you're hearing things like that every single day, it wears you down. We're all human. It gets to the point where you just think, 'Oh my God, the world is broken. What are we even living in?' The physical violence and the threats we deal with are one thing. But that relentless emotional toll—that's massive in housing. (Frontline, CHP, I13)

For some frontline workers, encountering clients or tenants living in squalor was a 'really common thing' (Frontline, STHA, I08). As one interviewee stated: 'The squalor we see in some of the properties is really upsetting. And it's not just about the person living in those conditions—nine times out of ten, there are kids there too.' (Frontline, CHP, I13)

Frontline workers and stakeholders both repeatedly stressed that behaviour, however problematic, needed to be understood in the context of what clients themselves had experienced. Clients had frequently been let down by other systems and services and were justifiably angry. That anger was then expressed at the worker in front of them. As one stakeholder said, 'Our staff get blamed for everything' (Stakeholder 09). This was echoed by a frontline worker who stated: 'I think we get a lot of that, it's being the easy target. As property and tenancy managers, we're easy to blame for everything' (Frontline, CHP, I7). Another stakeholder pointed out that 'we see people pretty much at their worst. For some it's their worst day, and we're asking them some really personal, really poignant questions, and that can make them upset and a bit hyper' (Stakeholder 05).

When stakeholders made comments like this, they were not dismissing the impact on workers. Rather, they were acknowledging that bearing the brunt of anger was not easy—but that they saw the context for client anger:

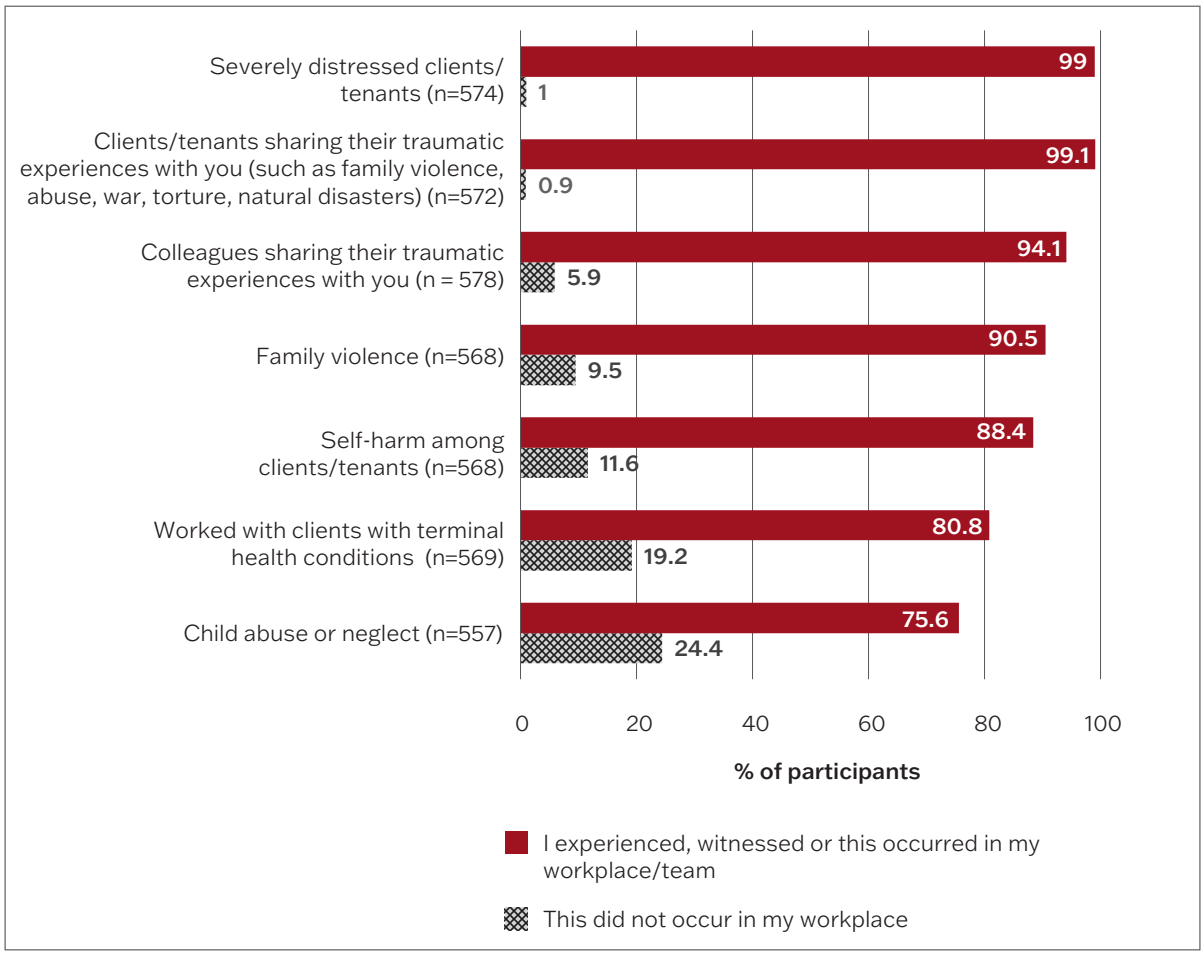
> That can be a bit hard to get used to, that aggression and that frustration by your client. It's not aimed at you personally, it's aimed at what's happening in their lives, and the system … A lot of the time they're people that had homes and lives, and all of these things, and then just something broke and it just got all too much. Or there were really unfortunate circumstances that led to those things. (Stakeholder 05)

2.2.2 Sources of vicarious trauma

Exposure to emotionally intense and traumatic experiences was highly prevalent among survey respondents (see Figure 2). Nearly all respondents (99%) reported encountering severely distressed clients or tenants, and an equal proportion (99.1%) indicated that clients or tenants had shared their traumatic experiences with them. Additionally, 94.1% reported that colleagues within their teams had also shared their own traumatic experiences that had occurred in the workplace.

Experiences of family violence among clients or tenants were reported by 90.5% of survey respondents, while 88.4% had experienced, witnessed or had knowledge of clients or tenants engaging in self-harm. A large proportion (80.8%) of respondents reported working with clients with terminal health conditions. Close to three-quarters (75.6%) had experienced, witnessed, or were aware of incidents of child abuse or neglect among clients or tenants.

Figure 2: Percentage of participants who had experienced, witnessed or had occur in their workplace: sources of vicarious trauma



Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

The open-ended survey responses confirmed that frontline housing and homelessness workers are regularly exposed to traumatic events, including witnessing domestic violence, and to hearing detailed disclosures of clients' traumatic experiences, including sexual assault, child abuse, and torture. One participant noted that 'sexual violence stories are often shared' (Survey, SHS). Many frontline interviewees also described the cumulative emotional toll of having to frequently create space for distressed clients to express their deep fear, anger and anxiety about the overwhelming experiences and challenges they were facing. Workers experienced this as 'trauma dumping', and described the difficulty of being left to respond to crises they could not resolve, and the moral injury of being unable to protect vulnerable clients, particularly children, who often faced severe neglect, abuse and systemic failure. One tenancy worker explained:

> We get a lot of trauma dumping just from general inquiries. People ring up already upset and give you their whole story, and you just have to say, 'I'm really sorry, we don't have anything …' You just have to explain the best you can, knowing that they're not going to understand it, and they're perfectly justified in how they're feeling and how distressing that is. So that is really difficult to deal with. (Frontline, CHP, I07)

Another tenancy worker described the difficulty of 'not [being] battle ready' when hearing and experiencing clients' traumatic stories. This participant referred to times when they had made a simple phone call or routine house inspection, and a client had unexpectedly shared their traumatic experiences:

> These most traumatic of things have happened and you're the first person that has spoken to them and suddenly, you know, all of this stuff … They're unloading and you're like, 'Oh my goodness, I didn't expect this.' (Frontline, CHP, I06)

Frontline workers supporting marginalised populations frequently described the profound emotional toll of their role. One reflected on the emotional impact of what they were witnessing:

> The sadness and shame which people experiencing homelessness carry with them. You've got grown men in tears, exhausted from sleeping rough, feeling like they've let their families down. Some have kids and nowhere to take them. (Frontline, SHS, I10)

The frontline worker noted that new workers often feel an initial emotional shock: 'It's overwhelming, and until you're in it, you don't really understand how heavy that is' (Frontline, SHS, I10). The emotional toll extended beyond the workplace, as this interviewee explained:

> It's walking beside these people and knowing their stories. You've got to be very careful to put that down and go home, which I don't always. There are days here I've left work on Friday night and wondered if my resident will be alive on Monday. (Frontline, SHS, I20)

As noted earlier, frontline workers spoke of hearing about and witnessing episodes of domestic and family violence. One recounted a time where they and another staff member had attended a property to find a person who had just been violently attacked by their partner:

> We knew something had happened because [Department] called me, asking us to retrieve the baby to return to the mother. We already knew it was a volatile relationship, but nothing prepared us for what we saw. When we walked in, there was blood everywhere. The entire place had been turned upside down … We later found out he had stabbed her … And there were two babies in that house at the time. It was horrific to see and to be exposed to something like that. (Frontline, CHP, I13)

Interviewees said that situations involving children were always more distressing and emotionally challenging. Confronting severe neglect, such as children sleeping on floors without beds, lacking food, and living in unsanitary conditions 'was really difficult' (Frontline, STHA, I08). Such experiences evoked a deep sense of sadness, helplessness and guilt about being part of a society that allows 'kids to fall through the cracks' (Frontline, STHA, I08). One worker said that the persistence of such suffering 'makes me feel really sad to think that I am a part of a society that lets this happen over and over again' (Frontline, CHP, I21). Many workers reflected on the long-term consequences for children growing up without adequate support, describing it as a growing and deeply concerning issue.

The overall toll of work in the homeless and housing sector was highlighted by a story related by one frontline worker, whose work had involved such highly traumatic and complex cases that even their EAP counsellor was overwhelmed:

> I almost had to cancel the EAP counsellor because they were traumatised by what I was telling them. The work we do is intense—we work with perpetrators of child sexual abuse, with people who've been perpetrated upon, and with all sorts of complex cases. If you talked about it publicly or with people outside the sector, they'd be horrified. (Frontline, SHS, I10)

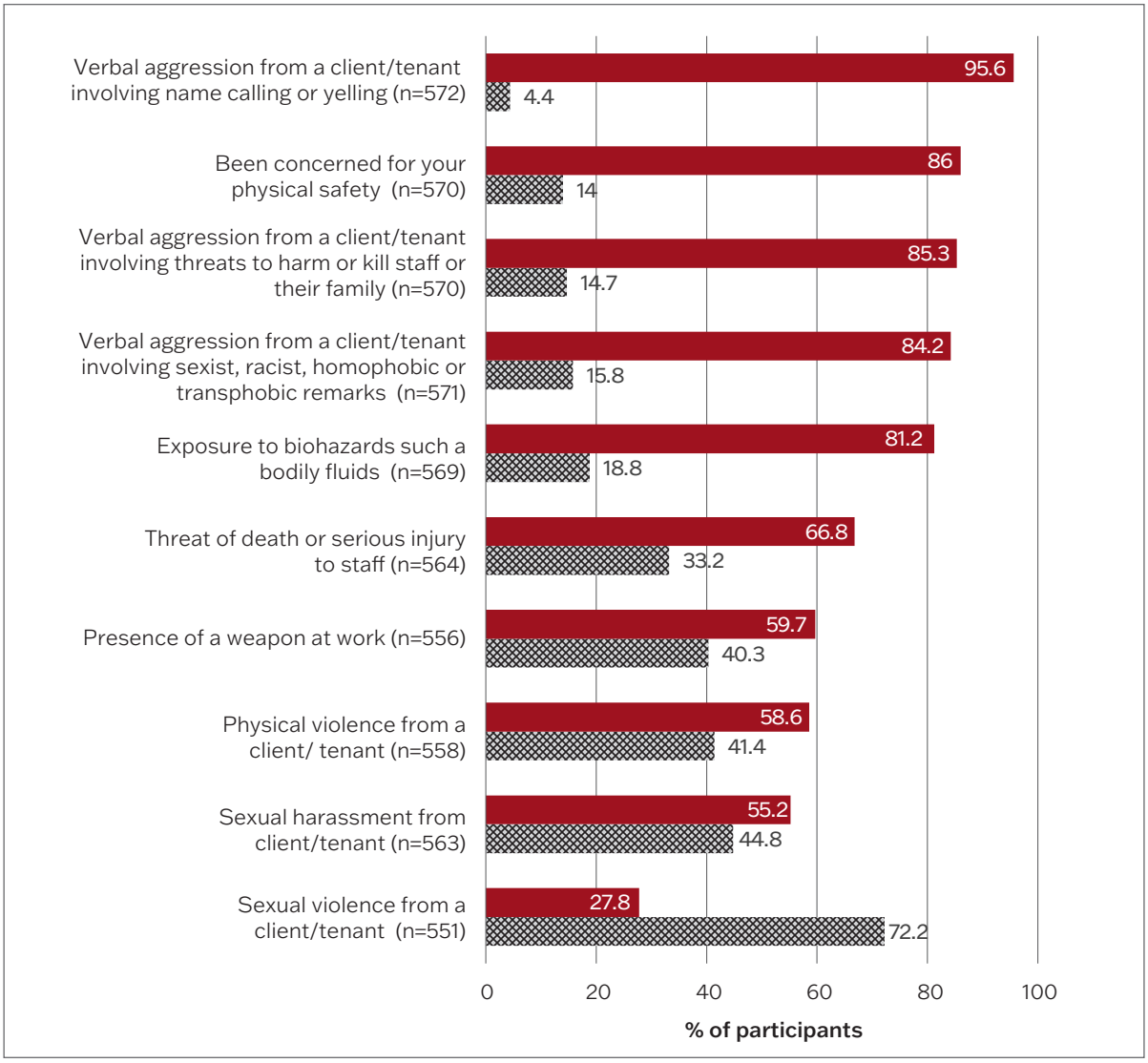
2.2.3 Sources of direct trauma

Experiences were grouped in the category of direct trauma if they involved exposure to verbal aggression or physical or sexual violence from a client or tenant (see Figure 3). A significant majority of respondents (95.6%) reported experiencing verbal aggression involving name-calling or yelling, while 85.3% reported verbal threats directed at their families, and 84.2% experienced verbal aggression involving sexist, racist, homophobic or transphobic remarks.

The majority (86%) of survey respondents indicated they had been concerned for their physical safety while at work. Over three-quarters (81.2%) of respondents reported being exposed to biohazards, such as a bodily fluid. Two-thirds (66.8%) of respondents had experienced, witnessed, or heard reported incidents that threatened serious injury or death for staff, and 59.7% reported that a client or tenant had brought a weapon into the work site.

Over half of the respondents had experienced, witnessed or were aware of physical violence against staff in their workplace (58.6%), and sexual harassment perpetrated by clients or tenants (55.2%). More than a quarter (27.8%) also reported experiences of sexual violence against staff in their workplace. The remainder of respondents for each event had indicated that this had not occurred in their workplace.

Figure 3: Percentage of participants who had experienced, witnessed or had occur in their workplace: sources of direct trauma



Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

The frontline workers we interviewed described being threatened by clients/tenants as a routine, frequent part of their job, across various service settings. Numerous participants noted that crises involving violence, aggression or threats occur weekly or even daily.

Many clients/tenants have unmet needs related to their mental health or substance use, and their frustration could easily escalate to verbally and physically aggressive behaviour including threats (verbal, physical, or sexual), assaults, and property damage. Interviewees reported being yelled at, having items thrown at them, and receiving inappropriate sexual messages or phone calls. They also mentioned damage to offices, such as broken windows or fires, and exposure to dangerous situations such as hostage situations, gun violence, and bomb threats. Some workers described being stalked by clients.

Frontline workers shared numerous examples that illustrate how this violence and aggression played out in real and distressing ways, both inside and outside the workplace. One frontline worker stated, 'We have had staff who have been assaulted in the workplace' (Frontline, SHS, I03). Another explained, 'My car has been damaged in the past. I know other colleagues have had their cars damaged' (Frontline, CHP, I06).

Incidents often stemmed from clients' or tenants' frustration when services could not meet their needs. One interviewee recounted, 'I've had clients come in and throw things, scream, and yell out of frustration because their needs weren't being met' (Frontline, STHA, I11), showing how verbal aggression and unsafe behaviour were often linked to services pressures. Others described experiences of physical danger, including being trapped by a client/tenant: 'I've been in situations where I've been trapped in rooms with clients on the other side smashing the door down, trying to get to myself and my colleague' (Frontline, STHA, I15).

Sexual harassment and unwanted contact were also described by some frontline workers, as one frontline worker shared:

> We've had staff receive phone calls and text messages that were sexual in nature—suggestive and inappropriate. In one case, a client managed to get hold of a staff member's private number and began contacting her on her personal phone. That was really frightening. (Frontline, CHP, I13)

Several workers described receiving explicit threats of violence: 'I've been threatened with being hunted down and killed' (Frontline, SHS, I20). Another shared that, 'My interactions with her [client] were really aggressive. "You effin' c, I know who you are." She found out my surname, she knows where I live. She's said she is going to come and kill my dog' (Frontline, CHP, I21).

Violence and threats with a weapon not only occurred when workers visited the homes of clients and tenants but also occurred in homeless accommodation services and at offices. Interviewees recounted experiences of being threatened and attacked by clients with knives and machetes. One reported: 'A guy once pulled a machete out when I was at a home visit' (Frontline, SHS, I02). Another described getting caught up in a knife fight at their office—and the reported response from the organisation is worth noting in the context of later chapters:

> I've had knife fights happen in the building—I actually got caught between a knife fight. Thankfully, I knew I couldn't do anything, and I couldn't move. But you know, only certain knives were taken away from the clientele. That makes a big difference when you've got this kind of stuff happening often. Management is like, 'Oh yeah, whatever. Next.' (Frontline, SHS, I19)

One frontline housing worker was attending a property to change the locks, along with a locksmith and a smoke-alarm technician, when they unexpectedly encountered a tenant hiding in the bathroom with a knife. The tenant was experiencing a severe mental health episode and reacted violently:

> She swung wildly—like a windmill. We all had to dodge the blade. Eventually, the locksmith and I managed to get out. But the poor smoke-alarm technician was stuck in the back of the property and couldn't move while it was all happening. The woman had a severe mental health condition and believed she was a police detective. The police didn't handle the situation well at all. Eventually, the technician got out—but he was so traumatised, he resigned and never worked again. (Frontline, STHA, I14)

Another frontline worker recalled a traumatic incident from more than a decade ago in which they had been helping a client leave a domestic-violence situation:

> I'll never forget it to this day. I could describe that stairwell as if it's in my office that I'm in right now. I'm in this stairwell and I'm backed in a corner, and he's holding this knife out to me and it's right here, to the neck. And then, eventually, he put the knife down and walked away, and I thought, 'Phew, thank God.' Because I'm thinking, 'How do I get out of this situation?' And that's years ago. I can't remember what I had for dinner two nights ago, but that sticks there. (Frontline, SHS, I03)

Home visits can be straightforward, but they can also be unsafe. Although the majority of people with mental health conditions are not violent, engaging with some clients who had experienced significant trauma and mental health challenges could be unpredictable:

> You never know what you're going into. You're going into someone's home and you often don't know who's there, what's in there, what's going to happen. You've really got to make sure you're on guard at all times. You're often dealing with people who have had a lot of trauma in their lives, or they've had a really difficult upbringing and have had horrible things happen to them. (Frontline, STHA, I08)

One stakeholder summed up much client behaviour as 'abusive, rude, emotional, sometimes physically threatening' (Stakeholder 02). Problems could arise from frustrations entirely unconnected to the worker on the ground, such as a maintenance issue the client had reported but which had not yet been resolved. Other factors could be mental health issues, the consequences of drug and alcohol abuse, or the stresses of adjusting to life outside prison. Some stakeholders suggested the prevalence of methamphetamine use had added to the problem by increasing the unpredictability and volatility of client reactions (Stakeholder 06).

Threatening behaviour could be genuinely dangerous for the client and others. This was recognised by stakeholders as well as frontline workers. One SHS provider explained the risks of 'clients coming back intoxicated, or if they're not travelling well with mental health, clients acting on suicidal ideation, attacking staff, attacking other clients' (Stakeholder 7). Another stakeholder, who worked in a social housing service, described an incident in which two workers visiting a property encountered the tenant 'standing in the middle [of the room] with a big knife' (Stakeholder 06). Recalling their own frontline experiences, another described being 'followed home a number of times' by clients (Stakeholder 10).

However, it was not always the client or tenant posing the threat:

> A very well-behaved tenant who has some friends who are not very well behaved. Trying to support that tenant to manage that relationship and not have those people try and move into their apartment, for example. Or the partners of women fleeing domestic violence coming and—I know we had an incident a while ago where someone was incredibly violent at one of our sites, smashed a bunch of windows, was violent towards staff. No one was physically harmed but people did express how distressing that situation was. (Stakeholder 09)
>
> Someone went to see a little old lady. Lovely lady. Grandson? Not so much. Grandson was an ice addict. He happened to be staying over, incident occurred. And that's what I'm saying, every other interaction with that lady at that property has been fine. But he was in the spare bedroom and walked in and up it blew. (Stakeholder 06)

2.2.4 Working with emergency services and mandatory reporting

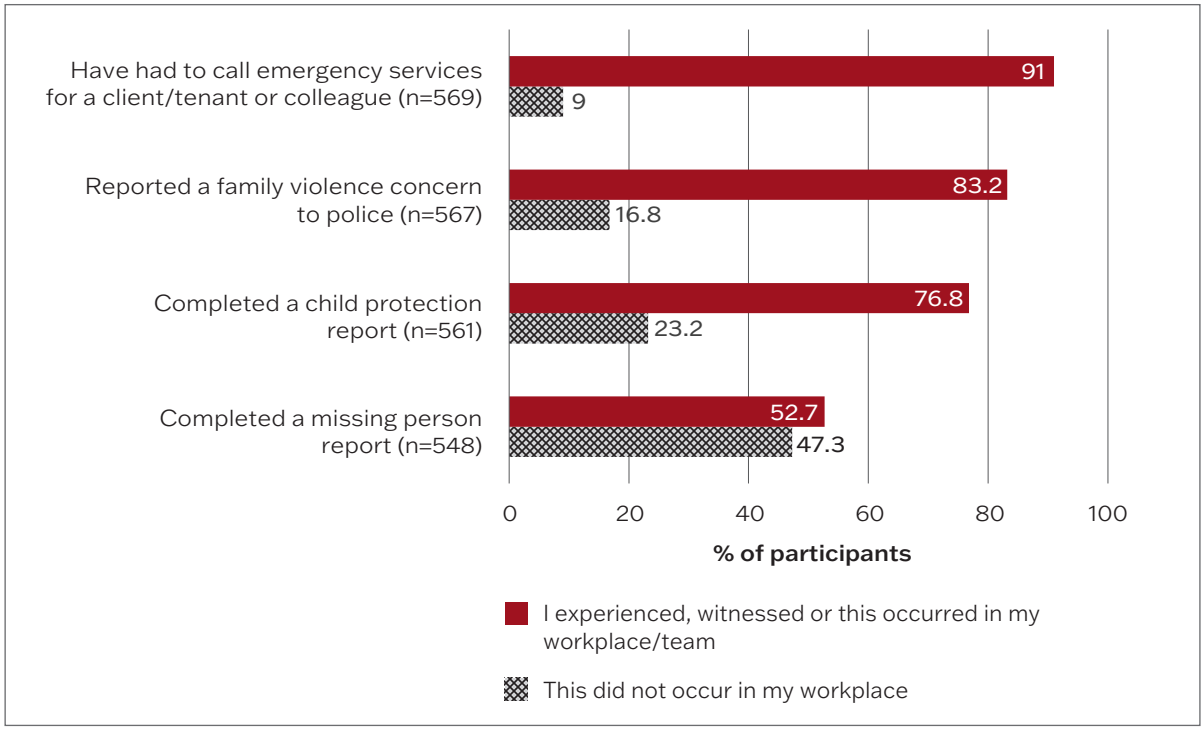
A significant proportion of survey respondents reported frequent contact with emergency services as part of their frontline work (see Figure 4). Specifically, 91% of survey respondents had experienced, witnessed or were aware of instances in their workplace where emergency services were contacted on behalf of a client, tenant or colleague. This is important, as it highlights the frequency with which clients and workers are involved in time-critical crisis situations.

Formal reporting responsibilities were common. Among our participants:

- 83.2% had reported a family violence concern to police
- 76.8% had completed a child protection report
- 52.7% had submitted a missing person's report.

In all these cases, the worker is exposed to situations that could lead to trauma.

Figure 4: Percentage of participants who had experienced, witnessed or had occur in their workplace: reporting and engagement with emergency services



Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

For example, when describing events and experiences they found hard, one interviewee nominated: 'Having to remove children from a family. So, contacting Child Protection and making that direct report and staying there until they were removed by the police, that was a really hard day' (Frontline, STHA, I08). An interviewee working in social housing described an experience working with a client whose child was removed:

> One of the women had a child removed. And I happened to call her, just my luck I guess, right as that was happening … Normally she dodges my calls, so I think she answered entirely because she wanted to yell at somebody, take that distress out on somebody. That was quite confronting. I think we get a lot of that, being the easy target. As property and tenancy managers, we're easy to blame for everything. (Frontline, CHP, I07)

Other workers shared incidents where they had to contact the police. One described conducting a property check and encountering a young woman and her aggressive partner, both apparently under the influence of drugs. The situation escalated when the woman became violent, verbally abusing the worker, threatening them, and smashing windows, requiring a police response (Frontline, CHP, I21). Another worker described an incident where two colleagues on a home visit were trapped inside a property when a violent individual attempted to force entry, threatening their lives: 'They tried to press their duress alarms, but they weren't working properly. Then they started calling our office. We were all in a bit of a meltdown, trying to get to them and get the police there' (Frontline, CHP, I13).

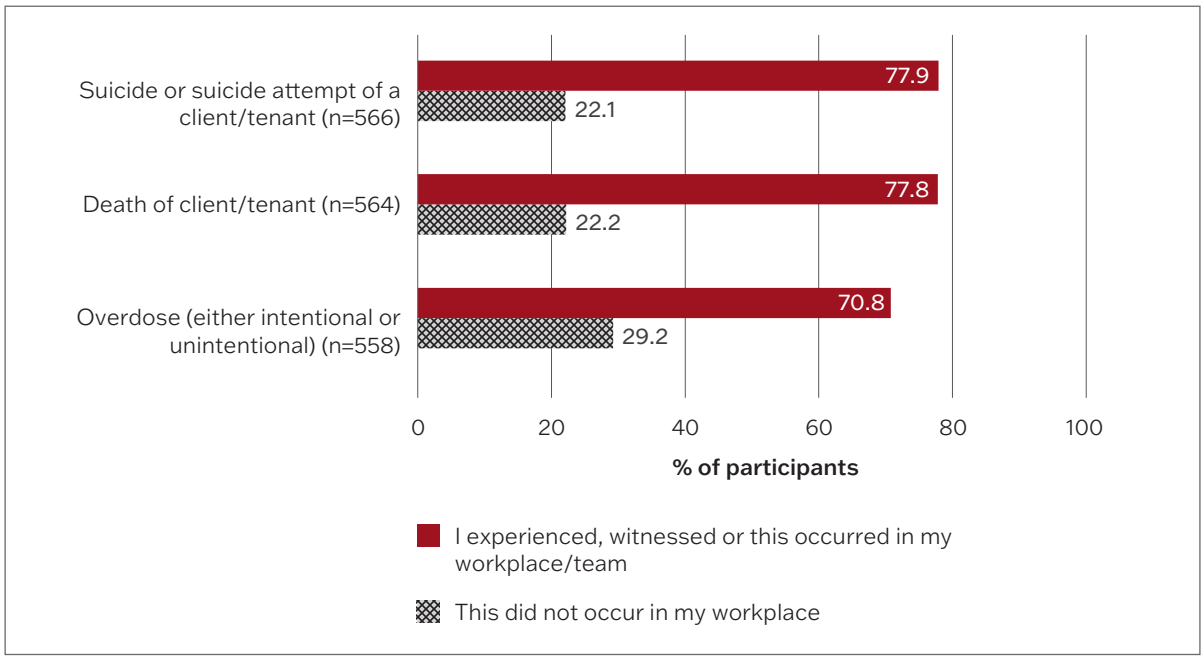
There were also reports of frontline staff calling ambulance services for people who had self-harmed or attempted suicide. This is explored further in the next subsection.

2.2.5 Critical incidents

The term 'critical incidents' is commonly used in the SHS sector to refer to incidents that are particularly distressing and significant, such as the overdose, suicide or death of clients or tenants.

Survey participants reported frequent exposure to such critical incidents (see Figure 5). For example, 77.9% of survey respondents had experienced, witnessed or were aware of a suicide or suicide attempt by a client or tenant within their workplace. Drug overdoses among clients or tenants were reported by 70.8% of survey participants. A high proportion (77.8%) reported experiencing the death of a client or tenant as an incident they had encountered. Some noted that they then needed to become involved with their deceased client's estate, including coroner reports, planning memorials, recovering items from the property for the client's partner, or providing emotional support to the bereaved partner during this time.

Figure 5: Percentage of participants who had experienced, witnessed or had occur in their workplace: critical incidents



Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

In the interviews, frontline workers also shared a range of experiences related to client deaths—including discovering deceased individuals, performing unsuccessful CPR, and identifying bodies at the coroner's office. These deaths had resulted from natural causes, overdose or suicide.

The emotional toll of these tragic events was intensified when workers had longstanding relationships with the clients. As one interviewee stated: 'It's very traumatic, finding a body or doing CPR and losing someone' (Frontline, SHS, I03).

Some frontline workers were routinely exposed to severe emotional trauma through frequent encounters with client suicidality, self-harm and death, including witnessing suicide attempts, administering CPR, and supporting clients through self-harm crises.

As one SHS worker stated, 'I've done more suicide assessments than I could think of. You know, CPR, first aid, I've seen some horrendous cuts in my time, taken people to hospital' (Frontline, SHS, I03). A stakeholder reported that finding the body of a deceased client was not uncommon in some services (Stakeholder 02). One housing worker recounted witnessing a client attempting suicide in front of them during a home visit:

> I have this one client who has complex mental health issues … She has extreme depression, and suicidal ideation is a big part of that, and daily she threatens to kill herself. Once, she cut her throat with a knife when I was there. (Frontline, STHA, I18)

Some workers have had clients die by suicide despite previous interventions. Indeed, discovering deceased clients was described as a distressingly common part of the role. One participant shared that they had supported two clients who had died by suicide after several attempts. The worker had 'called the ambulance and helped them through' but ultimately the client died by suicide and it was 'really hard to lose them' (Frontline, CHP, I06).

A stakeholder told a similar story:

> We've had a number of residents threaten suicide and be talked down from that situation. The guy that killed himself last year, leading up to that he'd [details of self-harm]. And we engaged the [service], who decided to leave him in the house. That was probably the worst situation in the last two years. I had one staff member stay with that man for quite a few hours, and then three days later he died by suicide. (Stakeholder 08)

A frontline worker recounted a deeply traumatic experience where a person died by suicide during a client visit at a high-rise building known for such incidents:

> I was working in a high-rise in the inner city, talking with an elderly tenant who wanted to transfer. She said she couldn't cope anymore—people were climbing to the top of the building and jumping to their deaths. There were no barriers or restrictions, so it was happening regularly. While I was sitting in her living room, discussing her transfer, someone jumped. I literally heard the sound of their clothes as they passed the window. When I looked down, they had hit the car park. I could see the pool of blood.
>
> The police arrived and asked me to go with them to the man's unit before they notified his mother. The door was open. We had to get emergency cleaners in before the mother could enter. That whole incident has never left me. (Frontline, STHA, I12)

2.2.6 Other experiences of workplace trauma

As well as the experiences described earlier, survey respondents reported other work-related issues that caused them distress and trauma. These included:

- witnessing and managing acute mental health crises and psychotic episodes
- exposure to extreme substance abuse and antisocial behaviour
- being forced to evict clients into homelessness
- witnessing crimes being committed
- witnessing or being involved in homicide or serious criminal cases
- observing the mistreatment or neglect of animals and pets.

These types of experiences were echoed in the interviews.

One interviewee described the emotional toll of evictions: 'That's a really common part of my job and it's not nice. I'm really passionate about ending homelessness, but sometimes we do have to evict people for different reasons and it's awful' (Frontline, STHA, I08).

Another interviewee said: 'My greatest frustrations, and what causes me the most trauma, is witnessing the systemic racism that our clients experience and the re-traumatisation of the client by services' (Frontline, SHS, I05). One interviewee had been involved in a homicide investigation and had to give evidence in court in relation to the death of a child (Frontline, STHA, I15).

Animal hoarding was 'sadly really common'. One participant described their distress at finding 'dead animals from the animal-hoarding property and then having to take them to the RSPCA' (Frontline, STHA, I08).

Survey responses highlighted structural challenges that led to trauma, including high caseloads, understaffing and limited resources, which often prevented them from providing adequate support to their clients/tenants. One worker spoke of the trauma of supporting clients through 'deeply broken, Kafkaesque service systems' (Survey, SHS). Such situations resulted in the expenditure of high levels of labour and advocacy for very marginalised clients with little to no positive outcome.

Other workers reported feeling: dismissed or unsupported by management when raising concerns; pressure to maintain clients in housing despite safety risks; workplace bullying and sexism; exclusion by colleagues or management; poor leadership; unrealistic expectations; and toxic workplace cultures.

Legal and ethical dilemmas were prevalent, with respondents navigating conflicts, such as:

- mandatory reporting versus maintaining client trust
- being pressured to ignore or minimise safety concerns
- facing accusations of misconduct, racism or negligence from clients or management
- struggling with bureaucratic processes that re-traumatised both clients and staff.

Depending on the type of service they are based in, a worker may have ongoing engagement with clients/tenants over a long period of time, which potentially exposes them to cumulative harm. For some, this meant witnessing people decline steadily over time while waiting for meaningful assistance:

> Where we are, which is an engagement hub where someone might just come in for a coffee and a meal, you get to watch that decline over a period of days, weeks, sometimes months. We've seen people with active psychosis, who were actually fairly bright and communicative and optimistic about life, gradually decline to the point where they barely talk, where their grooming has suffered. It's really confronting to see that decline. (Frontline, SHS, I01)

2.2.7 Feeling hopeless

On top of the myriad of difficult and traumatising incidents at work, most workers (91.2%) also reported that they or their colleagues felt that they could not meaningfully assist clients or tenants. As one interviewee summed up:

> The hopelessness of actually—the reason we do this job is to help, and the majority of the time you can't, so I think that is pretty upsetting most days. (Frontline, CHP, I07)

Frontline housing workers frequently experience emotional distress and a sense of helplessness due to systemic barriers. They witness clients struggling with mental health issues and crises, but are unable to provide adequate support due to limitations of their roles and a lack of early intervention services. As one worker put it: 'Systems aren't set up, they're not there for early intervention when people are in crisis' (Frontline, CHP, I06).

It was particularly distressing when people were facing homelessness and frontline workers knew they could not find accommodation. This was further exacerbated when children were involved 'and you know that that child's going to be homeless and on the street for the weekend' (Frontline, SHS, I10).

Another frontline worker described the emotional toll of supporting clients in systems that fail to deliver the outcomes both workers and clients hope for:

> Knowing that I can't help you in a system that can't help people. Those repeated experiences of despair are soul destroying. You're trying to help someone who is equally experiencing despair. (Frontline, SHS, I04)

One stakeholder reported that research their organisation had conducted showed that this simple inability to help clients/tenants was itself a key source of trauma. For workers in the homelessness sector, for example, 'There's the trauma of not being able to house people in need' (Stakeholder 03). Another stakeholder agreed, noting frequently reported psychosocial injury due to 'sending those people away, time and time and time again. We give them a sleeping bag. Workers say, 'Where does that go in my body? Where does that go in my mind?' (Stakeholder 10).

Many clients of homelessness services are also repeat clients or 'chronically homeless':

> One of the things that's most devastating about working there is the fact that you get the same people coming back over and over again because they've gone and they've done their 12 weeks in crisis, which is already more than crisis is funded for, incidentally. And then the person leaves crisis. Maybe they go to [transitional housing], maybe they don't. And then they have nothing. And then they come back to [intake and assessment service] again. And as that person comes back to [intake and assessment service] again and again and again, it's like this churn, and eventually they become harder to house. (Stakeholder 09).

People who are chronically homeless are among the most vulnerable people in the community. This meant that even though workers were in effect being harmed by clients, as being unable to help them to a lasting solution was itself traumatic, they were unable to stop working with them:

> Those clients are the clients that have no other services to access. You live with the stress that you've been sending these people away all the time or you work with a client who's potentially putting you at risk on a day-to-day basis. (Stakeholder 10)

2.3 How frequent is the harm?

Frontline housing workers described a consistently escalating exposure to trauma and violence, both direct and vicarious. One noted: 'There's been an increase in violent responses toward us—much more than there was 25 years ago' (Frontline, STHA, I11). That daily exposure was common and repeatedly emphasised: 'You're constantly exposed to these things—constantly', and, 'Just listening to people's stories takes a toll—unfortunately, it's an everyday part of the job' (Frontline, STHA, I12). The emotional toll was profound: 'Listening to clients' stories is a daily thing—multiple times a day … the level of vicarious trauma is just off the charts' (Frontline, CHP, I13). Another worker commented: 'If I were to report every incident that [management defines] as an incident, I'd spend all my time incident-reporting, and to what end?' (Frontline, CHP, I21).

There was no clear consensus from the small sample of stakeholder interviews on the frequency of harmful experiences. Some did put an approximate number on it: 'We had at least one incident report go through a week' (Stakeholder 01). 'A staff member in a front-facing role would expect a negative interaction once a week, minimum … if not twice a week' (Stakeholder 02). And 'In our [tenancy support program], it is at least weekly. Easily weekly' (Stakeholder 01). Essentially, traumatic experiences were 'a frequent occurrence' (Stakeholder 10).

Estimates of prevalence were also arguably conservative because of under-reporting: 'There's a lot of, "Yes, I'm doing okay", when in fact they're not. They're under-reporting because they're under-valuing or underestimating the experiences that they're having' (Stakeholder 03).

The type of service or client group had some influence on frequency (Stakeholder 01, Stakeholder 07). In general, however, the consensus was that workplace trauma happened often enough to be a problem:

> Stakeholder: I couldn't tell you [how often], but it's enough to say that it's causing them burnout and it's causing them distress and anxiety to the point that it's long-term. (Stakeholder 03)

There was such a broad range of events and experiences involved that the high frequency is unsurprising. As one stakeholder said: 'You've got high job demands, low job demands, working in isolation, traumatic content and events. … The nuance of stuff that happens to staff here, I think policy makers would be very shocked by' (Stakeholder 09). A stakeholder working in a social housing service reported that while 15 years ago, the proportion of tenants who posed a risk was around 3%, 'I reckon it's probably more like 20% now' (Stakeholder 06).

The frequency and the unpredictability combined to produce an atmosphere of necessary hypervigilance:

> You're going in prepared for something to happen. Most of the time it doesn't, but you are constantly prepared for something to happen and that's the only way to keep yourself as safe as possible. But in fact, what's keeping you safe is actually probably causing you a little bit of damage on the way through. (Stakeholder 06)

In saying this, this stakeholder was pointing to a significant feature of the problem—often it wasn't single incidents that were the issue, but the build-up of harm over time. In a string of incidents, the final one might not be exceptional, but it might be the last straw. Another stakeholder stated:

> Frontline workers that have been fine for 20 years and then suddenly something happens. They just snap, or they're impacted more than what they've ever been, even though they may have experienced dealing with this type of violence or this type of critical incident year in, year out. (Stakeholder 07)

2.4 The nature of frontline work

In both the survey and the interviews, frontline workers reported managing an extensive and demanding range of responsibilities, often extending well beyond their formal roles or training. They frequently encounter high-stress and traumatic situations, including mental health crises, domestic violence, suicide, child protection issues, and client/tenant death. Despite not being emergency or specialist services, these workers often serve as the first point of contact in crises that, if they occurred elsewhere, would typically involve police, paramedics or mental health professionals.

> I feel like when you're working in community services on the frontline, you're dealing with everything. You get the police incidents, you get the child protection incidents, you're dealing with death. […] You're dealing with suicide and domestic violence. You have every single facet of life that you're dealing with, that services like the police are actually funded and trained and staffed to deal with, but we don't have any of that … As a frontline housing worker, you're dealing with everything that multiple different services are specialised for, but we have it all. The first port of call is us in a lot of instances—even if we're not equipped to respond. (Frontline, CHP, I07).

As well as housing-related concerns, workers must respond to other issues facing clients, such as health problems, relationship breakdown and education problems:

> It doesn't matter if it's housing-related or not. We are there. We are the people they call. Regardless of whether it's housing-related or not, if it's a health issue, if it's a mental health issue, if it's something to do with their children's schooling, if it's a relationship issue, they ring us, and then we do the referrals to get them sorted. We are dealing with people's crises all the time. (Frontline, STHA, I18)

While the breadth of issues clients bring to services indicates a level of trust in those services, workers report feeling they are expected to manage complex and critical situations without adequate resources, recognition or systemic support. This contributes to a sense of being undervalued, both personally and professionally, which echoes the broader marginalisation experienced by the people they support. One worker described the sector's role as 'not even the ambulance at the bottom of the cliffs—we're at the bottom of the cliff when the ambulance didn't show up', adding, 'homelessness sector staff get treated like they don't matter' (Frontline, SHS, I05).

Stakeholders were asked if there was anything distinctive about the experience of workplace trauma in their sector. Their responses suggested that part of its distinctiveness stemmed from the role of housing and homelessness services within the broader welfare system. One stakeholder described housing and homelessness as 'a forgotten sector' (Stakeholder 05). Another used the phrases 'the poor cousin' and 'an afterthought' (Stakeholder 09). This lack of profile, combined with a generalised crisis in being able to access affordable housing, produce an extremely challenging situation:

> There is no systemic answer and you are just constantly band-aiding … seeing the same people and their children coming through the door. And you do see that in other community services, but I think the uniqueness to housing and homelessness is when there is no housing. You're going to see people presenting with exactly the same problem, and maybe they've changed their behaviour, but a house doesn't eventuate. (Stakeholder 10)

However, although homelessness services and social housing services are interconnected, stakeholders identified some qualitative differences in the ways in which workers were confronted with trauma in each context.

Clients of homelessness services do not usually approach the service via referral pathways or waiting lists—instead, they may self-refer and present directly in person to services. This means workers were dealing with the unknown: 'Workers are really in situations where they just don't know if there's a danger' (Stakeholder 10). And for homelessness services, turning away clients was a significant driver of trauma. One stakeholder stated: 'Turning people away in the most dire situations, when they've experienced violence, would be the hardest thing that [workers] would be doing' (Stakeholder 03). This was because workers knew very well the consequences of turning people away:

> In other work within the community services sector, in mental health or AOD [Alcohol and other drugs], the client may have somewhere safe to sleep or they may have been able to access some assistance to be OK through that night until the next day, when they can present again and access more support. Whereas working with clients who are primary homeless—that person is sleeping rough tonight. (Stakeholder 10)

However, in social housing services the situation is not usually a crisis one: 'I say, "This is housing, there's nothing that urgent that you can't do it another day"' (Stakeholder 06). This means walking away from a difficult situation and coming back later, more prepared, is an option. However, this does not mean that housing providers were immune from the emotional impact of not being able to help someone. One stakeholder, who worked in public housing, explained the different threshold for action that their agency had:

> We would recognise and try to work with a lot more issues. So, we don't accept a breach [of the lease], particularly where it's extreme damage, or interaction with the rest of the community is poor, but we will spend a lot more time and effort working with them, trying to get resources around them to try and stop those behaviours rather than saying, 'Get out.' (Stakeholder 06)

This higher threshold arose because of the significant disadvantages the public housing client group inevitably faces in the private market. A stakeholder articulated the consequences of making difficult decisions: 'If we throw someone out, they're homeless. That's pretty much it. And given where a lot of them are, you're condemning them to homelessness for at least two years' (Stakeholder 06).

Another aspect of social housing services that differentiated them from their homelessness counterparts was that workers were essentially representatives of the client's landlord, and this meant they were working, at least partially, in an enforcement capacity, but also a helping role:

> It's that combination of a client group with complex behaviours and a role which requires some sort of enforcement action, or being an authority figure, or asking people to give up money for their rent when they haven't got a lot and it's not something they want to do. (Stakeholder 04)

One stakeholder suggested that, in OHS terms, social housing was neither high nor low risk but sat 'somewhere in the middle' (Stakeholder 06). Yet precisely because social housing was not regarded as a high-risk sector, and the bulk of the work was administrative and technical in nature—for example, conducting property inspections or processing rental payments—the workforce profile differed substantially from that of homelessness services:

> For the housing providers, there potentially is a lack of knowledge and understanding and training around those complex needs that people are experiencing and being exposed to … It's perhaps coming from a background of working in real estate and tenancy, and maybe not so much in working with people who have experienced significant traumas throughout life. (Stakeholder 01)

Stakeholders drew attention to the fact that many frontline positions in housing (and homelessness) services were entry-level positions, which meant that staff were very 'green':

> We need them to hit the road and run, and they just don't have that. [Managers] sort of wish they had somebody who was far more ready to go, but unfortunately they haven't got a lot of choice and they're just getting people that are green, new, that need handholding, and they just haven't got the time for that. And that then puts pressure on the other staff. (Stakeholder 03)

There were also factors that housing and homelessness services held in common. Clients were almost always experiencing extremely complex and distressing circumstances and often faced disadvantage across a range of aspects of their life—for example, social and economic issues. Thus, workers needed to be able to address a wide range of needs, unlike mental health workers, for example, who were supporting a single aspect of the client's situation.

> In the housing and homelessness sector, they're dealing with not only the homelessness, but they are dealing with mental health. They are dealing with domestic family violence. They are dealing with AOD or acting out or child abuse or child protection issues. (Stakeholder 07)

Several stakeholders pointed out that they were the last resort for many clients—as one said, 'Half of the [SHS] sector will not take most of the clients that our organisation provides a service to' (Stakeholder 09-SHS). This willingness to take on people other organisations had given up on meant that some specific services and the SHS sector generally were perceived as a 'dumping ground'. One stakeholder, who worked at a crisis shelter, explained how their service functioned as an easy exit point for institutions:

> The psych ward at the [hospital] … the prison's another good example, where they're all wanting to get rid of people so they can get more people in, because the waiting lists are huge … Another one is the court-mandated drug diversion program, which has notoriously had a very low success rate, so we've taken on people from that program and normally they're back on the drugs very quickly, which means that we have to evict them … All stakeholders [in the sector] are stretched, and are overrun with clients, and are looking for, at times, easy options to move people on. (Stakeholder 08)

This stakeholder added that their service did the same in turn, relying heavily on the public housing provider to accommodate their clients once their time in the shelter ended. Public housing remains in most states the landlord of last resort, accommodating not only those who are unable to find housing in the private market, but also those who are unable to sustain a tenancy in the community housing sector.[3]

2.5 Considerations for policy makers

Our findings demonstrate that frontline workers are exposed to a range of confronting, stressful and traumatic events in the course of their work. Workers face a wide variety of risks from responding to client/tenant behaviour resulting from unmet needs, ranging from hearing clients/tenants recount their own traumatic experiences to experiencing direct threats to their physical safety.

Exposure to distress, aggression and trauma are frequent and cumulative—and embedded in frontline housing and homelessness work. This includes critical incidents as well as ongoing exposure to distress and trauma that may cause cumulative harm.

SHS, STHA and CHP workers are uniquely exposed to trauma because they—and the services they work for—are a last resort for individuals who have complex, high-risk needs but who often lack adequate systemic support. Frontline workers face moral distress and emotional strain as they navigate unpredictable crises, enforce tenancy rules and provide care within a severely under-resourced system.

The widespread nature of these harms—and the lack of documented evidence about them in the sector—suggests that the issue is insufficiently recognised and understood within policy and service commissioning. Better monitoring is needed. This could be in the form of aggregated incident reports from services, perhaps within a standardised framework that captures a predefined list of negative events and experiences. This would give decision makers a clear picture of the extent and scale of the issue, and guide the investment needed to tackle it.

The stories shared by participants in this study also speak to the critical need to:

- ensure that workers are better equipped to navigate the complex scenarios that are intrinsic to their work
- resource services sufficiently to support workers who are traumatised in the course of their work.

Such support would enable frontline workers to continue to provide critical support for the most marginalised members of communities across Australia.

The next chapter discusses the drivers of workplace trauma based on a review of the literature and our extensive survey data collection and fieldwork.

3 However, community housing take most of their clients from the priority waiting list in many jurisdictions.

3. The drivers of workplace trauma in housing and homelessness services

To properly address workplace trauma, it is necessary to understand the nature of the experience, as well as the causal factors behind those experiences. This chapter addresses our second research question: What are the drivers of workplace trauma in social housing and homelessness service delivery?

The chapter begins with a summary of relevant literature on drivers of workplace trauma. We then present what the research participants had to say about how these drivers manifest in practice, in their day-to-day experiences, their interactions with clients and tenants, the services they worked for and with, and the broader system of which they are a part. This discussion is organised using the same structure as the literature review section below. The chapter concludes with a brief discussion of the implications for policy makers.

3.1 What does the literature say about the drivers of workplace trauma?

A range of factors can produce workplace trauma across homelessness, social housing sectors and allied fields, including domestic and family violence, social work, mental health, allied health, and nursing. These factors can arise at the individual, interpersonal, organisational or systemic level.

Some research has suggested that homelessness workers' personal experiences of trauma (Waegemakers Schiff and Lane 2019), including adverse childhood experiences (ACEs) (Aykanian and Mammah 2022), may increase the risk of trauma symptoms. For example, one review found that mental health professionals with a personal history of trauma are at a higher risk of developing STS (Henderson, Jewell et al. 2024). The intersection of personal vulnerabilities with intense work demands can raise the risk of compassion fatigue, and increase burnout (Voth Schrag, Wood et al. 2022). Multiple studies support the association between personal trauma exposure and the risk of STS among workers in various fields, including substance misuse, rape crisis support, and medical trauma (Henderson, Jewell et al. 2024; Ogińska-Bulik, Gurowiec et al. 2021)

These studies outweigh the number of studies that found workers' personal trauma does not predict STS scores (Benuto, Singer et al. 2019).

However, the risk is not entirely due to individual vulnerability. Waegemakers-Schiff and Lane (2019) connected other factors to elevated levels of burnout and PTSD symptoms, including:

- the challenges of working with clients who are themselves traumatised by abuse, mental health issues and addiction issues
- workplace factors such as poor training, inadequate supervision debriefing, limited peer-to-peer support, low pay, constrained resources, and difficulty obtaining outcomes for clients.

Similar findings were made by Steenekamp and Barker (2024). Benuto, Singer et al. (2019) found that the number of hours working with trauma survivors is an important predictor of STS.

Empathy is one of the key requirements of client-facing work—yet that same empathy may also increase risk. In one study, empathy towards patients who shared traumatic stories made mental health clinicians more vulnerable to symptoms of PTSD (Henderson, Jewell et al. 2024). In another study, nurses who absorbed the emotional pain of their patients were at greater risk of burnout and compassion fatigue (Zhang, Zheng et al. 2021).

In healthcare settings, occupational violence and aggression can arise due to patient behaviour, lack of training, insufficient support, understaffing, and poor workplace policies (Somani, Muntaner et al. 2021).

Workplace culture and support are critical, as workplace violence—from both clients and colleagues—is more likely in environments where staff are under pressure. An Australian study of workers in the family violence and sexual assault sectors found that staff who agreed to feeling under pressure were 1.8 times more likely to experience repeated client violence, and 1.6 times more likely to experience repeated colleague violence (Natalier, Cortis et al. 2020).

More generally, many US and European studies into the work of frontline homelessness services note the challenging working conditions in the sector, and the role they play in driving turnover, burnout and other symptoms among workers (for example, Olivet, McGraw et al. 2010; Twis, Petrovich et al. 2022; Baptista, Benjaminsen et al. 2020; Carver, Price et al. 2022; Devilly, Wright et al. 2009; Wirth, Mette et al. 2019b). However, there is also some research with more mixed findings about the connection (Lemieux-Cumberlege and Taylor 2019).

Research in the domestic and family violence (DFV) sector has found that challenging organisational factors create an environment where workers may feel overwhelmed, underprepared and burnt out (Kulkarni, Bell et al. 2013; Mann 2023; Natalier, Cortis et al. 2020; Tsantefski, Humphreys et al. 2023; Voth Schrag, Wood et al. 2021). These organisational factors are further exacerbated by poor supervision and unsupportive workplace cultures (Natalier, Cortis et al. 2020; Voth Schrag, Wood et al. 2021).

In one study, moral distress among service providers was linked to the resource constraints that hindered their ability to support clients at the level they deemed ethically appropriate (Scharg, Fantus et al. 2023). Studies of social workers have similarly found constraints on time and resources in the face of demanding work targets and high caseloads to be significant contributors to workplace stress and trauma symptoms (Cocker and Joss 2016; Collings and Murray 1996; Louth, Mackay et al. 2019; Senreich, Straussner et al. 2020).

Kerman, Ecker et al. (2022b) suggest the concept of 'systems trauma' to refer to the structural and systemic factors that extend beyond individual workplaces. The concept of systems trauma is backed by the findings of other studies (for example, Robinson 2022; Wirth, Mette et al. 2019a; Lenzi, Santinello et al. 2021) and applies to other sectors working with clients in crisis, such as the DFV sector (Humphreys et al. 2023; Mann 2023; Tsantefski, Voth Schrag, Wood et al. 2021).

In defining systems trauma, Kerman, Ecker et al. (2022b) argue that the same factors that perpetuate homelessness—lack of affordable housing, inaccessible or inadequate mental health services, underfunding of services and the social safety net, along with the stigma of homelessness—harm frontline workers as well as the people experiencing homelessness.

Gaps, under-servicing, and inadequate support from other service systems and parts of society make supporting people to exit homelessness harder. People working in homelessness services end up acting as a 'catch-all safety net', battling other service systems to provide a better response, feeling frustrated at their inability to do more and worrying that they may be part of the problem.

The societal context that produces homelessness also devalues the work of homelessness services. This leads to persistent underfunding, low rates of pay, high caseloads and insecure employment (Kerman, Ecker et al. 2022b).

3.2 Empirical findings: drivers of workplace trauma on the frontline

Frontline workers and stakeholders in our national survey and individual interviews detailed a range of drivers that, in their experience, contribute to workplace trauma in the housing and homelessness sector. These included the extent to which personal commitment to the work and lived experience of homelessness, housing insecurity and other hardships acted as both motivators and sources of empathy, and increased the vulnerability of workers to workplace trauma. Other drivers, consistent with the experiences described in Chapter 2, arose from interactions with tenants, including the emotional and physical toll of supporting people through significant periods of crisis, the escalation in the complexity of need and the levels of client distress, and the extent to which workplace trauma was normalised in the sector.

At the organisational level, participants pointed to drivers such as under-resourcing in the face of consistently high demand, structural constraints on the capability and capacity of the workforce, inadequate coordination across different service systems, and failures by employers to meet WHS requirements—in part due to a lack of genuine understanding of frontline experiences.

Participants also pointed to the way service funding and contracts operated in the sector and talked about how the valorisation of a 'client-first' culture could unintentionally create a context in which worker safety was secondary.

Finally, workers talked about systems trauma—how the ongoing shortage of safe, affordable, appropriate housing and the erosion of the social safety net through under-resourcing of essential services made their work harder and more distressing.

3.2.1 Backgrounds and experiences

Both frontline workers and stakeholders identified that individual characteristics and personal histories of workers in the sector may increase risk of trauma. They explained that many people are drawn to the housing and homelessness sector by their own values, which are often shaped by lived experiences of trauma or marginalisation. Such a personal connection can enhance empathy and improve workers' ability to understand and meet client need (Black 2014; FEANTSA 2015). However, such connection can also heighten frontline workers' susceptibility to distress and vicarious trauma—particularly when systemic barriers limit their capacity to provide meaningful help. As one frontline participant reflected:

> The majority of people who work in community services, we all have our own story. We have a reason: we're there because we've experienced something ourselves that drove us to want to help other people, or prevent other people from experiencing what we have. So we all have our own underlying trauma to begin with. That's obviously a contributing factor. (Frontline, CHP, I07)

In addition to lived experience, some participants pointed to the failure of some workplaces to accommodate staff with a disability as a contributor to workplace stress. The failure to provide appropriate accommodations is discriminatory. As one worker observed:

> We have so many neurodivergent people in the workplace, and our workplace is so hostile to that. I reckon that is a pretty broad issue. Community services attract neurodivergent people, and community services bosses are just not accommodating. (Frontline, SHS, I02)

Stakeholders also thought that vulnerability to trauma could arise from the personal experiences and motivations of those drawn to the work. Stakeholders believed that the nature of housing and homelessness services—and the values that underpin them—tends to attract individuals with existing trauma histories.

One stakeholder explained, 'Lived-experience people are drawn to these roles, and often they can get triggered by the trauma that they deal with' (Stakeholder 03). Another suggested that 'even something as simple as coming across a client that has a very similar story to their own story' could be emotionally destabilising (Stakeholder 09). However, stakeholders were clear that this should not be seen as blaming workers for their vulnerability. Rather, they emphasised the need to recognise and respond to the additional emotional load carried by some staff—particularly when trauma histories or mental health issues were undisclosed or undiagnosed. One participant explained:

> It adds an extra layer … the impact of an undiagnosed or not advised mental health issue such as anxiety or depression … It becomes a bit like entering the unknown … You offer all the organisational support, but something is triggered or acted out at home, and it's an extra layer to manage. (Stakeholder 07)

The need for enhanced cultural safety within services (Tually, Tedmanson et al. 2022), as well as the importance of incorporating the views of clients/tenants and others with lived experience into trauma-informed service delivery and design (FEANTSA 2015; Henderson, Everett et al. 2018), means that having appropriate supports and accommodations for all staff members are critical in preventing workplace trauma.

3.2.2 The nature of the work: interactions with clients/tenants

Across both frontline and stakeholder interviews, exposure to traumatic events was viewed as a persistent and unavoidable aspect of working in the social housing and homelessness sector. Participants described a work environment in which vicarious trauma was embedded in daily practice, driven by continuous exposure to clients who are experiencing acute distress, are in crisis or are grappling with past traumatic experiences. Frontline staff consistently emphasised the emotional toll of hearing clients' graphic and distressing personal experiences, including DFV, sexual assault, childhood abuse, self-harm and suicide:

> We're constantly hearing stories about domestic violence—about the perpetrators, the victims, and the survivors … We hear incredibly horrific things. Necrophilia, for example. Things most people wouldn't even imagine confronting in their daily work. (Frontline, STHA, I14)

Crucially, trauma exposure in this context is not limited to witnessing or listening. Frontline workers were often directly involved in managing acute client crises, including high-risk physical interventions. These included responding to suicide attempts, administering CPR, or providing medical assistance for serious self-inflicted injuries. As one participant noted:

> It is being on the frontline and being invariably abused, physically threatened, maybe physically assaulted, having to give CPR compressions or redressing someone's self-harm wounds and things like that, the suicide-risk assessments. (Frontline, SHS, I03)

In some instances, staff found the intensity of client crises and the extreme nature of the interventions required deeply confronting. One frontline worker described their experience with one of their clients:

> Staff have had to attend her property, and there's been blood everywhere [due to self-harm]—you could smell it the moment you walked in. That level of harm is extreme, but even if it's not always that severe, this kind of exposure is something our staff deal with regularly. (Frontline, CHP, I13)

Interviewees consistently suggested that the complexity and severity of client presentations are escalating with time. Many reported that violent assaults, untreated mental illness, and forensic-level cases were becoming more common in routine service delivery. One worker with 20 years' experience said it was 'becoming more and more frequent—we're seeing clients every day who've been assaulted or raped in their own homes' (Frontline, STHA, I15). They went on to say:

> One of my current clients, who's on a forensic mental health order after [assault and kidnapping details] has been re-housed in one of our properties. The hospital tells me this is 'normal'. I've been doing this for 20 years—I completely disagree. (Frontline, STHA, I15)

Stakeholders shared these concerns, confirming that trauma in housing and homelessness services was experienced not as an occasional hazard but as an inescapable feature of the work in the sector. One stakeholder remarked: 'It's the norm. It's your everyday work, isn't it? You're like, "That's just part of the territory," and that can have long-term impact' (Stakeholder 03). Another confirmed the inherent risks associated with frontline client work:

> We must deal with the clients. The clients are the risk factor … As [Workplace safety agency] says, there is no such thing as a totally safe environment when you're working with people. (Stakeholder 06)

Visceral, cumulative and emotionally overwhelming experiences on a day-to-day basis contribute significantly to the risk of vicarious trauma among housing and homelessness workers. Frontline workers frequently stressed that it was the ongoing and repeated exposure to such events that gradually undermine their psychological wellbeing. Stakeholders noted that the inevitability of exposure placed the realities of frontline practice at odds with existing workplace safety legislation—which typically assumed that harm can be prevented through elimination or containment of risks. As one stakeholder explained:

> Most language in the safety legislation is: 'We'll remove it. Just don't allow your worker to be exposed to it. Do your best to contain it, to isolate it, to come up with different workarounds and controls.' I think, given the environment and the work environment that we're in, to do that would mean we're not providing the service. (Stakeholder 02)

However, some stakeholders warned that there can be consequences when the acknowledgement that trauma exposure is inevitable is taken too far, including workers becoming 'numb', or complacency that prevents any remedial action. In other words, when risk is normalised, it may no longer be recognised or reported—which leads to unresolved harm and a culture where suffering is silently absorbed. As one stakeholder explained:

> I think there's a risk of risk normalisation as well. Where some people start to see that as, 'That's just the job.' We risk under-reporting when people experience risk normalisation. (Stakeholder 09)

3.2.3 Organisational and sector-wide drivers

Both frontline workers and stakeholders consistently identified conditions in organisations as critical drivers of vicarious trauma in the housing and homelessness sector. While these issues occur within individual workplaces, they are also characteristic of the sector, so we have grouped them together for analytical purposes.

Participants described work environments characterised by chronic under-resourcing, fragmented systems, and inadequate structural supports—factors that collectively undermined staff wellbeing and intensified emotional burden. These conditions also created moral distress, particularly when workers were unable to meet the needs of clients despite their best efforts. As one worker described:

> We could have 10 more staff and we'd still be struggling—but it would make a huge difference … We've got a waiting list now, with each worker carrying around 25 clients … We've got around 80 unallocated clients—that's 80 men waiting for a case worker, and all of them are homeless. (Frontline, SHS, I10)

This pressure was particularly acute in the context of the ongoing housing crisis. Workers reported that the volume and complexity of referrals was increasing, alongside intensifying administrative demands. As one frontline worker explained:

> In previous years, we were lucky if we were getting one to five calls a day. Now we get 85 calls per week [an average of 17 calls a day] … By the time you get to Friday, you have a worker who is very distressed about not being able to meet demand and carry out the necessary reporting requirements … The manager was pulled in part-time and still couldn't meet demand. (Frontline, SHS, I04)

There were also concerns about the sector's over-reliance on underqualified, casual or temporary staff. This trend not only posed safety risks, but placed added pressure on more experienced team members. One frontline worker reflected:

> We're putting people in roles who are probably not the sort of people we would have put in roles 10 years ago … We're promoting people sometimes just on the basis of them being the last person standing … Locums might do two shifts and never return. Casuals may not know what's going on. That confusion can cause major issues with clients. (Frontline, SHS, I01)

The chance of attracting better-trained workers was undermined by persistent underpayment and insecure employment. Stakeholders noted that short-term contracts and low wages contributed to high staff turnover and financial pressure, even among committed workers. As one stakeholder complained:

> We lose really good people in May and June every year [around funding cycles] … because people need to be able to pay their mortgages or pay their rent or whatever. And the cost of living and the housing affordability crisis doesn't help that at all. (Stakeholder 09)

This stakeholder also pointed out that contract terms are largely controlled by government funders rather than service providers, as is contract timing:

> I'm actually so surprised since coming into the not-for-profit sector, at how late in the game we find out. I'm often only finding out whether we need to move people into new roles weeks before the end of the funding … You have people coming to talk to you about, 'Well, what's happening with my job?' And you're like, 'Well, I actually genuinely don't know the answer to that.' (Stakeholder 09)

Even when contracts were renewed, stakeholders noted that funding levels were frequently inadequate to ensure safe staffing levels. One recalled:

> We were having one staff member on overnight, and managing some really critical incidents … It was significant self-harm … so many high-level incidents. (Stakeholder 01)

Poor supervisory practices were also widely reported. Supervision, in the sense of a structured opportunity to reflect on practice, was described as infrequent and inadequate. One participant complained of supervision 'being used interchangeably with line management' (Frontline, SHS, I04). (See Chapter 4 for a more detailed examination of supervision, and its relationship to trauma outcomes.)

Along with internal stressors, workers described the pressure arising from inadequate coordination across service systems. They felt isolated and unsupported in a fragmented environment:

> The broader community services system is not pitched for us to collaborate well … We're hitting walls with other workers, and they're just trying to get through their day as well. (Frontline, SHS, I02)

Stakeholders also pointed to the consequences of delivering core welfare functions across a disjointed network of government, non-government and for-profit providers. This fragmentation, they argued, created major obstacles to effective collaboration and information-sharing, and contributed to problematic client behaviour:

> We ask the same questions. Different services or different people ask the same questions, and we're asking people to re-live the things that have led up to where they are at the moment. And I think that can cause some frustration. (Stakeholder 05)

Stakeholders strongly echoed the concerns raised by frontline workers and identified several additional organisational-level factors that contribute to vicarious trauma. Union stakeholders cited persistent failures by some employers to meet basic workplace health and safety obligations, including poor implementation of risk management procedures and minimal engagement with staff feedback on safety issues. As one stakeholder stated:

> [There is often] a lack of adequate controls, employers not taking psychological health and safety seriously, employers not understanding their obligations, employers not caring to understand their obligations. (Stakeholder 10)

Union stakeholders reported that even when staff raised concerns about unsafe practices, such as working alone or managing high-risk clients without adequate backup, their input was often dismissed or deprioritised. They suggested that this was connected to the lack of frontline or sector experience among senior managers:

> They don't know how the work is done, how the clients or client groups operate, and practices are put in place that might work in corporate, for example, [but] lead to unsafe experiences and ongoing risks in housing and homelessness services. (Stakeholder 10)

Frontline workers reported similar concerns:

> I remember calling to report the incident, and they just said, 'Make sure you do an incident report.' I said, 'Yeah,' and they replied, 'Okay, there you go.' That was it. I was in shock. I couldn't believe I was nearly stabbed. (Frontline, STHA, I14)

A prevailing culture of resignation and emotional suppression was also described:

> At this point, if we say we feel unsafe, it's brushed off. There's this ingrained culture that we just have to be tough—like we're expected to laugh it off even if someone's attacking us. That's where things are at. (Frontline, STHA, I15)

Despite the pressures, workers strove to prioritise the needs of clients. But this ethos of 'the client comes first' was linked by some stakeholders to an exacerbation of workplace trauma. While centring client needs is essential, some stakeholders suggested that an unintended consequence was sometimes the deprioritisation of worker safety and wellbeing. One stakeholder described a situation in which a worker, despite being alone and without a duress alarm, was directed to conduct a welfare check:

> The client wasn't answering, and doing a safety check on their own was unsafe, but their concern was so great for the client and that the client might die on their watch, they undertook that task. (Stakeholder 10)

This stakeholder went on to say:

> When you have the workers and the employers saying that these are vulnerable people and we do need to prioritise their needs, you create this atmosphere where it's almost expected that the health and safety needs take a backseat. (Stakeholder 10)

Another stakeholder reflected on the same issue, saying that although the tendency of workers to put themselves last and the client first meant they could develop strong, effective connections with clients, 'what it does mean is that oftentimes people don't recognise, until it's too late, that they need a change or they need some leave or they need some support' (Stakeholder 09).

3.2.4 Working within crumbling welfare and support systems during a housing crisis

Both frontline workers and stakeholders pointed to systemic drivers as a core source of workplace trauma and distress. A dominant theme across interviews was the emotional toll of being unable to meaningfully support people in crisis due to system barriers—particularly the lack of available, appropriate housing and inadequate government support:

> Just the other day, I had some workers come in and tell me they couldn't sleep the night before. They were so upset about having to deliver outcomes to homeless clients—telling them there's no help available. (Frontline, STHA, I14)

> A lot of it is vicarious trauma—seeing people in trauma day in and day out and not being able to adequately meet their needs. You're watching people struggle, and often it feels like we're just putting a Band-Aid on a gaping wound. (Frontline, STHA, I11)

> That's probably the thing that traumatises me more than the actual shit that happens here onsite. There's no way of making this better. (Frontline, SHS, I20)

These reflections underscore the need to reframe vicarious trauma not solely as an outcome of working with traumatised individuals, but as a consequence of working with traumatised people in such severely under-resourced systems—specifically the chronic underinvestment in housing and support services. As one worker argued:

> I think government probably need to understand that the impact on people's psychological wellbeing—and I mean by that the client group—is hopelessly compromised by the lack of investment in services, and in housing and support. (Frontline, SHS, I01)

Frontline workers consistently identified interactions with government departments as a major source of workplace distress. For SHS workers, this included interactions with STHAs. These experiences were often described as being equally or even more emotionally taxing than direct client work. Many workers were left feeling emotionally depleted after navigating bureaucratic systems marked by rigid eligibility criteria, long delays, and inflexible procedures. Rather than supporting effective outcomes, these systems were frequently seen as obstructive and compounded the trauma of working with people in crisis. One frontline worker detailed:

> I always joke that we get paid by Housing just to fight with them—because that's what we spend most of our time doing: arguing to stop people from being put on the street. The most traumatic part of the job is dealing with Housing. It's like being on a battlefront—we're constantly having to fight on behalf of our clients. If we weren't doing it, they'd be doing it themselves and getting into trouble. (Frontline, SHS, I10)

More broadly, frontline workers and stakeholders both pointed to the complexity of a service-delivery landscape marked by outsourcing, fragmentation and chronic underinvestment. Rather than operating as an integrated safety net, the support system frequently functioned as a collection of disconnected services, each with its own narrowly defined eligibility criteria, referral processes and limitations. This left staff and clients caught in a web of silos, forced to navigate complex bureaucracies to access even the most basic supports.

The fragmentation was particularly acute for clients with multiple or overlapping needs—such as mental health challenges, disability, or substance use issues—who frequently found themselves excluded from the services they needed:

> We have so much trouble collaborating with other services because they'll say that our clients are not eligible because they're homeless. (Frontline, SHS, I02)

> It's almost like it's the other way around … being homeless isn't enough to get support, you have to have something else. These people are the ones that fall through the cracks, then they move in [to social housing] and they have a mental breakdown, and everyone's like, 'No one saw it coming.' (Frontline, CHP, I06)

As well as client distress and risk of crisis, these systemic barriers also placed significant emotional and logistical strain on frontline workers.

Another consequence of fragmentation was that the contract-based model placed legal responsibility for workplace health and safety on individual organisations—but then often left those organisations with limited control over the policy, funding, or structural settings that shape their operating environment. At its worst, stakeholders described this disconnect as leading to a culture of 'buck-passing' between government and service providers:

> I think government and employers point the finger at each other as the responsible party. Obviously, the Act says that it's the employer who has the responsibility. But the employer says it's the sector, or it's the worker or it's the funder, or they just deny it. But there isn't active ownership by either of the parties to know the buck stops with us in terms of prevention. (Stakeholder 10)

Under-resourcing exacerbated the effect of fragmentation. Services were described as operating in a constant state of crisis, with staffing stretched thin and resources falling short of demand. This left little to no room for early intervention, recovery-oriented work, or sustained engagement with clients, despite clear evidence that these approaches are more effective and less costly in the long term. Instead, staff were forced to prioritise the most acute cases, often making difficult trade-offs and working in reactive, high-pressure environments. This cycle of reactivity diminished the quality of support available to clients, eroded staff morale and heightened the emotional toll of the work:

> The reality is that, across most services, resourcing is so stretched that responses are largely limited to crisis intervention. We know that early intervention would be less intensive, more effective, and likely more cost-efficient—but the capacity to provide that level of support just isn't there. (Frontline, STHA, I11)

As noted in Section 3.1 Kerman, Ecker et al. (2022b) use the concept of 'systems trauma' to refer to the effects of these kinds of systemic barriers. To identify whether systems trauma was applicable to the Australian context, we included in our survey seven statements intended to assess the importance of systemic issues in frontline homelessness and social housing work. Survey participants were asked to rate their agreement with each statement (see Table 4). Their responses strongly suggest that systems trauma is significant in the Australian system.

Over 90% of respondents agreed that the lack of affordable housing and crisis accommodation significantly limited their ability to deliver outcomes for clients (92.1% and 90.7% respectively). Close to the same proportions identified inadequate income support (88.9%), underfunding of services (89.5%), and gaps in other systems—such as mental health and child protection—as key barriers (86.5%). Three-quarters (75.6%) agreed that limited organisational resources had negatively impacted the quality of their own work with clients. Together, these results illustrate the extent to which external structural constraints are experienced as both a practical and emotional burden in day-to-day practice.

Table 4: Percentage of participants agreeing or strongly agreeing with systems trauma statements

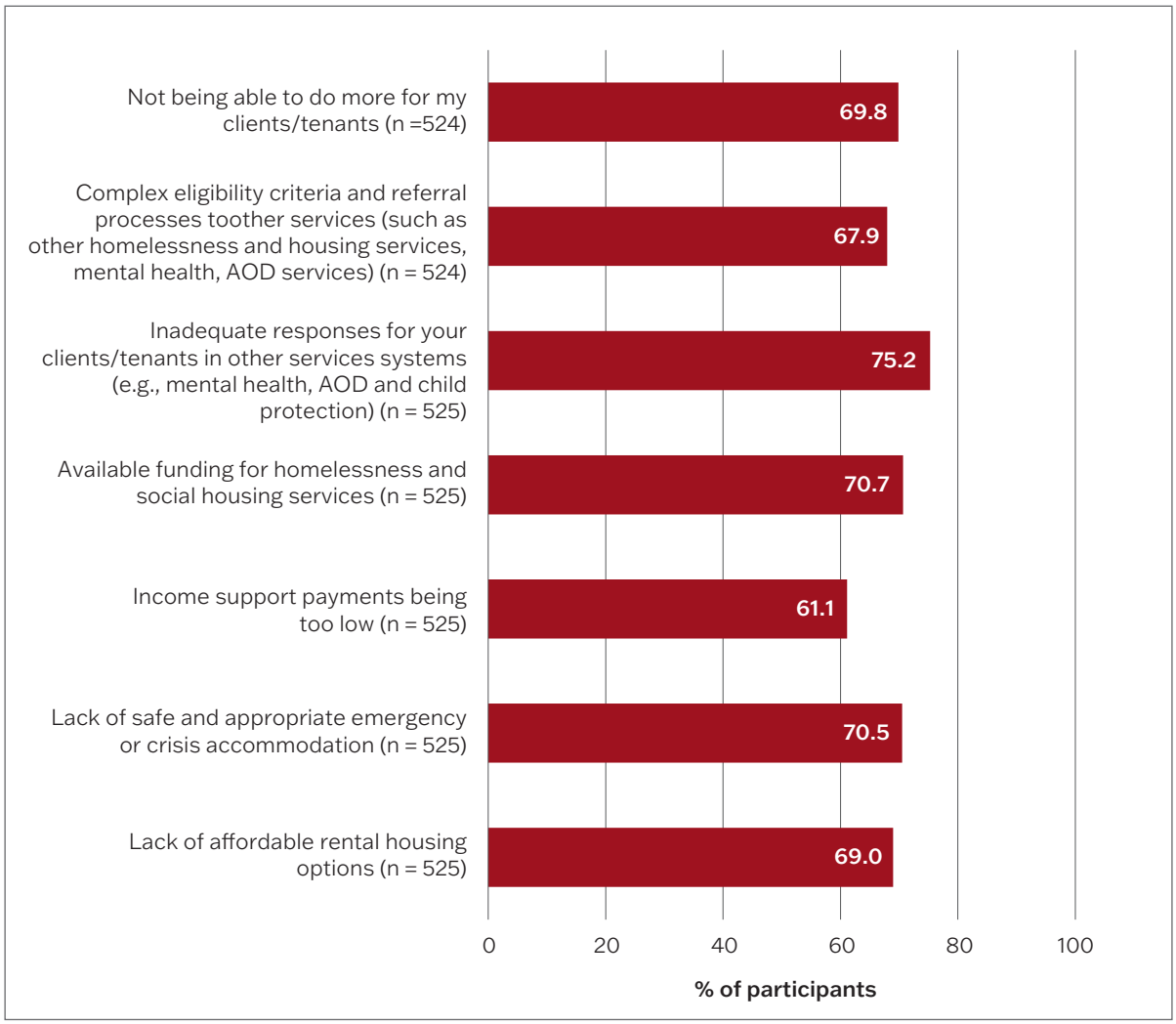
Statements about systems trauma	Percentage of participants (%)
The lack of affordable housing options limits my ability to provide outcomes for my client/tenant. (n=492)	92.1
Current low levels of income support payments make it difficult to source or provide housing for my clients/ tenants. (n=488)	88.9
The levels of funding for homelessness and social housing services negatively impact the quality of service that can be provided to clients/tenants. (n=505)	89.5
Lack of safe and appropriate emergency or crisis accommodation limits my ability to provide outcomes for my client/tenants. (n=473)	90.7
Limited resources at my organisation have negatively impacted on the quality of service I can provide to clients/tenants. (n=505)	75.6
Other services and service systems (such as mental health, AOD and child protection) often provide inadequate responses to people experiencing homelessness and those living in social housing (n=496)	86.5
I spend a lot of time at work battling with other service systems to get support for my clients/tenants. (n=484)	83.5

Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

In addition to indicating their agreement with the statements, participants were asked to rate the extent to which each of the seven systemic factors contributed to stress in their day-to-day work using a five-point Likert scale (see Figure 6). The results point to the extent to which systemic problems contribute to the risk of workplace trauma.

Three-quarters of participants (75.2%) said inadequate responses from other service systems caused them stress ‘quite a bit’ or ‘extremely’. Almost three-quarters reported stress arising from funding constraints (70.7%), and the lack of safe and appropriate emergency or crisis accommodation (70.5%). Over two-thirds were stressed by the inability to do more for clients (69.8%) and the lack of affordable rental housing available to clients (69.0%).

Figure 6: Percentage of participants who reported each systems factor contributed 'quite a bit' or 'extremely' to stress in their day-to-day work



Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

3.2.5 The limitations of residential tenancy law

Frontline workers and a stakeholder discussed challenges posed by current residential tenancy law for dealing with aggressive tenant behaviour. While there was a general understanding that some behaviour stemmed from unmet needs, workers noted that at times tenant behaviour was sufficiently problematic and tenancy managers had limited options at their disposal beyond eviction.

As one frontline worker explained:

> We had a scenario here where we were getting abused every day … we had every single staff member to the point that they were ready to quit because of the impact of this one person … but the only way we can actually get someone kicked out of this place is if they hit—if they assault staff, or if they don't pay their rent. That is the only two reasons that [Organisation] will take somebody to court to have them evicted. Management just went, 'Oh well, yes, they can abuse them but if we take it to court, court is not going to actually kick them out so we're not going to bother taking them to court.' (Frontline, SHS, I20)

A CHP stakeholder and other frontline housing workers provided further examples of extreme behaviour that posed a risk to other tenants and to staff, including:

- threats with weapons
- organised criminal behaviour
- physical and sexual assault of other tenants.

Despite the severity of these behaviours, residential tenancy laws made eviction difficult. The stakeholder described instances of attempts to evict tenants with these extreme behaviours, but being unsuccessful at the tribunal because it would mean evicting the person into homelessness. As a result, staff and neighbouring tenants were left in dangerous situations.

In Victoria, neighbourhood impact statements have been introduced to allow housing providers a formal way to document the negative impact of some tenants upon others in an effort to support evictions, when necessary. However, according to one stakeholder, these impact statements are not given much weight by the tribunal, which limits their effectiveness.

3.3 Conclusion and considerations for policy makers

Workplace trauma within the social housing and homelessness sector is shaped by systemic and organisational conditions. While individual and interpersonal dynamics—such as workers' own histories of trauma, or their exposure to distressing client experiences—contribute to psychological risk, the broader environment in which services are delivered significantly deepens this risk. For participants, organisational, sector and systemic issues converged to create a persistent source of moral and occupational distress. Many of these are issues over which policy makers exert some control.

To meaningfully prevent or mitigate workplace trauma in the housing and homelessness sector, interventions must extend beyond individual level supports to address the structural and systemic conditions that drive harm.

Pressure on frontline workers could be reduced with better infrastructure for collaboration across services and between sectors, careful workforce planning to ensure there is a skilled workforce to match demand, and strategies to retain experienced staff and support them into management roles. There also needs to be significantly increased and much more reliable longer-term funding for social housing, homelessness and allied sectors. The current degree of underfunding for allied sectors such as mental health has serious implications for worker safety wellbeing in the homelessness and social housing sectors and beyond.

The next chapter examines the impacts of workplace trauma on frontline workers, service delivery, organisations, and the broader sector.

4. The impacts of workplace trauma on workers, organisations and service delivery

Previous chapters examined the experience of workplace trauma and the factors that drive it. In this chapter, we turn to the consequences of workplace trauma, responding to our third research question: What are the impacts of workplace trauma on housing and homelessness workers, organisations and service delivery?

The chapter begins with a review of the relevant literature. It then presents data collected through our interviews and survey data, including the results from the validated screening tools for PTSD, VT and burnout included in the survey. We explore the consequences of trauma exposure for individual workers, service delivery and organisations in a bid to examine the way workplace trauma extends into different levels of the social housing and homelessness system. The chapter concludes with a discussion of implications for policy makers.

4.1 What does the literature tell us about the impacts of workplace trauma?

Workplace trauma has a significant impact on frontline workers, both personally and professionally. On a personal level, one of the key effects is the deterioration of psychological wellbeing (Maheen, Dimov et al. 2021) and mental health (Cocker and Joss 2016; Kapoulitsas and Corcoran 2015; Ogińska-Bulik, Gurowiec et al. 2021; Ravalier, Jones et al. 2022). Employees may experience symptoms such as burnout (Baptista, Benjaminsen et al., 2020; Kerman and Ecker, 2022a; Mann 2023; Reamer 2022; Natalier, Cortis et al. 2020), anxiety, stress and emotional overwhelm (Kapoulitsas and Corcoran 2015; Smith and Hanna 2021), depression (Smith and Hanna 2021; Zhang, Zheng et al. 2021), fear and anger (Zhang, Zheng et al. 2021), and even PTSD (Cocker and Joss 2016).

One qualitative study in the US found that moral distress had damaging effects on emotional and psychological health, and contributed to a lack of empathy and motivation, sadness, frustration, isolation, avoidance and detachment (Scharg, Fantus et al. 2023). Like primary trauma, VT can distort workers' worldviews, affecting their sense of trust, safety, control, self-esteem and intimacy (Isobel and Thomas 2022), which can lead to increased substance use, and emotional withdrawal from family and friends (Vrklevski and Franklin 2008).

Workplace trauma also has physical health repercussions (Cocker and Joss 2016). Exposure to high-stress environments can lead to issues such as chronic fatigue, disturbed sleep and exhaustion (Louth, Mackay et al. 2019; Menschner and Maul 2016), headaches, musculoskeletal disorders, tinnitus, gastric disorders, and increased susceptibility to diseases (Wirth, Mette et al. 2019b). Occupational stress is associated with a higher rate of hypertension and other cardiovascular conditions (Vrijkotte, van Doornen et al. (2000).

From an organisational perspective, the repercussions of VT extend beyond individual wellbeing. Research shows that VT can adversely affect motivation, productivity, and the core of therapeutic or helping relationships. For example, studies in housing and homelessness services indicate that trauma can impair workers' ability to connect with clients (Steenekamp and Barker 2024). This reduces the quality of services and workers' decision-making abilities (Cocker and Joss 2016), along with their effectiveness in responding to clients' needs (Newcomb 2022). Emotionally depleted workers may struggle to maintain empathy and patience (Henderson, Jewell et al. 2024; Ravalier, Jones et al. 2022). VT in nurses has been associated with negative patient outcomes (Isobel and Thomas 2022) and organisational challenges, such as financial strain due to increased sick leave (Raunick, Lindell et al. 2015).

Another significant organisational impact of workplace trauma is high turnover rates and decreased commitment to—or disillusionment with—the organisation (Newcomb 2022; Vrklevski and Franklin 2008). This creates a cycle of instability within the workforce, diminishing service quality as new staff require time to adjust and train, leading to inconsistent care delivery (Brown et al. 2021). Staff turnover can also create a negative feedback loop, exacerbating similar feelings among remaining employees (Menschner and Maul 2016). Furthermore, high demands and insufficient resources can affect overall job satisfaction and effectiveness (Ravalier, Jones et al. 2022) and lead to burnout (Henderson, Jewell et al. 2024; Scanlan and Still 2019). In homelessness services, such pressures affect service delivery by limiting the time workers have to respond to clients (Robinson 2022).

In their study, Louth, Mackay et al. (2019) noted that although participants recognised VT as a factor in staff retention and burnout, it was not perceived as a high priority for organisational attention—which is particularly concerning given the significant emotional, social and economic costs associated with trauma. They argue that rather than viewing trauma solely as an individual issue, it should be understood as an occupational hazard for helping professionals, thus warranting organisational responsibility (Louth, Mackay et al. 2019; Smith and Hanna 2021).

4.2 Empirical findings: the many consequences of workplace trauma

4.2.1 Consequences for workers

In this research, frontline workers identified a range of ways workplace trauma affected them as individuals. The effects included persistent hypervigilance, emotional exhaustion, moral distress and physical symptoms of stress. These effects manifested during work and spilt over into their personal lives:

> I go into a hypervigilant mode where I like to know exactly who's around me and what's going on. Yeah, and that's not good for mental health. (Frontline, SHS, I19)

> When I hear a voice raised, I'm much more likely to go into: 'I need to resolve this,' or you go into the work mode very quickly. You find yourself problem- solving. 'Oh, is this going to be an incident? What do I do now?' That's okay at work to some extent, but if it's happening on the tram and in a restaurant … and I would say there's a little more vigilance than perhaps I need. (Frontline, SHS, I01)

> I don't always realise it myself, but my sister says I'm really hypervigilant—I notice everything. I'll say, 'That person over there doesn't have any shoes on,' or point out other little details. I think it comes from working in post-release, where we had to deal with knives, guns, all sorts of things. You just learn to constantly scan your surroundings. (Frontline, SHS, I10)

Other workers found that they had become increasingly focussed on particular things that might suggest ongoing risk of harm to clients, such as children in their day-to-day work. For example, one tenancy manager commented:

> I'm always looking out for kids, I can't help [it]. I don't just walk in and go, 'The house is messy,' stuff like that. Naturally, I'm looking to see the kids' clothes and their faces and their bed. If their bed [has] actually got sheets on it, and I'm a lot more—I don't know if that's because I'm a mother or because of that incident [where child protection were called]. (Frontline, STHA, I08)

Another worker described how workplace trauma had affected their ability to use the phone:

> As a seasoned worker, there are times when that phone rings that I have a physical response of terror—what was going to come at the end of that line? Having to play messages back—that is equally very distressing. (Frontline, SHS, I04)

One worker reflected on the experience of one of their colleagues:

> I watched a worker sitting behind perspex at reception, repeatedly being yelled at. I watched him be constantly yelled at, or preparing to be yelled out. He was already outside his window of tolerance at the start of the shift. (Frontline, SHS, I04)

Following a serious assault at work, another worker shared:

> When I recently responded to an overdose and the person was non-responsive, it really triggered me. I didn't realise in that moment, and then, when my co-worker and I reflected on it afterwards, I said, 'When I went to roll that person over to start CPR, I kind of froze', and I realised afterwards that had taken me back to what had happened, and that's why my brain just froze in that moment. Ninety-nine per cent of the time I'm good, but there's definitely one per cent of the time [when I'm not] (Frontline, SHS, I05)

Some workers reported being fearful of clients—both on their own behalf and on behalf of their families:

> Sometimes the job, it wears you down. Like for example, I don't walk through town with my children, deliberately, so they cannot be targeted as, 'Oh, they're [worker's] kids. Let's go after them.' That kind of stuff. (Frontline, SHS, I19)

> You have things in the back of your mind. I live quite close to a lot of the properties that I look after, so when things are happening in that pocket, that can be a bit scary because it's very, very close to home. (Frontline, CHP, I07)

Workers reported physical symptoms similar to those that commonly arise from stress, depression or traumatic stress, including sleeping difficulties and preoccupation with events and content from work. Some reported maladaptive coping skills among colleagues, such as drinking alcohol after-hours to cope with distress about work. For example, one worker said:

> I was ruminating a lot on that stuff and leaning on informal supports quite a bit. Friends and my partner. Through to losing sleep at times, and having stress and anxiety symptoms on the weekends: gut pains, trouble sleeping, just not being able to wind down. (Frontline, SHS, I02)

Workers also described feelings akin to moral injury—responses of frustration and anger towards their own and other service systems for failing to provide an appropriate response to clients. This applied particularly to mental health and child protection services, but also to family violence, drug and alcohol services, and police and health services. Workers felt implicated in the harm caused to clients from these inadequate responses. This was particularly the case when workers had a longer-term relationship with clients and watched them deteriorate over time despite determined efforts to find appropriate supports for them. Feelings of distress at not being able to do more for clients were common.

> I've had relationships with some people for over 20 years, and I've watched them come back every two or three years—and each time, life has gotten worse, not better. It's heartbreaking to think that the system meant to support them has failed so badly that they're actually in a worse place than they might have been without us. (Frontline, STHA, I11)

Following a tenant who died by suicide after interventions and advocacy, a tenancy manager reflected:

> I felt really angry at the mental health system … I felt really angry because I had rung the [crisis response mental health team] so many times. I had rung mental health so many times. I felt really angry about that because on so many occasions this person was saying, 'I want to kill myself.' … It felt like they were crying out for help and no one was listening. (Frontline, CHP, I06)

Another tenancy manager said:

> I find it really challenging having to say 'No' to people, knowing exactly what the next step is for them—and knowing there's nothing I can do. I've tried to advocate, but the rules are strict. They're strict on the budget—sometimes it feels like [management are] acting as if they're going to get a bonus at the end of the month for sticking to it. (Frontline, STHA, I14)

A number of workers reported relying on family and friends for support due to an absence of appropriate support at work. Some described negative impacts on their relationships with their immediate family and reported being controlling or overly reactive, while others described themselves as being emotionally unavailable at times at home. For example, one worker said:

> I find for myself [that] if lots is going on here at site, I'll go home and I'll micromanage my family like a little Hitler because I need control. I scream, I yell, I become verbally abusive to my family because I need some semblance of control. (Frontline, SHS, I20)

Another relied on their friends:

> We are shiftworkers—if I've had a really difficult shift from 5.45pm till midnight, who am I meant to vent to? All I can say is, thank goodness I have friends who live across the world who I can vent to, who understand my job. I can just get there and go, 'This is what happened at work today, what a joke,' or whatever, and they don't take it personally. (Frontline, SHS, I19)

The intensity of negative experiences and events at work meant workers needed additional time and resources to process and manage outside of work hours. One worker reflected on their recovery from an assault at work two years prior:

> There's no recognition of the amount of time that you have to spend outside of the workplace getting your head right after something like that happens. It can take you a concerted effort of hour upon hour, or day after day, to get yourself to a place where you feel good again. I think generally, doing this work, that I have to spend a lot of time doing that, making a concerted effort to make sure that we're okay. (Frontline, SHS, I05)

The cumulative effect of trauma emerged strongly from many interviews:

> About 18 months ago, I came really close to burnout. I still remember the day, even though I don't know why that moment hit me so hard. A client blew up at me—which happens all the time—but I was already so burnt out that it completely floored me. I had to leave, sit in my car, switch my phone to aeroplane mode, and just be unreachable. I sat there and cried for about four hours. Your cup just gets so full. That's why people either leave, or it starts to affect their personal life. It impacts everything—not just work, but your whole life. (Frontline, CHP, I13)

Stakeholders acknowledged that people's capacity to manage trauma varies over time: 'Our resilience, our capacities, all those things vary and they vary throughout our lives' (Stakeholder 06). And while some workers experienced stress, burnout and mental health issues, others found that 'it made them more determined' as the 'meaning and purpose' they found in their work 'increased their motivation in general … and kept them there' (Stakeholder 03).

One stakeholder explained how the consequences of workplace trauma could cascade through a worker's life:

> Low productivity. The individual worker that's impacted—it can play out in any way, low productivity, not coming to work, they're not engaged with their clients. All the way to—depending on the trauma or the impact—not being able to return to the work environment, depression, anxiety. Increase of drug and alcohol use in some [workers], and just general disengagement from clients. (Stakeholder 07)

Despite the very challenging nature of frontline work and the myriad of negative impacts, many workers continued to work in the sector because of a deep commitment to social justice. However, some felt this led to exploitation by their employer:

> We all have a strong sense of social justice. We do it for the clients—that's what drives us. That's why we work extra hours, skip lunchbreaks, and go above and beyond. Most of us are deeply empathetic—we genuinely want to help. We want to make a difference. And that's what makes it incredibly hard [to not be able to really help]. (Frontline, STHA, I14)

Some stakeholders felt that some workers were better able to cope with the work than others. Yet some frontline workers felt that employers deflected responsibility with the view that some workers were not 'cut out for the work':

> I keep trying to point out Section 19 of the Work and Health Safety Act, you are responsible as the PCBU. But as I said, there's nothing I can do … even when people go to Workers' Compensation, which happens a lot here, particularly under mental health stress, it just comes back to, 'Oh, that person wasn't coping. That person wasn't meant for here.' They [management] take no accountability. (Frontline, sector removed to protect confidentiality)

One coping strategy used by participants was dark humour:

> I had to tell a resident—who was really mentally unwell—that I had to end his time here, because he was physically threatening and destroying his room and things like that. I told him outside in the front area, myself and another team leader and his caseworker, and he stood up and he was a menacing human being. I'll never forget, he was eating this sausage roll, and he just kind of started spitting it everywhere, going, 'I'm going to fucking kill you.' And he ended up chasing me down the street. I remember running, and I ended up just laughing, because I'm going, 'What are people thinking? I'm running down the street, I'm wearing this bright-red T-shirt, I'm carrying a two-way, my keys are flying everywhere.' I knew that I could outrun him, that's fine. But it didn't affect me at all at the time—I was more worried about, 'Shit, did the caseworker and the other team leader get away?' And then I ended up doing a lap around the block, and then he's walking towards me, so I go for another run, and I'm thinking, 'I'm getting my steps up here, I'm doing a bit of cardio.' And I'm thinking, 'Wrong day to wear dress shoes, wrong day to wear tight jeans.' I just thought it was hilarious, because the worst thing to do is wear a bright-red T-shirt when someone's chasing after you, right? Like waving a red flag at a bull. I can laugh about it. I didn't see it as a big deal. Maybe if he caught me—obviously that would have been a very, very different story. (Frontline, SHS, I03)

4.2.2 PTSD, vicarious trauma and burnout

As noted in Section 1.4, the survey included three formal screening tools for certain forms of trauma. This section presents the results for each of these.

Overall, almost half (42.7%) of the participants (n=518) screened positive for post-traumatic stress symptoms. Results differed by sector, with a positive screen recorded by:

- 35.7% (n=84) of workers in CHPs
- 42.4% (n=337) of workers in SHS
- 49.4% (n=97) of workers in STHA—including SOMIH.

This finding is in line with two recent Canadian studies that investigated the prevalence of PTSD symptoms among workers in homelessness services (Kerman, Ecker et al. 2022a; Waegemakers Schiff and Lane 2019).

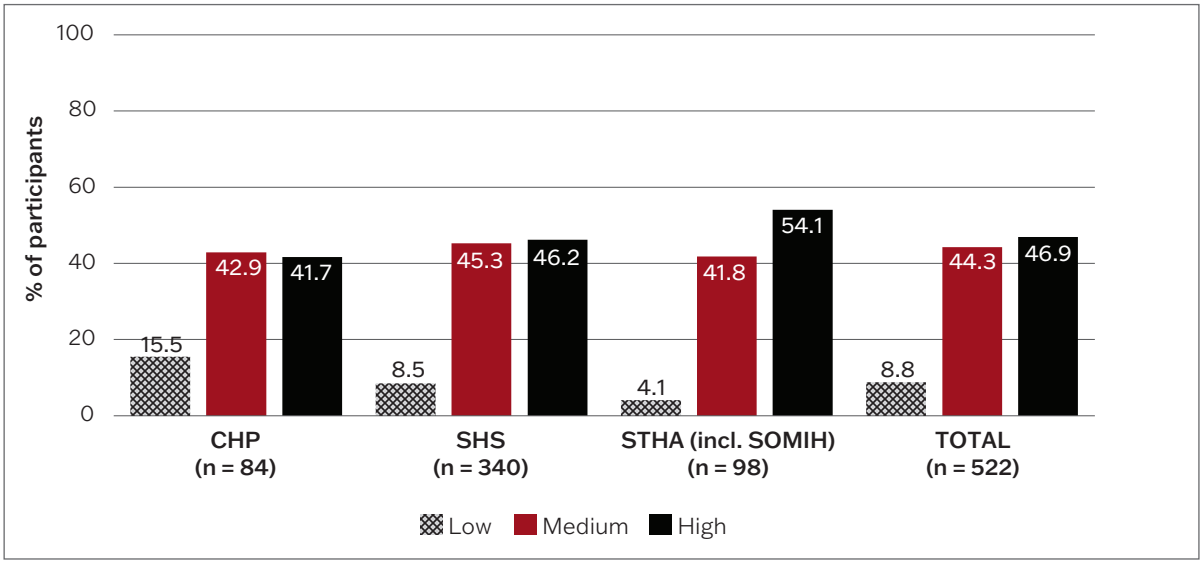
Using a different screening tool (the PCL-6), Kerman, Ecker et al. (2022a) found 41.9% of 701 workers in their study had symptoms of PTSD, while Waegemakers Schiff and Lane (2019), using the PCL-C, reported a figure of 33% (n=472). The different tools used in different studies make comparisons between sectors challenging without complex statistical analysis.

However, a systematic review of rates of PTSD symptoms among emergency services workers estimated a 12-month prevalence rate of 20% (Hoell, Kourmpeli et al. 2023). An Australian study (n=14,868) suggested lower rates for police (11%) but used a modified version of the PCL with additional questions (Kyron, Rikkers et al. 2022). Regardless, the rates of PTSD symptoms found in our survey are alarmingly high and suggest a significant level of harm is experienced by frontline workers.

Overall, nearly half of the participants in our survey (46.9%, n=522) scored high for VT, with a further 44.3% (n=522) scoring moderately. This suggests widespread symptoms of VT within our sample. Our finding is comparable with a recent Australian study (Cao 2022) of frontline homelessness workers, in which 48.4% scored high for VT, and most other participants scored moderately.

As with the post-traumatic stress symptoms, a greater proportion of those working in STHAs (including SOMIH) had high VT scores (54.1%) compared with those in SHS (46.2%) and CHPs (41.7%).

Figure 7: Percentage of participants with low, medium and high vicarious trauma scores, overall and by sector



Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

Overall, 61.3% (n=524) of participants reported one or more symptoms of burnout. Again, a greater percentage of workers in STHAs (66.3%, n=98) reported one or more symptoms of burnout, compared with 61.6% (n=341) in SHS and 54.1% (n=85) in CHPs.

Compared with a recent Canadian study using the PROQoL tool (Waegemakers Schiff and Lane 2019), which found that almost a quarter of workers were suffering from burnout, our results suggest concerningly high levels of burnout symptoms among our participants. These results are comparable with rates of self-assessed burnout in a US study of emergency medical services workers (60%, n=1,547; Rosenberger, Fowler et al. 2019).

4.2.3 Consequences for service delivery

Workplace trauma experienced by individual workers flows through to service delivery and relationships with clients. Some workers reported that repeated exposure to distress meant they felt a creeping desensitisation to the traumatic experiences of their clients/tenants—including loss of compassion and emotional responsiveness. Others reported becoming more emotionally reactive. One worker acknowledged compassion fatigue as a risk in their work, but battled against it:

> How many times do you hear the same story about domestic violence before you start to lose your compassion? It happens—you become desensitised. But you have to stay aware of that. You have to treat every single person with the same level of compassion, tailored to their individual circumstances. I've said this to people many times: you might have one client come in and absolutely abuse you over some perceived injustice. But then the very next client walks through the door, and you've got to greet them with a smile, listen to their story as if it's the first time you've heard it, and not fall into that 'Here we go again' mindset. I do worry about people who've been in the job as long as I have but who don't have that awareness—who haven't developed insight into things like compassion fatigue. Because if you're not recognising it, how are you managing it? (Frontline, STHA, I12)

Some frontline workers reported witnessing staff or management dehumanising clients as a strategy for coping or self-protection.

> There's a culture of not being able to hold both of those things, that these are people we care about, and terrible things happen, and there's a lot of risk. And I think what can sometimes happen, and what I've witnessed, is dehumanisation of the clients for the protection of the staff, instead of [asking], 'How do we support the staff better to hold both of those things?' And I think it's a lack of skills and leadership. (Frontline, SHS, I05)

While it was important to give workers who were burnt out space and time, stakeholders explained that it could mean: 'You flip it and go, "Hang on a second, we've now got team members that are on leave all the time, but others are picking up the work demands"' (Stakeholder 02). One stakeholder suggested that the impact of trauma on one worker was thereby multiplied through the organisation: 'Because if someone is out because of trauma, then it increases the workload of other staff, and then puts more pressure on other staff' (Stakeholder 05). Another stakeholder expanded further:

> If you've got a team of five, and one person's out, there's increased workload or capacity that needs to be absorbed by that team, which then becomes a vicious cycle as their work increases. Client support and client outcomes are impacted as they don't have that sense of continuity. It's hard to get other staff members because you don't know how long that person's going to be away for. So individually and service-wise, on the team, the impacts can be significant. (Stakeholder 07)

Another stakeholder suggested that people who are experiencing trauma symptoms may be more prone to make mistakes:

> If you get a psychological or a physical injury because you're rushing in to help someone, either inappropriately or without the right resourcing, or with the right resourcing but not in the right headspace, you not only just did that person in front of you a disservice, but potentially all the other clients as well. (Stakeholder 09)

4.2.4 Consequences for organisations

According to one stakeholder, workplace trauma 'is hitting the bottom line … There has been an increase across the board of workers taking time off or lodging workers' compensation [claims]. That has a direct impact on your workers' compensation premiums' (Stakeholder 07). Another explained:

> In any job where you've got workplace hazards, it costs. And it's time. And then, yes, the cost of turnover, losing good staff. That workplace churn, and you lose institutional knowledge and you're not necessarily able to attract the best people if they don't see it as an attractive job. (Stakeholder 04)

There was also 'the pure cost of doing business' (Stakeholder 06). Some housing providers, for example, routinely send two workers to a property inspection, largely for safety reasons. This meant organisations needed to 'have the correct procedures in place so that's [two workers] actually achievable' (Stakeholder 01). All of these costs are evidence that organisations did not escape the impact of workplace trauma.

When workers were harmed and needed time to step away, whether through a formal workers' compensation process or by taking leave, their work did not go away. One stakeholder explained that in one part of their organisation, at the time of interview, one in six of their workers (17%) were on leave:

> They've been replaced, but there's a cost while they're recovering and coming back into the workforce—if they do. Along with workers' compensation premiums going up, all those sorts of things, we're actually having to replace those people there. So we're doubling up on wages. So there's a significant ongoing cost with any damage to a worker. (Stakeholder 06)

Another stakeholder suggested that the cost of safety should instead be viewed as an investment in safety:

> It comes down to resourcing, to allow people to do their jobs effectively and safely, and the long-term impact of that, of not having high staff turnover or not having people who are on stress leave is so critical. Put those measures in to start with. It saves everyone in the long run. (Stakeholder 01)

In the tightly resourced circumstances in which these sectors operate, the consequences of any absences, let alone longer-term and unpredictable ones, extend beyond cost. As one stakeholder said:

> Any losses of staff for any periods of time have an impact on productivity, but also on client service. If you don't have someone there to do something for someone then that person doesn't get it. We spend a lot of time trying to balance workloads across to ensure that there is a level of client service for everyone. Just because you're off for a month on your holidays, work can't stop there. So how do we spread that work to make sure that every client gets the level of service that they should get? Anytime there's any decrease in capacity, we're dropping some level of interaction with the client to actually accommodate that. (Stakeholder 06)

Giving staff time away was therefore not easy. As another stakeholder said:

> You just don't have enough time or resources to be able to pull people out when they're not coping well. Some people may not even talk about it because they've normalised that so much that they just carry on. And they're probably not functioning as well as they should be if they were not experiencing that level of stress. The resourcing tends to be the biggest thing, because being able to pull people out and giving them the time they need would give people a break to recoup, come back and get back into the role when they're ready. (Stakeholder 03)

The consequences of staff running themselves into the ground were often a longer absence in the end:

> People come into this type of work because they want to make a difference, and they want to do well. So they work those long hours and they do all those things, and they probably don't take care of themselves as well as they should, and that then has an impact. And so when they do have that trauma and need to go off, they may go off for longer periods because they were working, probably, longer than what they should have at the start, because they wanted to help. It's one of those kind of vicious cycles that you have. (Stakeholder 05)

However, the alternative to people going on leave could be losing the staff member altogether. And this also had consequences for the service: 'A lot of people leave homelessness work because of these issues. And with that, all that skill and experience walks out the door' (Stakeholder 10).

Frontline workers also pointed to numerous organisational impacts, including high staff turnover and staff leaving the sector:

> They recruit people, but a lot of them don't last—because they become overwhelmed by the workload. Realistically, if you're employed in housing, it takes at least 12 months before you can really be considered experienced and confident in the role. But the expectation is that people will pick it all up within the first month—and that's why they get overwhelmed. We have high rates of unplanned leave and workers' compensation, and to me, that's a clear sign that people aren't happy and the system isn't working. (Frontline, STHA, I14)

> We've gone through more team leaders than I've had hot lunches in the last five years. That's got to say it all. And it's not because they're not taken care of renumeration-wise. It's because they have to deal with so much crap. And that's the problem. (Frontline, SHS, I18)

> We get a lot of people leaving, a lot of resignations. People are constantly looking for a way out. Everyone's flat out trying to find their escape route. (Frontline, STHA, I14)

The impacts on organisations were interconnected with the impacts for services and the impacts for workers. The line from individual despair and feelings of helplessness in the face of systems trauma ran through to the departure of valuable people from the sector:

> I've known a number of workers to leave because they've said, 'Look, I've tried this but I can't be a functioning social worker in this sector, because the options and the tools available to me are too minimal. And I'm going to go somewhere like a hospital or work directly in women's services,' or something along those lines. 'Because I can't get people into housing and then I can't support them in their new housing.' (Frontline, SHS, I01)

4.3 Conclusion and considerations for policy makers

A significant level of harm is being experienced by frontline workers across the social housing and homelessness sectors. The seriousness of the harm and its widespread nature is similar to or greater than that recorded in recent international studies. Rates of burnout are higher than those reported for Canadian homelessness workers, and comparable to those of US paramedics. Rates of significant PTSD symptoms in the social housing and homelessness sectors appear to be higher than among Australian emergency service workers. The impacts of workplace trauma in this sector are serious and widespread—and require urgent action.

The problem is significant, as the effect on workers extends to impacts on:

- the quality of service provided to clients
- the functionality of the teams those workers work within
- their organisations.

Current practices, discussed in the next chapter, are clearly insufficient to ensure worker safety.

These issues are occurring at a scale and severity that requires a collective solution, with significant support from government. A detailed suite of options to address this issue is outlined in Chapter 6.

5. Current practices for preventing and responding to workplace trauma

This chapter addresses our fourth research question: What is currently being done to address this issue in workplaces and what are the gaps? Our data shows there is a range of current practices in place across the housing and homelessness sector to prevent, address and manage workplace trauma. These include incident reporting, employee assistance programs (EAPs), and workplace policy and procedures. Participants discussed various practices for managing and monitoring ongoing risks, the significance of supervision and training, and the role of supportive workplace culture.

However, while both frontline workers and stakeholders identified these current practices, there appeared to be considerable differences of opinion between workers and stakeholders about how such measures were experienced and perceived, and how well each of these measures was implemented in different workplaces.

In this chapter, we report on current practices used to prevent and respond to workplace trauma, as identified by participants, as well as the limitations of these practices and notable gaps. We also consider the impact of lack of funding and time on services' capacity to respond to workplace trauma—an issue that was raised by several participants.

5.1 What is being done—and how well

5.1.1 Incident reporting

Stakeholders consistently emphasised the importance of incident-reporting systems as vital tools for organisational learning and risk management. For many, these processes were seen as foundational to maintaining staff safety and responding proactively to patterns of harm. As one stakeholder noted:

> I'd rather know about it and not need to know about it, than need to know about it and not know about it. (Stakeholder 09)

In several organisations, incident data were reviewed regularly to identify trends, monitor staff needs and inform strategic responses:

> We're seeing this sort of issue emerge across the business—what is it that we need to do to support our staff? (Stakeholder 09)

> If we're identifying that there are a large number of incidents occurring in a specific area, we can throw in additional specialised supports there as well. (Stakeholder 01)

In some cases, this practice had led to broader organisational reform to better address the problem of workplace trauma. One stakeholder described how a review of incident patterns led to a significant overhaul of their WHS protocols:

> Looking at where things have been going in the last couple of years before that, we decided that we need to ramp-up our risk assessment … but we also needed to improve our training in terms of our protocols, and also just general skills. (Stakeholder 06)

Other examples of practical change included increasing staff numbers in high-risk settings (Stakeholder 09).

For many stakeholders, the incident-reporting system was understood not as a static tool, but as part of a dynamic, iterative process of risk monitoring and staff care:

> It's also about monitoring on an as-needs basis—looking at things and working out: could we improve processes? Could we improve training? Are there ways to eliminate [the risks]? (Stakeholder 02)

In contrast to these positive accounts, frontline workers frequently described incident-reporting systems as procedurally burdensome and emotionally draining. Reports were often seen as bureaucratic formalities—performed more to fulfil compliance obligations than to support staff recovery or enhance safety. As one worker put it:

> We have a really arduous, glitch-heavy incident report process that we make workers complete before they leave for the day, and it sucks, because someone's already fried from whatever's gone down. (Frontline, SHS, I02)

More concerning than the process itself was the widespread perception that incident reports rarely triggered meaningful organisational responses. Several frontline workers shared experiences of submitting reports after traumatic events, only to receive no follow-up, debriefing or even acknowledgement:

> I put in an incident report once—about the time [client] tried to cut her throat—because I thought, 'That's not okay, something needs to be done.' I wasn't the only one there; the cleaner was with me. I just felt I had to report it. And what happened after that? Nothing. No one followed up, no one asked if I was okay or if I needed to debrief. You'd think someone would check-in after something like that—but there was absolutely nothing. (Frontline, STHA, I03)

These concerns were particularly pronounced among frontline staff working in government social housing agencies, who were also among the most critical of incident-reporting systems more broadly. As one frontline worker reflected—capturing the frustrations voiced by many—reporting processes were perceived as ineffective, burdensome and disconnected from meaningful organisational responses:

> We do have a system for documenting traumatic events, but you never see any outcome from it. No one follows up, no one comes back to talk about it. We don't have meetings to say, 'This year we had x number of safety incidents—let's review them, let's talk about how we handled them, or what we can do to reduce them.' Nothing. It just disappears into the ether. Most people just see it as a 'cover your arse' exercise, nothing more. (Frontline, STHA, I12)

5.1.2 Employee assistance programs

EAPs were frequently identified by stakeholders as a central component of organisational responses to workplace trauma. For some, the EAP was described as 'the first point of conversation' following a critical incident (Stakeholder 02). However, views on the effectiveness of EAPs varied considerably between and within organisations. One stakeholder said frankly: 'We have an Employee Assistance Program, but it's not great' (Stakeholder 08). In contrast, another described recent improvements in their EAP: 'We changed to a clinical model of service and it's been much better' (Stakeholder 09).

In some organisations, use of the EAP was flexible and responsive to staff needs. One stakeholder explained: 'If a worker didn't want to use the EAP, we were happy to support them to access their own support and [we] cover the cost' (Stakeholder 07). Others described expanded roles for EAPs, including leadership development and capacity-building:

> Our EAP provides not just counselling, but also coaching for managers to better support their teams. (Stakeholder 09)

However, some stakeholders expressed concern about the limitations of relying too heavily on EAPs. As one participant noted:

> It's the support within the teams, and how that's set up. Everyone's got to have an EAP—it's how you use it, whether it's effective enough, and then how you set up the culture of being supportive and debriefing and valuing safety and valuing support. (Stakeholder 04)

This more equivocal perspective was echoed in frontline interviews, where EAP referrals were frequently described as hollow gestures made by managers in lieu of more engaged or trauma-informed responses. For many workers, being directed to an EAP felt like a deflection—an individualised solution to what was often a deeply systemic and relational problem. The term 'tick-box' was frequently used, with several workers noting that EAP referrals were routinely offered without follow-up or genuine concern for their wellbeing in what felt like an outsourcing of trauma management. What was often lacking for these workers in their organisations was sustained in-house engagement around the trauma workers were experiencing—both in terms of critical incidents and cumulative trauma over time.

Several workers described EAP services as impersonal and poorly aligned with the realities of frontline work, with many feeling that EAP providers often lacked the specialised knowledge and sensitivity required to support staff who had experienced workplace trauma. As one frontline worker explained:

> I dealt with EAP, and it was just a waste of time. They were not qualified—they didn't know what to do. They had no idea why I felt such guilt over somebody being raped. And I realised that these EAPs, they sound fantastic, but realistically, if they're not used to dealing with frontline workers, there's no point having them. (Frontline, SHS, I19)

Others echoed the view that EAPs had become a default response used by management to discharge responsibility without addressing underlying issues. One participant reflected:

> That's generally what we're told: 'Contact EAP if you've got any problems.' And that's the end of it. We used to have professional supervision years ago, where we could actually talk things through and find strategies to cope—but they haven't brought that back. It's probably been 10 years or more since that was offered. (Frontline, STHA, I14)

> Yeah, you get three visits and then you're done. So even if you're in the middle of working through something with the support person, you're done after three. So it feels almost pointless. [I was] in the middle of seeing them—they changed the days they worked on. I kept booking the same date and time, but for multiple instances after that I didn't get that same person. And I was like, 'I want to see this person,' so I had to reschedule it. It was quite frustrating. (Frontline, CHP, I07)

Despite these concerns, experiences with EAPs were not uniformly negative. For some workers, particularly those in organisations with more responsive or clinically focussed providers, EAPs offered a valuable source of independent, confidential support. These workers described the service as a safe space to process traumatic events and workplace stressors, especially in contexts where internal supervisory structures were limited or unavailable.

5.1.3 Policies and procedures

In our online survey, we asked participants to rate their agreement with a range of statements about current practices. Findings indicate that while foundational systems are widely in place, there are concerns regarding implementation, responsiveness and proactive prevention.

The majority of respondents (80.7%) agreed or strongly agreed that their workplace has established policies and procedures for managing critical incidents, such as client overdoses or deaths. A similar proportion (80.3%) reported access to an easy-to-use system for reporting workplace hazards, risks and critical events. These high agreement rates suggest that most organisations have formal structures for incident response in place.

However, confidence in psychosocial safety procedures and organisational responsiveness was lower. While 69.5% agreed or strongly agreed that their organisation had clear policies for reporting psychosocial hazards, 30.3% disagreed. Fewer than two-thirds of respondents (64.3%) agreed that their workplace responds promptly and appropriately to reports of risk or negative events, and just 63.2% believed their employer takes proactive steps to prevent critical incidents or other harmful workplace experiences.

These results suggest that while appropriate policies, processes and practices exist in most services, consistent application and proactive risk management remain areas for improvement—and there is work to be done to improve frontline workers' sense of trust in these systems.

Table 5: Percentage of survey participants agreeing or disagreeing with statements about existing workplace policies and procedures

Types of support provided in current workplace	Strongly agree or agree (%)	Strongly disagree or disagree (%)	Not applicable to my role (%)
My workplace has policies and procedures for dealing with critical incidents (such as an overdose, death of a client/tenant) (n=488)	80.7	19.2	0.0
My workplace has a system for reporting workplace hazards, risks and critical events that is easy to use (n=488)	80.3	19.7	0.0
My workplace has clear policies and procedures for reporting psychosocial hazards in the workplace (n=488)	69.5	30.3	0.2
When negative events and risks are reported, my workplace responds promptly and appropriately. (n=488)	64.3	35.5	0.2
Where possible, my employer is taking proactive steps to prevent critical events and other negative experiences at work (n=486)	63.2	36.4	0.4

Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

5.1.4 Risk management

In addition to processes for responding to critical incidents, both frontline workers and stakeholders identified a range of procedures designed to monitor and manage ongoing risk. These strategies aimed to reduce the likelihood of harm to staff and clients, and were seen as essential elements of trauma-informed and safety-conscious practice.

Across services, environmental and procedural safeguards were frequently cited. These included physical infrastructure such as duress alarms, interview-room design and reception layouts, as well as staffing protocols like ensuring multiple workers were present during potentially risky interactions. One stakeholder described this approach:

> Our team definitely always has the two workers when it's known that there's any risk, even if that's potential risk of a family violence situation that's not even for our tenant—that there might be an ex-partner or something involved. (Stakeholder 01)

Modifying the physical environment was a common risk-mitigation approach:

> We obviously have interview rooms, we have receptions, we've got physical barriers, we've got personal alarms. We've got cameras. We've got specific barriers that can be put in place, whether it be closing a second door, locking down an office if we receive threatening phone calls or personal threats to individuals or a team. We have lockdown processes for that. (Stakeholder 02)

Duress alarms were another frequently cited tool, valued both for their practical function and the sense of psychological safety they offered to staff. Some organisations also described more extreme or last-resort strategies for managing ongoing or repeated threats. In homelessness services, this sometimes included issuing permanent bans to clients who had posed significant safety risks to staff.

While the importance of safety infrastructure was noted, many faced significant hurdles in obtaining it in their workplace. One worker explained their decade-long battle to get CCTV installed:

> With the security cameras that we're going to be getting [that haven't been there for the past 10 years]. The argument was that the organisation didn't have to pay for that, [it] should be coming from [Housing department] because it's their property that we manage. But [Housing department] was like, 'No, we won't fund that.' And so it's just that I rattled enough chains and wrote an email just strong enough that my management thought, 'Oh, we need to do something about this. Or this is gonna get bigger than Ben-Hur.' So they [Management] said, 'We're gonna do that' and then the [Housing department] went, 'All right, you rolled out at that workplace, and if we see that works well, we'll then roll out at every other facility.' And it shouldn't have to come to that. (Frontline CHP, workshop)

5.1.5 Training

Both frontline workers and stakeholders consistently identified training as a central strategy for managing workplace trauma. Many stakeholders argued that recruitment practices themselves were important, to ensure that new staff were 'fit for role' and equipped to manage the complex, high-pressure environments they would encounter (Stakeholders 01, 07). Some organisations used structured induction programs to communicate safety procedures and organisational expectations. As one stakeholder explained, staff were taught that:

> Your safety is number one. Always put your own safety first. Because it's not just about the client in front of you—it's the other 10 clients on your caseload. (Stakeholder 09)

Frontline workers also described training as an ongoing necessity in a constantly evolving service environment. As one worker reflected:

> It is constant staff professional development training—whether it's mental health first aid, physical first aid, if there's recent drug and alcohol trends, if there's recent mental health trends or research—we're always updating and adapting. (Frontline, SHS, I03)

Effective training addressed the needs of workers before, during and after critical incidents. This included learning to de-escalate situations, to set boundaries, and to disengage when necessary. As one stakeholder noted:

> Just because you're dealing with troubled tenants, doesn't mean you need to cop it. You're given the opportunity to leave, hang up, set the boundary, and you'll be supported in that. (Stakeholder 02)

Another emphasised the importance of training in equipping staff with the knowledge of when to walk away from potential traumatic client engagements: 'Sometimes things go bad—it's not about what you've done. You need to be trained to recognise that and to safely extricate yourself' (Stakeholder 06).

Training also extended beyond frontline workers. Several organisations provided training in 'wellbeing conversations' to line managers to help them engage in post-incident support, and to enhance leadership capacity around psychosocial hazard prevention (Stakeholders 02, 09).

When asked about the resourcing of training, one stakeholder stated that training should be considered a core safety obligation—not a discretionary extra: 'This is a required workplace health and safety response … It's essential, so it's paid for centrally' (Stakeholder 06).

Our survey included a number of specific questions about the content of training, particularly in relation to trauma. As seen in Table 6, a majority of respondents reported receiving foundational training in key areas of trauma understanding, including the:

- relationship between homelessness and trauma: 74.7%
- relationship between mental health and trauma: 71.3%
- relationship between substance use and trauma: 70.8%
- nature of traumatic stress: 71.1%.

However, fewer respondents reported training in more specialist or intersectional areas of trauma-informed practice. For example, only 59.4% had received training on how trauma affects child–caregiver attachment, and only 60.3% had received training on cultural differences in trauma understanding and response. These findings suggest that while core concepts are widely covered, gaps remain in areas requiring deeper contextual and developmental knowledge that may be critical—especially depending on the community being supported by workers in a particular organisation.

Table 6: Percentage of survey participants agreeing or disagreeing with statements about training received on trauma

Did participant receive training on this topic?	Strongly agree or agree (%)	Strongly disagree or disagree (%)	Not applicable to my role (%)
The relationship between homelessness and trauma (n=491)	74.7	23.4	1.8
The relationship between mental health and trauma (n=491)	71.3	27.9	0.8
What traumatic stress is (n=491)	71.1	27.3	1.6
The relationship between substance use and trauma (n=490)	70.8	28.0	1.2
The relationship between childhood trauma and adult re-victimisation (e.g., domestic violence, sexual assault) (n=490)	64.1	33.1	2.9
How traumatic stress affects the brain and body (n=491)	62.5	36.3	1.2
How trauma affects a child's development (n=491)	62.3	32.4	5.3
Cultural differences in how people understand and respond to trauma (n=489)	60.3	39.5	0.2
How trauma affects a child's attachment to their caregivers (n=490)	59.4	34.3	6.3

Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

Responses about training related to client and tenant support showed a similar trend. While the majority of workers reported receiving training in de-escalation strategies (76.9%) and general risk assessment (75.6%), only about half had received training to help clients identify trauma triggers (51.3%) or to manage intense emotions such as rage, helplessness or sadness (49.5%). This suggests strong preparedness in managing immediate safety risks, but more limited training in longer-term emotional support and trauma recovery work (see Table 7).

Table 7: Percentage of survey participants agreeing or disagreeing with statements about training received on supporting clients and tenants

Did participant receive training on this topic?	Strongly agree or agree (%)	Strongly disagree or disagree (%)	Not applicable to my role (%)
De-escalation strategies (i.e., ways to help people to calm down before reaching the point of crisis) (n=489)	76.9	22.1	1.0
How to develop safety and assess various risks (e.g. family violence) (n=487)	75.6	23.2	1.2
How to help clients/tenants identify triggers (i.e., reminders of dangerous or frightening things that have happened in the past) (n=489)	51.3	45.4	3.3
How to help clients/tenants manage their feelings (e.g., helplessness, rage, sadness, terror, etc.) (n=489)	49.5	47.2	3.3

Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

Survey respondents were also asked about the training they had received regarding staff wellbeing and the impacts of trauma work (see Table 8). A majority (76.2%) agreed or strongly agreed that they had received training on how to establish and maintain healthy professional boundaries. However, training related to the personal and professional impacts of working with trauma survivors was less consistently reported. While 58.5% of respondents indicated they had received training on how trauma exposure can affect staff, a substantial proportion (40.9%) disagreed or strongly disagreed, suggesting they had not received such training.

Table 8: Percentage of survey participants agreeing or disagreeing with statements about training received on professional boundaries and the impacts of working with trauma survivors

Did participant receive training on this topic?	Strongly agree or agree (%)	Strongly disagree or disagree (%)	Not applicable to my role (%)
How to establish and maintain healthy professional boundaries (n=488)	76.2	22.5	1.2
How working with trauma survivors impacts staff (n=489)	58.5	40.9	0.6

Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

5.1.6 Supervision

Both frontline workers and stakeholders consistently identified high-quality supervision as a critical component of an effective trauma response. For workers, the most valued supervision practices included immediate support following critical incidents, consistent availability, space for reflection, and a recognition that the significance of an incident should be defined by the worker, not imposed by organisational hierarchy. Approaches that integrated structured psychological first aid, routine wellbeing check-ins, a mix of individual and group debriefings and clinical elements were seen as particularly effective.

BOX 1: Supervision, clinical supervision, reflective practice and debriefing

Participants in this research used the term 'supervision' to refer to several different practices. This is unsurprising, given the eclectic backgrounds of participants and the range of meanings commonly attributed to supervision in a service delivery context.

Supervision can simply refer to the tasks involved in managing workers. However, it is also a term used in social work practice to refer to 'a forum for reflection and learning […] an interactive dialogue between at least two people, one of whom is a supervisor. This dialogue shapes a process of review, reflection, critique and replenishment for professional practitioners' (Davys and Beddoe 2010: 21). Undergoing regular supervision is a requirement in the Australian Association of Social Work Practice Standards (2023). Formal supervision is therefore mandatory for social workers, but anyone working on the frontline of the social housing and homelessness sector might benefit from some kind of structured opportunity to discuss and reflect on their experiences, regardless of whether they are a social worker.

According to the practice literature, supervision has several functions; it assists in the administration of client cases, allows practitioners to reflect and learn, is a support for staff, helps mediate the relationship between employee and employer, and can be a form of professional development (Carpenter, Webb et al. 2012).

For the purposes of this report, we distinguish between supervision, clinical supervision, debriefing and reflective practice.

Supervision refers to a practice that takes place within a management context (Centre for Workforce Excellence 2023b). This type of supervision focusses on 'doing the job'—a way to review and discuss the key tasks required from the worker and the best way to carry them out.

Clinical supervision refers to a practice that develops a practitioner's awareness and skills more generally, and in a context that allows consideration of personal reactions, values, power dynamics and ethical issues (Centre for Workforce Excellence 2023b).

This distinction between supervision and clinical supervision is important. Davys, May et al. (2017: 120) suggest that the conflation of 'educative and supportive' supervision with a 'portfolio model' akin to line management can lead to supervision being used punitively or as a form of performance management, and pose the question of whether '[it is] time for social work to confront the issue and finally separate the organisational from the professional in supervision'.

Debriefing refers to a process of structured unpacking of a traumatic incident, where those affected can talk in a safe and confidential space about what happened, how they reacted and how they are reacting. Debriefing can be cathartic, and where multiple people are involved in an incident, takes place in a group setting (Bell 1995).

Reflective practice refers to a broader theoretical perspective used in social work, and in many other applied professions (Ferguson 2018). The breadth of the concept means it does not have a precise meaning, but it captures the idea of reflecting on one's actions and decisions so as to learn from them. In fact, Ewing, Waugh et al. (2021: 5) suggest that:

> The most important and valid evidence of someone engaged in reflective practice, is observing them changing their plans and behaviour as a result of reflecting while engaged in their practice.

Reflective practice can offer a mechanism by which the theory, or 'thinking', of social work can be connected to the actual doing of it (Payne 2002). Effective reflective practice is facilitated by the availability of supervision (Centre for Workforce Excellence 2023a).

Overall, Carpenter, Webb et al. (2012: 16–17) argue that:

> Given the evidence that supervision is associated with job satisfaction and protects against stress, practitioners should insist that good supervision be provided by their employers. The emotionally charged nature of the work places particular kinds of demands on people working in the field which need to be contained by the organisation.'

The descriptor 'emotionally charged' certainly captures the work described in this report.

One frontline worker described a flexible and worker-led approach to post-incident support, emphasising that decisions about significance were left with the team—not management:

> So we would prioritise—after an incident we would prioritise talking it through at our check-in meeting. And we'd let the team decide if it's significant. It's not my decision or the management team's decision. (Frontline, SHS, I01)

Beyond formal supervision structures, frontline staff also emphasised the importance of an 'open door' culture where staff were encouraged to speak up early and often. As one manager at a frontline service explained, early intervention was vital to preventing cumulative harm:

> As a line manager, it's like we'd rather you tell us in the moment what's going on for you than it get too much. It's all a pressure cooker, right? If you just keep it bottled up, it's just going to blow up. (Frontline, SHS, I03)

Flexibility and empathy from management also played a critical role in creating a supportive environment. One frontline manager described a trauma-informed approach to managing time off and day-to-day needs:

> I never say no when my staff ask for a day off. If they request one, they get it. There've been days where they've said, 'I just need to have a mental health day,' and I know their cup's too full. I never question it—because I've been there, and I don't want anyone else to have to go through that. (Frontline, CHP, I13)

Frontline workers emphasised the importance of having access to external or informal support outside of traditional line management structures. These forms of supervision—whether formal mentoring or peer-based reflection—were viewed as valuable complements to internal systems, particularly when delivered by someone with sector experience:

> Having a mentor, I think that's a big thing. It can be official, unofficial, go for coffee, or whatever. As long as it's productive … Someone who's been there, done that in the sector. [Who] can guide and coach their practice without stepping on the toes of their line manager or their agency. I think it's a great idea, rather than having one central focal point of line management. (Frontline, SHS, I03)

Stakeholders also affirmed the value of one-to-one support, but there was significant variation in how it was delivered across services. Some organisations offered dedicated internal supervision roles focussed on reflective practice, learning and leadership support. Others relied on external providers, sometimes embedded temporarily, to deliver individual or group reflection:

> [The program] actually has someone external linked in … they do a lot of group reflection or individual reflection. (Stakeholder 01)

Additional support structures included wellbeing and safety teams, contact officers[4] and onsite counsellors, designed to be approachable alternatives to human resources or line managers.

Several services adopted a layered approach. One stakeholder described a comprehensive system involving management check-ins, specialist team members, onsite counselling and monthly supervision:

> If staff have had a bad experience, they can reach out. And in some of our offices we have a person onsite, so they can go and see that person as it happens. (Stakeholder 05)

However, not all support was embedded into routine practice. In some organisations, supervision was available on request, and often incident-triggered and worker-initiated:

> As long as our workers have a relationship with someone who's qualified … we'll pay for it if there is an issue or an incident. (Stakeholder 07)

Although this reactive model is well-intentioned, it risks being underutilised—especially given the time and emotional pressures on staff.

4 A contact officer is a general staff member within an organisation who takes on a role to support other staff with issues around discrimination, bullying and harassment. They support staff in navigating the organisation's formal process and provide emotional support during that process.

Stakeholders also indicated that managers often served as the first line of support. While some organisations trained managers in basic debriefing skills (Stakeholder 02) or implemented leadership frameworks to formalise accountability (Stakeholder 09), concerns remained about managers' capacity and appropriateness for the role. As one stakeholder reflected:

> Some people go into leadership for career progression, but don't want to move away from client work … If we had better pathways that weren't just into people leadership, we'd see a better cohort of leaders—people really passionate about supporting staff. (Stakeholder 09)

These concerns were echoed by union representatives, who noted growing demand for clinical supervision led by qualified professionals:

> People are asking for proper clinical supervision—especially after critical incidents. Not your team leader who used to do your role. (Stakeholder 10)

These qualitative accounts of supervision practices were supported by survey data, which provide a broader picture of how supervision is structured and experienced across the sector. Survey respondents were asked to reflect on the types of staff support available in their current workplaces—particularly in relation to individual supervision (see Table 9).

While 67.8% agreed or strongly agreed that staff have regularly scheduled time for individual supervision, the quality and focus of these sessions appeared more variable. Fewer than half (43.9%) agreed that their supervision was conducted by someone trained in understanding trauma, and only 43.6% reported that supervision time was used to help them understand their own stress responses. Even fewer (41.3%) said that supervision addressed how their emotional reactions might impact their work with clients or tenants.

These findings suggest that while supervision is a widespread structural feature of frontline roles, it often lacks the reflective and trauma-informed components necessary to effectively support staff.

Table 9: Percentage of survey participants agreeing or disagreeing with statements about support provided in supervision

Is this type of support provided in the participant's current workplace?	Strongly agree or agree (%)	Strongly disagree or disagree (%)	Not applicable to my role (%)
Staff members have a regularly scheduled time for individual supervision. (n=488)	67.8	30.7	0.8
Staff members receive individual supervision from a supervisor who is trained in understanding trauma. (n=488)	43.9	54.3	1.0
Part of supervision time is used to help staff members understand their own stress reactions. (n=489)	43.6	55.0	1.0
Part of supervision time is used to help staff members understand how their stress reactions impact their work with clients/tenants. (n=489)	41.3	57.1	1.0

Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

5.1.7 Supportive workplace cultures

Both frontline workers and stakeholders consistently identified supportive workplace culture as central to mitigating trauma and sustaining wellbeing in high-pressure service environments. While frontline workers emphasised the role of peer relationships and informal team dynamics, stakeholders focussed on leadership practices, flexibility and systems that promote psychological safety and inclusivity.

For frontline staff, support from peers was an essential everyday buffer against stress, drawn on through informal check-ins, group supervision and shared debriefing. These interactions not only helped manage distress but fostered solidarity, learning, and early identification of emerging client trends such as changing patterns in substance use. As one worker explained:

> You learn so much from your peers, because I might be sitting there quietly going, 'I'm not too sure about the new process,' and someone asks the same question, and I'm like, 'I'm not alone here. We're all struggling with this new process.' Or, 'I didn't know that—I'm going to use that when working with that guy or this guy.' (Frontline, SHS, I03)

Another worker simply stated: 'It's reliance on co-workers that will make or break you' (Frontline, SHS, I19).

Small but powerful moments of shared understanding helped sustain wellbeing in high-pressure environments:

> I think the most helpful thing is that we all understand what each other is going through. Being able to have a laugh together—chocolate helps too, lollies are surprisingly helpful! But more than that, it's the ability to say how you're really feeling, and have someone truly understand, because they've felt that way too. That makes a big difference. (Frontline, SHS, I10)

In some workplaces, this supportive peer culture was reinforced by managers who actively promoted flexibility and psychological safety. Frontline staff described leaders who encouraged mental health days, accommodated longer breaks, and modelled open conversations around emotional wellbeing. Stakeholders also thought leadership played a critical role:

> It's your manager's job to cover you so that you can have space to develop your skills. That's how we show staff they are valued. (Stakeholder 09)

> I'm not waiting for staff to say they're stressed: I look for signs and meet the need early. (Stakeholder 08)

Trauma-informed leadership required relational awareness and proactive support:

> If I don't talk with my team about life, the impact will be worse. Life is life—you can't leave it at the door. (Stakeholder 01)

Some organisations embedded this flexibility, with procedures that allowed workers to take paid time out, adjust schedules, or ease back into work without using up leave. They sought to create:

> … a workplace that is inclusive and safe for people who have different needs—not assuming there's a one-size-fits-all approach. (Stakeholder 09)

In other organisations, flexibility was informal:

> We just don't tell the CEO. We manage it locally and keep it unofficial, so it's sustainable. (Stakeholder 07)

However, sometimes that flexibility was still only aspirational:

> 'We need to encourage mental health days and staff connection, not a culture of "Work, work, work".' (Stakeholder 01)

Stakeholders also called for more safety awareness:

> When there's a real culture of reporting risk on both sides, things get caught early. (Stakeholder 10)

Our survey explored various elements of workplace culture that were potentially supportive (see Table 10). Among these are team meetings, debriefing and self-care.

Findings indicate that while team meetings are widely embedded across the sector, their use as a space for trauma-informed reflection is less inconsistent. A large majority of respondents (83%) agreed or strongly agreed that regular team meetings are held, and 74% reported that these meetings provide opportunities to debrief following a crisis.

However, when it came to addressing staff wellbeing and trauma-related content, responses were more divided. Only 49.3% agreed or strongly agreed that topics such as vicarious trauma, burnout, and stress-reduction strategies were discussed in team meetings, and just 41.5% reported that trauma-related issues were routinely addressed.

Table 10: Percentage of survey participants agreeing or disagreeing with statements about support provided through team meetings

Types of support provided in participant's workplace	Strongly agree or agree (%)	Strongly disagree or disagree (%)	Not applicable to my role (%)
Regular team meetings (n=489)	83.0	16.8	0.2
Support to debrief after a crisis (n=485)	74.0	25.6	0.4
Topics related to self-care addressed in team meetings (e.g. vicarious trauma, burnout, stress-reducing strategies) (n=489)	49.3	50.5	0.2
Topics related to trauma addressed in team meetings (n=489)	41.5	58.1	0.2

Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

5.2 Contextual barriers

It is clear from the previous section that many workplaces recognise their responsibility for psychosocial WHS and had sought to implement appropriate risk management and risk responses—although these responses were not always embedded as deeply and effectively as they needed to be. However, as implied in previous chapters, there were also features in the sector that actively worked against efforts to manage workplace trauma, and these in themselves represent a gap in current practices.

5.2.1 Normalisation, routine support and stigmatisation

Survey responses also revealed persistent concerns about workplace culture and resourcing (see Table 11). A significant proportion of respondents (67.4%) reported that potentially distressing events—such as those described in Chapter 2—were seen as commonplace and often treated as 'no big deal' within their organisations.

This normalisation of trauma exposure may contribute to cumulative harm, particularly in the absence of trauma-informed responses. Only 42.7% of respondents agreed or strongly agreed that their workplace engages external consultants with trauma expertise for ongoing education and consultation. It is possible, though, that some respondents who did not agree did so because their organisation had specialist expertise available internally.

As discussed in Chapter 3, problems with workload and staffing can drive trauma and undermine practice effectiveness. Most respondents (59.9%) did not believe their teams had reasonable staff-to-client or staff-to-tenant ratios, and two-thirds (66.7%) indicated their workplace was not adequately staffed (see Table 11).

Table 11: Percentage of survey participants agreeing or disagreeing with statements about other aspects of their current workplaces

Supportive elements in participant's workplace	Strongly agree or agree (%)	Strongly disagree or disagree (%)	Not applicable to my role (%)
Potentially distressing events and experiences seen as common and 'no big deal' (n=487)	67.4	31.6	0.8
Outside experts provide ongoing education and consultation (n=489)	42.7	55.2	1.4
Reasonable staff to client/tenant ratios (n=486)	37.9	59.9	2.1
Adequate staffing (n=487)	33.1	66.7	0.2

Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

As noted in subsection 3.2.2, the degree to which trauma was embedded in the work can itself present risks. One of these was that the normalisation of trauma meant that not coping with it became stigmatised, so people pushed on rather than taking a break and asking for and receiving support.

> It still has a little bit of stigma and taboo about it. People don't want to put their hand up and say: 'I'm not coping.' I've tried to create an environment where people feel safe and comfortable to be able to do that, but there is that sort of sector expectation that people will just continue regardless. (Stakeholder 08)

According to union stakeholders, stigma around asking for help could lead to a culture where workers are blamed for struggling, labelled as 'weak' or 'not cut out for the job'. As one put it: 'We hear that all the time—maybe you should go elsewhere, maybe someone else should step into your position in the meat grinder' (Stakeholder 10). And even when trauma support was available, it often focuses on critical incidents while overlooking the cumulative impact of daily exposure. Another stakeholder described it as 'the frog boiling in the pot'—slow, repeated stress that goes unacknowledged and unaddressed (Stakeholder 10).

The result is a system where safety measures are not only underfunded but culturally deprioritised. High-pressure roles often fall on the same few staff, creating single-point dependencies and increasing the risk of burnout. Without structural and cultural change, these conditions pose ongoing risks to both staff wellbeing and client outcomes. The culture can also be internalised by staff, driven by the sector's strong 'clients come first' ethos and concern for job security—which means that even when support is offered, workers may not accept it:

> We need to create an environment where it's okay to put your hand up and say, 'I'm struggling,' and that's okay. But there's still stigma—people worry what it will mean for their future if they speak up. (Stakeholder 05)

5.2.2 Limited funding

Stakeholders consistently emphasised that chronic underfunding severely constrains the ability of services to provide safe and supportive working environments. They highlighted that current funding models are narrowly focussed on direct service delivery, with little or no provision for staff wellbeing, recovery from trauma, or organisational capacity-building. As one stakeholder explained:

> The funding set-up—the underfunding set-up—is a massive issue. Community service or homelessness organisations are funded for work with the clients. They're not funded for downtime and for recovery from traumatic experience. So even with the employers that we see who do debriefing better than some of the others—the break [after an acute incident] is often really short and someone might be encouraged to take 10 minutes and walk around the block and come back, as opposed to other industries and other situations where people are allowed to stand down for the rest of the shift or take additional time to recover. (Stakeholder 10)

In this environment, trauma support, such as debriefing and reflective supervision, are often viewed as unaffordable luxuries. Many not-for-profit services are forced to operate, as one stakeholder put it, 'on the smell of an oily rag', with staff support treated as a discretionary spend rather than a core component of safe practice (Stakeholder 08).

5.2.3 Limited time

Another key gap identified by stakeholders was the lack of time available to embed safety measures or to support staff following traumatic events. Even when training was offered, heavy workloads meant staff often couldn't attend or were left with an unmanageable backlog when they did. As one stakeholder put it: 'We want training … but then it's like, 'I don't know if I've got the time to do that' (Stakeholder 01).

Training efforts were also undermined by poor scale and design. One stakeholder described how their service, with 400 staff, was only funded to send two people at a time to train on a major legislative change, with no support for a broader rollout or internal training capacity. They went on to note that training was often treated as a complete solution—and therefore the time or support needed to practise and apply what was learnt was not resourced:

> Doing the training course is like getting the theory—but you still need to go and practise it. (Stakeholder 09)

Time constraints also affected managers, who were often pulled away from developmental supervision to backfill frontline roles or to manage complex cases themselves. These pressures meant that less time was available for supporting staff growth or implementing procedures to enhance client safety.

5.3 Conclusion and considerations for policy makers

In summary, current practices are not enough to prevent and mitigate workplace trauma in social housing and homelessness services. Many services have some measures in place to prevent and respond to traumatic incidents such as incident-reporting systems, critical-incident procedures, environmental safety measures, and access to EAPs.

However, these practices are fundamentally undermined by:

- inadequate funding
- limited time and staffing
- inconsistent implementation
- workplace cultures (in some services) that deprioritise psychosocial safety.

To address these issues, program models and, by extension, funding models, need to include explicit and sustained provision for staff wellbeing. This includes ensuring:

- availability of recovery time following traumatic incidents
- access to clinical and reflective supervision
- ongoing professional development
- proactive risk-management strategies.

Some of these provisions imply explicit, additional funding allocations as part of service commissioning. It is not sufficient to fund only frontline service delivery. Trauma-informed care for clients/tenants requires systems that also support the health, safety and sustainability of workers. Where possible, funding accountability mechanisms should assess not only quantitative outputs but also the presence and quality of psychosocial safety measures.

Within services, managers play a critical role in shaping day-to-day culture and modelling safe, supportive practice. However, there is too much reliance on individual goodwill, rather than ensuring approaches are embedded in policy, practice and supervision structures.

Managers should be equipped with skills to support staff who are struggling because of workplace trauma. Managers should be both supported and expected to create psychologically safe environments where staff feel confident to raise concerns, request help, and take time to recover without fear of stigma or professional consequences. Creating a psychologically safe environment involves normalising conversations about distress, embedding wellbeing into team routines (such as check-ins and debriefs), and responding meaningfully to workers' needs. Investing in both peer-based and clinical supervision, having shared responsibility for wellbeing, and establishing clear escalation pathways can strengthen support systems, and reduce the isolation or over-reliance often placed on individual team leaders and team members.

6. Reducing workplace trauma and mitigating its impacts

This chapter addresses our fifth and final research question: What can organisations and policy makers do to reduce workplace trauma and mitigate its impacts? Participants had many ideas about what could be done to better address the problem of workplace trauma and shared these ideas in interviews and in response to open-ended questions in the survey.

Many of the suggestions made by participants were focussed on what organisations could do better, as well as changes to the systemic context in which services are provided. However, in making these suggestions, both frontline workers and stakeholders acknowledged that it was not simply that specific organisations just needed to 'do better', but rather that change was needed across the social housing and homelessness sector.

It is striking that, despite being a workforce under enormous strain and stress, participants reported both long tenure in the sector and a strong intention to remain. This persistence underscores the deep vocational commitment of workers—and also highlights the urgency of ensuring that their willingness to stay is supported by meaningful organisational and systemic change.

This chapter begins with an overview of the solutions suggested in the literature, then moves on to discuss the suggestions made by research participants. It concludes with a discussion of the levers for change.

6.1 What does the literature say about reducing workplace trauma?

The literature presents a range of recommendations for preventing and reducing workplace trauma in homelessness and allied sectors.

In a New Zealand study of social workers working in family violence (Mann 2023), supervision was found to be crucial in providing emotional support, opportunities for debriefing, and professional growth. Effective supervision was built on strong relationships between supervisors and workers, regular meetings, and attention to both personal and professional wellbeing (Mann 2023).

A systematic review of 22 articles on VT in nursing (Isobel and Thomas 2022) suggested reducing workplace trauma by providing supportive environments, managing caseloads, and offering systematic support such as clinical supervision, peer support, debriefing and developing policies for VT prevention, responses, and support.

A South Australian report (Louth, Mackay et al. 2019) found that one large community service organisation has implemented a set of policies to maintain a healthy and safe work environment, including the Vicarious Trauma Management Guidelines. These guidelines delineate the responsibilities of both management and individual employees, highlighting the necessity of adequate supervision, training, peer support, and staying informed with the latest research. The guidelines also recommend strength-based approaches, emphasising the importance of resilience training as an important component in managing the risks of VT.

There are also several studies on responses to workplace violence. Zhang, Zheng et al. (2021) found that following a violent incident, nurses needed personal support and emotional input from their managers, facilities and support to ensure their safety particularly from security personnel, practical competency-focussed training, and policies and guidelines that protect them.

One Colorado healthcare system (Varty, Mines et al. 2023) implemented an evidence-based online module to train their frontline staff in workplace violence prevention, focussing on scenarios like handling patients with substance abuse disorders, dementia, and delirium. The training resulted in a 10% reduction in inpatient incidents, a 34.4% decrease in workers' compensation claims for violence-related injuries, increased staff confidence, and an 11.1% reduction in the use of violent restraints. This demonstrated the effectiveness of the intervention in improving staff safety and outcomes.

Another review found that multicomponent interventions, which included a combination of training, policy changes, and environmental modifications were more effective in addressing workplace violence (Somani, Muntaner et al. 2021).

An Australian study (Crivari, Pointer et al. 2023) found that regular individual supervision for frontline workers was associated with lower odds of client violence. It argued that the lack of trauma-informed care awareness and training within organisations further increases the risk of trauma, as workers were not adequately equipped to manage the emotional toll of their work. Indeed, many of the actions canvassed in this study, and the literature on this topic more generally, are consistent with trauma-informed care.

6.2 What needs to be done

As mentioned earlier, participants made a range of suggestions for preventing and addressing workplace trauma. An overview of these suggestions follows.

6.2.1 Improving conditions

Pay, leave and flexibility

Frontline workers wanted to see better rates of pay that reflected the skill and difficulty of the work they do, with calls for pay in line with that of nurses or teachers.

Stakeholders generally agreed and saw increased rates of pay to invest in and strengthen the workforce.

Dedicated wellbeing leave (where it wasn't already available), rostered days off, and remote and flexible work arrangements were also all seen as important in reducing and preventing workplace trauma. Workers explained that greater flexibility in hours would enable them to improve their work-life balance, build self-care into their days through things like taking breaks and planning in exercise, and effect an overall reduction in workforce attrition.

Workers and stakeholders all felt that new staff should have relevant skills and experience and be aware of what to expect in their new role. This required improvements in recruitment and onboarding:

> It goes back to ensuring that we recruit the appropriate staff—are they qualified? Do they have the experience in working with complex individuals? Experience in homelessness? Do they have experience with drug and alcohol, mental health in a congregate residential environment? So we're not setting staff up to fail, but bringing in staff who can best support our residents. It starts from recruitment, induction, onboarding, making sure that they're all good to go. (Frontline, SHS, I03)

Strengthening managers' skills

Participants saw managers' skills and experiences as central to creating a safe working environment and a positive workplace culture. Good management meant taking workplace trauma seriously. One stakeholder suggested that some managers in the sector lacked understanding of their own responsibilities when it came to health and safety, while some workers lacked understanding of their rights (Stakeholder 10).

To be effective, managers needed to have sector experience, including with client interaction, that gave them 'a deep actual understanding of the work that the staff do and the client group' (Stakeholder 10). Another stakeholder suggested that, due to the nature of the work, managers also needed additional skills such as coaching.

Ideally, workers wanted skilled managers who were accessible when staff needed them:

> Particularly at the coordinator level, where a person, a staff member, may have had something happen that's unsettling or feel like something is about to become unsettling, and can walk into an open door [to their manager] and say, 'Hey, I'm not feeling great. This is happening. What do you reckon I should do?' I think we need all sorts of opportunities for a conversation about things becoming a bit unsafe. (Frontline, SHS, I01)

At the very least, understanding from leadership and management was seen as a critical to frontline work; its absence made experiences of trauma worse. As one survey participant explained:

> The most stressful part remains the significant lack of care or support from management. This absence of structured support or acknowledgement from leadership exacerbates the emotional toll of the job. Management's failure to provide consistent mental health resources or effective debriefing sessions means that staff must rely on their own methods for coping, which can feel isolating and unsustainable. (Survey, SHS)

Additionally, one stakeholder emphasised the importance of ensuring the 'back half' of the organisation worked as well as the frontline. Important features included smooth, timely recruitment processes; effective, functional information and communications technology; and efficient finance support.

Dedicated safety infrastructure

Workers and stakeholders both identified the need for targeted funding to improve safety infrastructure in the sector. One stakeholder raised this specifically as 'a funding matter' and emphasised the need to 'make sure that our workers have the right protection when they head out—do they have duress alarms that are responsive?' (Stakeholder 07).

Physical safety measures such as security screens, alarms, CCTV and—in some cases—security guards were seen as important to many workers in our survey.

6.2.2 Improving work design

Key to improving the working conditions in these sectors was work design. Participants suggested a range of improvements including smaller case/tenant loads that were fixed and enforceable, increasing staffing and backfill when staff were absent so that no staff member was carrying a higher load for a long period of time.

Lone-worker models were viewed as unsafe by frontline workers, who wanted to see a minimum of two staff for roles such as visits to client homes, outposts or standalone services. Job rotation was seen as a key way to manage cumulative harms. Dedicated time for decompression and administrative duties at the end of each day was also suggested as a way to help workers actually leave work at work. Finally, clear guidelines, policies and procedures for all aspects of work were also seen as important.

Smaller caseloads and fixed client:worker or tenant:worker ratios

Workers wanted to see reduced caseloads/number of tenancies and for client/tenant worker ratios to be enshrined in funding agreements, and monitored and enforced by funding bodies:

> They really need to look at the resources available to each team—and probably double them. That way, we could actually do our jobs properly, without losing so many staff and without the trauma getting to us the way it does. (Frontline, STHA, I14)

Caseload mix was also raised, with workers suggesting they include clients with both high-intensity support needs and lower intensity needs.

More staff, including backfill

'Increasing staffing' was the most common response given by frontline workers to the question 'What else needs to be done to prevent and reduce workplace trauma?' This included the provision of backfill: workers wanted to see any vacancies—including those arising from extended leave—filled quickly, so that other team members did not have to carry an excess load for months at a time:

> We have vacancies that go unaddressed for months and months on end, and depending on who your team leader is, you might just be expected to pick up the slack and continue meeting a program KPI. That's messed up. We need safety nets against that. (Frontline, SHS, I02)

Minimum two-worker model

Within SHS, whether in outposts—where a worker is co-located at an allied services at set times—outreach work, or tenant visits, frontline workers wanted to see a two-worker model. This would help with safety when directly interacting with clients/tenants and allow for peer support. As one worker explained:

> I think it should be a two-up job permanently … There's always two people who do all the tradesmen work, but then the housing officer, who's potentially the one who's going to have to say something that could be conflicting, like 'You need to mow your lawns,' or 'Got to pay your rent,' or something, you do it on your own. I think that's a bit ludicrous. (Frontline, STHA, I08)

Job rotation

A suggestion made by several participants was to use job rotation to facilitate downtime for workers and to ensure organisations could retain experienced workers rather than having them leave to access further career development options.

Participants considered that job rotation need not be permanent and would be dependent on qualifications, skills and experience, but would allow people time out of intense crisis environments; if rotating through entire positions was not possible, some form of task rotation could be an option.

Role clarity

Role clarity was an issue for many frontline workers who wanted clear, detailed position descriptions to provide role clarity, and targeted training to ensure people had the necessary skills for their particular role.

Dedicated, daily time for paperwork and decompression

Some workers wanted to see specific time allocated for administrative duties and decompression at the end of each day.

6.2.3 Improving workplace supports for staff

As described in Chapter 5, many organisations already had supports for workers in place. However, our findings suggest that these practices are applied inconsistently both within and between organisations.

A range of improvements was suggested, including clinical supervision and reflective practice, improvements to EAPs, improved critical incident management, and creating a culture in which asking for support was normalised. Frontline workers especially wanted peer-to-peer support to be valued and fostered, and for a focus on the safety and wellbeing of casual and after-hours staff.

Improvements to the way training was offered and provided were also suggested, as well as a shift towards staff—and clients and tenants—being supported in a trauma-informed way.

Clinical supervision and reflective practice

Frontline workers wanted to see a range of supervision options available to them. This included day-to-day support from their line managers, team-based reflective practice, and clinical supervision.

They wanted clinical supervision to be provided by someone with specialist training, rather than their line manager. Workers argued that while a line manager's role includes provision of day-to-day support, it may also include performance management. As such, staff may not feel comfortable raising concerns about their wellbeing and its impact on their work.

Normalising the need for support

In general, frontline staff wanted to see psychological first aid practised in workplaces, along with the normalising of self-care, in all the varied forms it can take.

According to stakeholders, there was still considerable stigma attached to 'not coping'. This was problematic, because, as one stakeholder pointed out, the effectiveness of existing measures, such as EAPs, 'is reliant upon the individuals to go, "Yes, I have a problem, and I'm prepared to have some sort of intervention to support it"' (Stakeholder 08).

Stakeholders felt that managers had an important role in encouraging staff to access support, and in creating a culture where it was normalised. They felt assessments about encouraging someone to get support should not be based on the severity of a workplace incident the worker experienced, but on the impact it had on them.

According to one stakeholder, this destigmatisation 'could easily be a role of government and sector bodies' (Stakeholder 08).

Critical incidents

Workers suggested several improvements to how critical incidents were managed and responded to. They wanted to see mandatory debriefing within set time frames and mandatory paid time off (24–48 hours) after such an incident; this time should not be taken from their sick leave balances.

Critical incident reviews were also requested. Such reviews should include all staff involved and examine what happened, what worked, what did not work, and if changes to processes and policies are needed:

> If we don't reflect on the critical incidents, how can we ever mitigate any risk, or look at how things get done better, or look at what the response was? I just think that's not taken seriously enough across the sector. (Frontline, SHS, I05)

Employee assistant programs (EAPs)

EAPs were seen as an important element of a comprehensive response to workplace trauma. However, workers were clear that EAPs were not a substitute for supervision (clinical and otherwise), and that improvements to EAP programs were needed. For example, they wanted flexibility so that people could approach a provider of choice, including those they may already be working with.

Workers also wanted more than the capped number of sessions available—caps varied from three to six sessions—so they did not want to have to 'out themselves' by asking for additional sessions or to feel that they had to be 'over it' after a set number of sessions. They also wanted provider continuity to avoid having to retell their story. One worker who completed the national survey commented:

> We need a greater level of EAP than the limited six sessions. Given the rate of acute stress we are regularly exposed to while still being required to maintain empathetic connections with our clients, we need far more counselling/psychological support from trained specialists than what is currently available. (Survey, SHS)

Workers also suggested that EAP should be centrally funded by government with a specialist, sector-specific provider with an understanding of trauma and the nature of the work undertaken in SHS and social housing.

Dedicated trauma clinics are provided by Phoenix Australia for emergency service workers through Responder Assist, for police via Blue Hub in Victoria, for veterans in Victoria and Tasmania, and for regional Victorians. These clinics are funded by the state government. While not an EAP service, one participant suggested a similar clinical service could be provided for frontline workers.

Centralised provision of debriefing and support was also suggested, with use of regular debriefing incorporated into funding guidelines.

Valuing peer support

Many of the most effective responses to workplace trauma are currently informal, deeply connected to the workplace culture, and specific to the teams in which people work. Strategies such as peer support, team solidarity and debriefing are commonly relied upon by frontline workers. However, these practices often exist in the absence of robust, organisational structures. Structured support is needed, but the importance of peer-to-peer support within teams is an existing strength that should not be discouraged:

> Currently, the aspects that work well to prevent or reduce exposure to potentially traumatic events in my workplace are mostly the informal systems and practices that staff members put in place themselves. Team solidarity and peer support play a significant role; colleagues often look out for each other and offer encouragement and guidance during tough situations. These connections help create a sense of community and shared resilience among staff. (Survey, SHS)

After-hours, casual and temporary workers (locums)

People in certain roles were understood to be particularly vulnerable to trauma exposure, especially after-hours workers such as those working in residential settings, or assertive outreach workers with less access to formal support from line management. Workers in these roles may also have limited access to EAPs because of their working hours. There were pleas for consultation with these workers to identify supports tailored for them.

Also vulnerable were casual workers and those brought in to fill vacancies on a temporary basis (locums). These workers must operate with only limited understanding of their clients' history and current context, and sometimes more limited understanding of existing supports in that workplace. One worker suggested that dedicated 'safety officers' (or senior practitioners—but not security guards) be funded to support or manage difficult client/tenant interactions. The benefit from this would extend to all workers.

Training

Workers valued training and wanted to see it made available to people at all levels of seniority, to be timely and accessible for staff working different shifts, and to be made available alongside backfill for staff attending.

> There are sector bodies and sector leaders that do run amazing training, but they're staffed by part-timers. Or a training course will be run the 17th of January, and the next time we run it will be the 31st of October. You know what I mean? (Frontline, SHS, I03)

Sometimes the cost of training combined with the cost of backfilling workers was prohibitive, which meant that workers were missing out on important training.

Workers also wanted time to share and embed the knowledge acquired from training into practice within their teams:

> One of the problems with training in the sector is it's sort of a tick-box. We can show that people have had training, and it's used in our risk-mitigation strategies to show boards and to show government and to show WorkSafe. But I think the problem with training is it rarely gets embedded. People do three hours of training around de-escalation, and then before they know it, it's been six months and it's forgotten. (Frontline, SHS, I01)

Some stakeholders wanted to see ongoing conversations between managers and frontline staff about skill development and training, where managers prioritise professional development for staff.

In terms of content, workers wanted:

- training for team leaders, coordinators and managers in supervision, critical-incident debriefing, and managing critical incidents
- training on communication and de-escalation strategies
- training in any new frameworks, paradigms and practices to help manage the increased load of change
- up-to-date training on trauma and its effects.

Stakeholders argued that training should also support workers to have and hold boundaries when needed, to protect their own safety:

> We should help staff to feel that they have permission to have boundaries around what behaviours in client groups are acceptable. And having really strong support and really strong training and methodology around how do you gently but assertively hold that boundary while maintaining the therapeutic relationship. (Stakeholder 09)

Stakeholders were also keen for training to include staff at all levels and roles in organisations, including administrative staff. And both frontline workers and stakeholders were keen to learn from other sectors, particularly first responders.

Professionalising the social housing frontline

The ever-growing complexity of need among social housing tenants (see subsection 1.2.2) means a greater need for skilled tenancy support. Yet most workers in this sector were 'relatively low-level staff members, with a technical skill, a practical skill' (Stakeholder 06) rather than qualified social workers. However, upskilling and professionalising of the workforce presented problems. These could be solved by concentrating professional skills where they were most needed—in tenancy support.

Trauma-informed organisations

Both stakeholders and frontline workers wanted to see a shift to trauma-informed practice at the organisational level. They argued that the same understanding of trauma that should inform service delivery to clients/tenants needed to be also shown to frontline workers, and to be integrated into the way that services are run.

This would involve workers and clients being included in program evaluation and workers being encouraged and supported to provide feedback on policies and procedures that affect safety. Indeed, this is a key component of trauma-informed care and trauma-informed organisations as originally conceptualised (Guarino, Soares et al. 2009; Hopper, Bassuk et al. 2009).

Trauma-informed design

Workers suggested changes to the physical environment of services to ensure clients felt comfortable and welcome, which would assist in reducing the load on workers. This included trauma-informed design of the physical spaces where services were provided and moving away from clients/tenants having to wait in reception areas.

> An appointment system and waiting in reception and all those sorts of things—for a good number of our clients that's not a helpful way of supporting them. It sets people up in a combative space to begin with. (Survey, SHS)

6.3 Systemic changes needed

As discussed in Chapter 4, chronic under-resourcing of SHS, CHPs and STHAs, along with the wider housing crisis affecting the whole community, placed added strain on frontline workers and intensified their exposure to traumatic situations. Both frontline workers and stakeholders pointed to a number of solutions to systems trauma that would benefit clients and workers alike, including:

- more homelessness services
- more affordable housing options.

In allied sectors such as mental health, AOD, family violence, child protection and justice, participants wanted better support for clients/tenants and for these sectors to carry the load with these clients rather than leaving it for someone else (specifically the homelessness and social housing sectors) to deal with. They wanted to see:

- more collaboration with allied sectors to better support clients/tenants and share information
- changes to residential tenancies legislation
- increased funding across homelessness, social housing and allied sectors to implement changes.

6.3.1 More homelessness services, more affordable housing

Workers wanted to see more homelessness services, more crisis accommodation and more affordable housing options. This increase was seen as critical to relieving pressure on the system, which was currently chronically unable to meet demand. It would provide more meaningful outcomes for clients, enable Housing First responses, and reduce moral injury among workers.

> People come to us needing help, and while we can support them to a certain degree, we can't put a roof over their heads. We're working with people in motel rooms, where they're stuck in a constant state of fight or flight. We're trying to help them stabilise, but they're just surviving. If we could get them into their own property—whether it's a tiny home or just something that's theirs—they'd be so much more settled. It would give us a real chance to work with them properly. Everyone knows housing is the issue. We just don't have enough of it. (Frontline, CHP, I13)

Both frontline workers and stakeholders also wanted to see greater investment in the prevention of homelessness.

6.3.2 Allied services

Inadequate responses from allied sectors increase client distress and workplace trauma, as homelessness and housing providers become the 'last resort'. As one survey participant put it: 'Homelessness and housing staff should not be expected to deal with all client issues because the system is broken' (Survey, SHS).

Address service failures

The sector nominated most frequently in the data as being 'broken' in this way was mental health:

> I think for us, it'd need to be a better mental health system to start with, because a lot of our crises are around that. And because our mental health system is so overwhelmed, unless you're a risk to yourself or somebody else, you don't get followed up. So, they give them a tablet, they quiet them down, they send them back home and if someone is not compliant with medication, that's not going to work. (Frontline, SHS, I20)

> Bump up crisis support for mental health so that if people aren't travelling that well, they're able to be seen pretty well straightaway rather than reach psychosis level and then act out. (Stakeholder 07)

Workers also wanted to see more capacity for their clients/tenants in AOD, family violence services and child protection services. They wanted policy reforms to better support the intersections between services systems to prevent perverse outcomes:

> There's nothing [housing] available within people's affordability, so it just goes around in circles. You've got parents whose children have been removed and they're doing everything they can to get them back. But they can't access proper income support, because they don't have the children in their care—so they're not eligible for the single parenting payment and are stuck on JobSeeker. Then, because they're technically a single person, they can only get a one-bedroom property. But they might have three children waiting to return home. The department says they can't have their children back unless they have a three-bedroom house. And Housing says they can't get a three-bedroom house unless the children are already living with them. It's a complete catch-22. (Frontline, SHS, I10)

The distress and frustration of clients in these situations is unnecessary and 'better support for clients ultimately means less burnout and less risk for our staff' (Stakeholder 09).

Another stakeholder commented:

> If you want to cut down on the incidents or levels of how many incidents are happening, other sectors need to really carry their weight. The police—are they resourced to respond when needed? Mental health services. If you look at what are the triggers or why are clients acting out, it's because they couldn't get into a rehab or they've lost custody of their children. They couldn't get a drug [and alcohol sector] response, things like that. I know there's always a risk, but having other sectors respond in a timely manner would cut down on the level of incidents being played out in crisis refuges or for client outreach workers. (Stakeholder 07)

Collaboration and integration

Ensuring that allied service sectors were appropriately resourced to take on their share of the load would also support more collaborative and integrated ways of working. As one SHS worker explained:

> One big shift that would make a huge difference is if, instead of constantly having to fight with [STHA], we could actually work together. That kind of collaboration would reduce so much trauma for us as frontline workers. It would be far less distressing if we were working alongside them to house people, rather than having to argue about why they're not helping those who are clearly vulnerable. (Frontline, SHS, I10)

Another worker explained how sharing information more efficiently would reduce stress and trauma for clients/tenants and for workers:

> When emergency services do welfare checks, we need to know outcomes. We need to know if there are risks we need to be aware of. Especially if we're managing a lot of properties on one side and we have somebody who is a violent offender or something like that, and we're not getting feedback on what's actually happened, what the outcome is, and then we're not able to protect other people in the building or other clients who might be impacted by that behaviour, things like that. That makes things really difficult. (Frontline, CHP, workshop)

Workers also suggested that better information-sharing within and between agencies would reduce the number of times that clients had to retell their story and help better communication of risk between workers in different services:

> If someone has already told their story—for example, to Child Services—we should be able to access that information, so they don't have to repeat it all over again when they come to Housing, or again at Centrelink. It's retraumatising, and it shouldn't be necessary. (Frontline, STHA, I12)

Finally, stakeholders and frontline workers called for multidisciplinary teams with a variety of expertise. This would ensure that all client needs were understood and met, appropriate risk assessments were undertaken, and workers were not pushed to work beyond the scope of their skills and expertise.

6.3.3 Changes to residential tenancies legislation

As mentioned in Chapter 3, residential tenancy laws, and their enforcement, created barriers to moving tenants who posed significant risk to others. There were two issues that frontline workers and stakeholders wanted to see addressed.

First, for there to be a lower threshold than the current grounds for eviction to transfer tenants to different properties to manage risk to other tenants. It was felt that transferring people away from more densely tenanted properties or areas would assist with managing the impact of antisocial behaviour—allowing these tenants to remain housed but have less impact on neighbouring tenants.

Second, a Victorian stakeholder wanted an option of a breach of duty notice for aggressive and threatening behaviour. At present, the only response provided in tenancy legislation in Victoria for threatening behaviour towards staff was to issue a 'notice to vacate'—an eviction notice. A breach of duty notice could be used to help manage such behaviour, allowing for multiple breaches and escalation over time before someone was issued with a notice to vacate.

6.4 Funding: the elephant in the room

All participants in our study wanted to see increased funding for services. They wanted funding to cover the full cost of safe service provision by improving such factors as worker/client ratios, attracting and retaining workers, providing supervision, and ensuring job security so that skilled and valued colleagues were not lost when program funding was renewed at the last minute—or not at all.

> Government needs to look at, 'Well if we're going to provide a program, we need to provide the program in full, without reliance on donations or volunteers or whatever.' It has to be funded completely. Not this half-arsed, 'We'll only cover the staff costs or the cost for this or that, but we're not covering food costs,' for example. (Frontline SHS, I19)

> I don't think there's any recognition at government level that there should be funding of services for supervision and for reflective practice. If we want to do that, we have to find the money elsewhere. (Frontline, SHS, I01)

As one stakeholder pointed out, trauma management was not a sensible place to cut costs: 'You might save a few dollars one year in a budget, but you're creating more problems' (Stakeholder 08). In essence, trauma needed to be treated as a budget priority:

> Normally when you're budgeting, some of the key things are salary and wages, superannuation, workers' compensation. I think managing trauma should sit in the same priority as all of those. So as a sector, like when the government is looking at funding services, they need to be thinking about: 'How do we manage it for the longer term?' (Stakeholder 08).

6.5 Key levers for change

Most workers in the homelessness and community housing sector are dependent on modern awards for their rates of pay, leave entitlements, and classification of their skills. Improvements in pay and conditions therefore need to be tackled via improvements to the relevant award. Policy makers have a role in supporting these improvements.

The Social, Community, Home Care and Disability Services Industry award (SCHADS award) that covers workers in SHS and CHPs is part of the priority awards review for gender-based undervaluation currently underway by the Fair Work Commission. The union representing workers in these sectors (the Australian Services Union) is currently campaigning for a review of the classification structure in the award to ensure workers' skills are recognised and remunerated more appropriately.

Those workers employed in STHAs, and some workers in SHS and CHPs, are covered by Enterprise Agreements, and so improvements to pay and conditions need to be sought through Enterprise Bargaining. Policy makers should consider how they can support advances in conditions for these workers in these processes.

The range of improvements to work design require additional funding and could be addressed at the point-of-service commissioning for SHS, and within government planning and budgeting for STHA. Funding models need to include:

- fixed client and tenant loads
- adequate staffing levels
- funding for backfill
- time for administrative duties
- dedicated safety measures
- clinical supervision, training and planning for a shift towards trauma-informed organisations.

Most funding for CHPs comes in the form of capital grants for new developments; the only ongoing revenue stream being rents (which include CRA). This creates an additional financial challenge for CHPs in addressing these issues. However, governments have previously provided targeted grants to support compliance with new regulations such as energy efficiency standards. This mechanism could also be used to support measures to address workplace trauma.

For SHS, some of the issues with work design could be addressed in service guidelines for homelessness services and enforced in provisions in funding agreements (as well as though the Secure Jobs Code in Victoria). Regardless, frontline workers argued that there needed to be mechanisms to enforce safe caseloads and safe working environments. There is a clear need for policy and best practice guardrails to enshrine minimum standards, and accountability for these, across the sector both within and between jurisdictions.

Policy makers may wish to consider directly funding an EAP program, perhaps along similar lines to the support available for emergency services workers through Phoenix Australia, to ensure that support is trauma-informed and that those providing support to workers understand the specific nature of the work performed.

Federal and state/territory WHS legislation and CoPs are highly relevant to addressing workplace trauma in the social housing and homelessness sectors. However, while this avenue can be used for enforcement and to compel action, it will not provide the additional funding required to enable the suite of options outlined in this chapter. Provision of additional funding is needed from governments.

In our final chapter we provide an agenda for change with priority actions for policy makers based on the findings of this chapter, along with a number of guiding principles for implementation.

7. A way forward

This research has examined the prevalence and impacts of workplace trauma on frontline workers in social housing and homelessness services in Australia. It responds to the urgent need to better understand how workplace trauma can be reduced and prevented to make these sectors safer—and to ensure quality services are provided to vulnerable members of the community.

The research employed a mixed-methods approach with four integrated components including a literature review, interviews with stakeholders and frontline staff, a national online survey with frontline staff, and workshops with frontline staff and stakeholders.

The literature review highlighted the complexity of workplace trauma in the homelessness, social housing and allied sectors. Data collected in the survey, interviews and workshops highlighted the complex array of challenges that frontline staff in these sectors regularly experience—from verbal abuse and threats, to witnessing client/tenant deaths, including suicide, to hearing details of abuse and torture.

The drivers of workplace trauma however do not exist merely at the level of worker and client/tenant interactions. Our findings make clear that harm is occurring and is compounded by poor organisational responses to traumatic experiences, inadequate and unsupportive processes, under-resourced working conditions, chronic underfunding across the sector, and broader systemic issues.

These compounding factors highlight the need for both structural and interpersonal approaches to trauma mitigation. Findings from this study document substantial negative impacts of workplace trauma on staff, on service delivery to clients and organisations, and on the sector as a whole.

While some practices aimed at supporting staff and addressing workplace trauma are in place, their implementation is inconsistent within and between organisations. Moreover, these measures are at times experienced by staff as tokenistic and insufficient to the realities of frontline work. Participants shared with us the multitude of ways that safety can be improved for frontline workers.

In this chapter we provide six guiding principles, derived directly from this research project, to guide policy maker and service provider approaches to preventing and mitigating workplace trauma. Flowing from this, we then offer an agenda for change with priority actions to begin addressing workplace trauma on the social housing and homelessness frontline.

7.1 Six principles to guide the response to workplace trauma

In responding to our findings, we encourage policy makers, peak bodies and leaders within these sectors to be guided by the following principles.

1. Acknowledgement: Recognise that exposure to workplace trauma is frequent, cumulative, and structurally embedded in frontline housing and homelessness work.

When frontline workers were asked what they would like us to do with our findings, they consistently expressed a strong desire for senior managers, CEOs of large organisations and policy makers to understand what they were grappling with at work.

We hope that this report provides a deeper understanding of the nature and demands of frontline work in the social housing and homelessness sectors.

2. Holistic system investment: Social housing and homelessness services are part of a broader health and social care system that requires increased investment.

Frontline staff and stakeholders consistently described the ways that inadequate responses from allied sectors impacted on client distress and increased the complexity of issues they were required to manage. Inadequate mental health care for clients/tenants that led to workplace trauma in homelessness and social housing services was common. Frontline workers also noted inadequate responses from first responders and AOD, child protection, justice, and family violence sectors.

Due to the failures of other service systems, homelessness and social housing services often function as de facto catch-alls for people who fall through the gaps of other systems, including the mental health system. This places significant strain on frontline staff and undermines efforts to provide safe, sustained and trauma-informed support to those in need.

3. Worker agency: Because workers understand their work deeply, change must be worker-led.

There was a strong view from participants in our study that frontline workers needed to lead changes and improvements to their safety at work. This was grounded in the recognition that frontline staff were closest to the work and had a detailed understanding of current issues. Workers generally know what safety issues need to be addressed and know what will work best on the ground.

As outlined in Chapter 1, the first stage in risk-management guidance under the Model Code of Practice is to identify hazards by consulting with workers. The Model Act, along with relevant state-based legislation, also stipulates that workers must be consulted in any changes that may have an impact on their health and safety at work.

Working through the detailed suggestions in Chapter 6 (and summarised in the 'Agenda for Change' below) must involve centring the expertise of workers and positioning them as leaders in driving change rather than as passive recipients of externally imposed mandates.

4. Commissioning safety: Program funding must include staffing and infrastructure to deliver services safely.

For services to be delivered safely, funding models must include funding for dedicated safety measures such as CCTV and duress alarms. They must also have adequate staffing to ensure that workers have manageable caseloads, clients whose needs are within their skills and capabilities, and are not working alone at outposts or during home visits.

Government funders and organisations funded by government have duties to prevent workplace trauma. To do this, services must be funded for safety, and not just service delivery.

As clearly articulated by frontline staff and stakeholders throughout this research, additional and sustained investment is necessary to implement effective safety measures. This issue cannot be addressed in a cost-neutral way, by shifting funding from one area of budgets to another. Current low funding levels are already contributing to the problem.

5. Culture of safety: It is not enough to have controls and responses in place—they must be effective.

The responsibility that employers and funders hold to provide a safe working environment is not reducible to a checklist of measures that must be in place. These measures must also be effective in reducing workplace trauma and minimising further harm.

In our chapter on current practices, many frontline workers noted that their workplaces had systems for matters such as incident or hazard reporting. Many reflected however that these systems were cumbersome and were viewed as a 'tick-box' exercise with no meaningful follow-up afterwards.

Current practices alone are insufficient to protect workers, and there is clear evidence of significant and widespread harm across the homelessness and social housing frontline.

6. Trauma-informed organisations: Trauma reduction will enhance organisational effectiveness and improve both worker and client/tenant wellbeing

Improving responses for clients—whether in homelessness and social housing services, or in allied sectors—reduces client distress and improves conditions for workers. Clients who are meaningfully supported by well-functioning systems and appropriately skilled workers can cope more effectively, and are more likely to be able to manage or address their trauma symptoms, which in turn reduces the load for frontline workers.

Similarly, improving workers' conditions will improve client experiences. Adequate staffing levels enable workers to respond more effectively to client and tenant needs. Staff who are not consistently overwhelmed are able to deliver services to clients that are more consistent and higher in quality.

Worker trauma and client trauma are inextricably linked, and the benefits of reducing trauma and increasing safety need to be understood as connected.

7.2 An agenda for change

Our findings clearly demonstrate that workplace trauma has many causes and varied impacts. Chapter 6 outlined the many ideas participants shared with us about what could be done to better address the problem of workplace trauma.

Inspired by the hierarchy of control framework and synthesising the findings presented in Chapter 6, Table 12 offers a sector-wide agenda for change, along with priority actions to prevent and reduce workplace trauma.

Table 12: Preventing trauma: an agenda for change

Agenda item	Priority actions
Reducing the risk of workplace trauma	• Reduce overall staff and client distress by increasing both social housing supply and the supply of crisis accommodation. Increase social work support for tenants in social housing • Increase the accountability and responsiveness of allied service sectors such as mental health, AOD, family violence, child protection and justice for responding to people experiencing homelessness or living in social housing • Enhance collaboration between allied service sectors • Improve information-sharing between agencies and sectors to minimise retraumatising clients/tenants
Reducing exposure to workplace trauma	**Improved work design** • Increase staffing levels, including backfill • Smaller case/tenant loads with guardrails to prevent overwork • Mandate two-worker models • Support job rotation • Improve role clarity • Build dedicated time for administration into daily activities **Improved conditions** • Improve leave options • Embed flexible working • Increase the skills of managers • Improve pay to retain skilled staff and help address staff shortages • Work with social housing providers to amend residential tenancies legislation on transfers and antisocial behaviour
Physical changes to workplaces	• Implement trauma-informed design principles in the architectural and interior design of services • Expand and improve dedicated safety equipment such as security screens, duress alarms and CCTV.
Changes to organisations' policies, procedures and practices	• Embed clinical supervision and reflective practice across these sectors • Improve efficacy and timeliness of critical-incident management • Increase social-work skill set among tenancy workers • Expand training programs to improve timely access to training • Focus on safety and wellbeing for casual and after-hours staff
Improved supports for staff to manage and protect against exposure	• Centrally provide EAPs, ensuring expertise in homelessness and social housing work, capacity for ongoing support from the same counsellor, and longer periods of support • Resource peer-support networks for frontline workers and acknowledge the value of peers supporting one another through workplace trauma.

Source: Authors' summary of fieldwork.

Implications for further research

Public housing, community housing and SHS all receive combined funding from the federal and state/territory governments. However, this funding is administered directly via the states and territories and is provided differently for each of these sectors. This means that different mechanisms are needed to regulate practices in these sectors (as discussed in Section 6.5).

Our research has highlighted the need for a framework for regulating practices:

- within jurisdictions between providers (in the case of CHPs and SHS), and
- across jurisdictions for all three sectors.

Such a framework could be used to specify client:worker and tenant:worker ratios, minimum staffing levels, and mandatory WHS practices and supports for frontline workers.

There is a role for the Australian Government to provide guardrails in this space; these are important topics for further research.

Final remarks

Our research has documented significant and widespread harm among frontline staff in social housing and homelessness services. This harm has multiple causes in addition to interactions with clients/tenants, and current practices are not sufficient to protect frontline workers.

In response, this report outlines a series of suggestions to improve safety and reduce workplace trauma, alongside a set of guiding principles to support organisations and policy makers in implementing meaningful changes.

Implementing these principles will require more than goodwill; it demands structural reform, accountability and sustained investment in the safety and wellbeing of the workforce at the heart of the homelessness and social housing sectors.

It requires policy makers to be brave. As said by a stakeholder in one of our workshops:

> Bravery from the people who fund it. For people to go, 'We're going do this thing. It may not actually increase the number of clients being seen, but we're going to double the funding for the sector because it's underfunded.' Instead of going, 'An additional dollar in, means this much out,' actually [accepting] that the government is funding a really harmful industry. Bravery at the funding level is not very common. (Stakeholder, workshop)

References

Aboriginal Housing Victoria (2020) *The Victorian Aboriginal housing and homelessness framework overview,* Aboriginal Housing Victoria, North Fitzroy, https://vahhf.org.au/wp-content/uploads/2023/09/victorian-aboriginal-housing-and-homelessness-framework_overview_26_02_20.pdf.

American Psychiatric Association (2022) *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.), https://doi.org/10.1176/appi.books.9780890425787.

Australian Association of Social Workers (2023) *AASW Practice Standards,* AASW, North Melbourne, Victoria.

Australian Bureau of Statistics (2023a) P*ersonal safety, Australia,* ABS, Canberra, accessed 4 June 2025, https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/latest-release.

Australian Bureau of Statistics (2023b) *Estimating homelessness: Census: estimates of people who were experiencing homelessness or marginally housed as calculated from the Census of Population and Housing,* ABS, Canberra, accessed 14 May 2025, https://www.abs.gov.au/statistics/people/housing/estimating-homelessness-census/2021.

Australian Government (2022) *National housing accord 2022*, Australian Government, Canberra, https://ministers.treasury.gov.au/sites/ministers.treasury.gov.au/files/2022-10/national-housing-accord-2022.pdf.

Australian Institute of Health and Welfare (2022) *Mental health services in Australia: stress and trauma,* AIHW, Canberra, accessed 23 June 2023, https://www.aihw.gov.au/mental-health/topic-areas/health-wellbeing/stress-and-trauma.

Australian Institute of Health and Welfare (2023) *Welfare workforce*, AIHW, Canberra, accessed 29 May 2025, https://www.aihw.gov.au/reports/australias-welfare/welfare-workforce.

Australian Institute of Health and Welfare (2025) *Specialist homelessness services annual report 2023–24*, cat. no. HOU 339, AIHW, Canberra, accessed 14 May 2025, https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-annual-report/contents/about.

Aykanian, A. and Mammah, R. O. (2022) 'Prevalence of adverse childhood experiences among frontline homeless services workers in Texas ', *Families in Society*, vol. 103, no. 4: 438–449, https://doi.org/10.1177/10443894211063579.

Baptista, I., Benjaminsen, L., Busch-Geertsema, V. and Pleace, N. (2020) *Staffing homelessness services in Europe,* European Observatory on Homelessness, Brussels.

Bell, J.L. (1995) 'Traumatic event debriefing: service delivery designs and the role of social work', *Social Work*, vol. 40, no. 1: 36–43.

Benuto, L. T., Singer, J., Gonzalez, F., Newlands, R. and Hooft, S. (2019) 'Supporting those who provide support: work-related resources and secondary traumatic stress among victim advocates', *Safety and Health at Work,* vol. 10, no. 3: 336–340, https://doi.org/10.1016/j.shaw.2019.04.001.

Black, C. (2014) *Homelessness, learning from those who've lived it: evaluation of the peer education support program,* Council to Homeless Persons, Collingwood, Victoria.

Bollard, M. (2018) *Review of the model Work Health and Safety laws: final report,* Safe Work Australia, Canberra, accessed 31 July 2024, https://www.safeworkaustralia.gov.au/system/files/documents/1902/review_of_the_model_whs_laws_final_report_0.pdf.

Bransford, C. and Cole, M. (2019) 'Trauma-informed care in homelessness service settings: challenges and opportunities', in H.L.A. Aykanian and C.L. Streeter (eds), *Homelessness Prevention and Intervention in Social Work: Policies, Programs, and Practices,* Springer Nature, Switzerland: 255–277.

Buhrich, N., Hodder, T. and Teesson, M. (2000) 'Lifetime prevalence of trauma among homeless people in Sydney', *Australian & New Zealand Journal of Psychiatry,* vol. 34, no. 6: 963–966, doi:10.1080/000486700270.

Callander, D., Wiggins, J., Rosenberg, S., Cornelisse, V., Duck-Chong, E., Holt, M., Pony, M., Vlahakis, E., MacGibbon, J. and Cook, T. (2019) *The 2018 Australian trans and gender diverse sexual health survey: report of findings*, accessed 4 June 2025, https://www.kirby.unsw.edu.au/research/reports/2018-australian-trans-and-gender-diverse-sexual-health-survey-report-findings.

Cao, S. (2022) *Secondary traumatic stress and vicarious trauma among frontline workers who support people experiencing homelessness in Australia,* Honours Thesis, Department of Psychological Sciences, Swinburne University of Technology, Melbourne.

Carpenter, J., Webb, C., Bostock, L. and Coomber, C. (2012) *Effective supervision in social work and social care*, Research Briefing No. 43, Social Care Institute for Excellence, London, https://www.drugsandalcohol.ie/18661/1/scie_briefing43_effective_supervision.pdf.

Čartolovni, A., Stolt, M., Scott, P. A. and Suhonen, R. (2021) 'Moral injury in healthcare professionals: a scoping review and discussion', *Nursing Ethics,* vol. 28, no. 5: 590–602.

Carver, H., Price, T., Falzon, D., McCulloch, P. and Parkes, T. (2022) 'Stress and wellbeing during the COVID-19 pandemic: a mixed-methods exploration of frontline homelessness services staff experiences in Scotland', I*nternational Journal of Environmental Research and Public Health,* vol. 19, art. 3659, https://doi.org/10.3390/ijerph19063659.

Centre for Workforce Excellence (2023a) *Reflective supervision,* Victorian Government, accessed 4 June 2025, https://www.vic.gov.au/best-practice-supervision-information-sheets/reflective-supervision.

Centre for Workforce Excellence (2023b) S*upervision definitions,* Victorian Government, accessed 4 June 2025, https://www.vic.gov.au/best-practice-supervision-information-sheets/supervision-definitions.

Cocker, F. and Joss, N. (2016) 'Compassion fatigue among healthcare, emergency and community service workers: a systematic review', *International Journal of Environmental Research and Public Health*, vol. 13, no. 6: 618, https://doi.org/10.3390/ijerph13060618.

Collings, J. A. and Murray, P. J. (1996) 'Predictors of stress among social workers: an empirical study', *British Journal of Social Work,* vol. 26, no. 3: 375–387, https://doi.org/10.1093/oxfordjournals.bjsw.a011101.

Community Housing Industry Association [CHIA Victoria] (2023) *Victorian community housing workforce strategy,* CHIA Victoria, Melbourne.

Cortis, N. and Blaxland, M. (2017) *Workforce issues in specialist homelessness services*, Report prepared for Domestic Violence NSW, Homelessness NSW and Yfoundations, SPRC Report no. 08/17, Social Policy Research Centre, Sydney, doi:10.4225/53/592628989f0ab.

Cortis, N. and Blaxland, M. (2023) At the precipice*: Australia's community sector through the cost-of-living crisis: findings from the Australian Community Sector Survey,* Australian Council of Social Service, Sydney.

Cortis, N. and Blaxland, M. (2024) *Australia's social and community services workforce: characterisation, classification and value,* Final report prepared for Australian Services Union, UNSW Social Policy Research Centre, Sydney.

Crivari, O., Pointer, S., Schroder, C., Randjelovic, I. and McMillan, J. (2023) *Vicarious trauma in the workplace: prevention and intervention strategies*, Evidence review 342, Institute for Safety, Compensation and Recovery Research (ISCRR), Monash University, Melbourne.

Davys, A. and Beddoe, L. (2010) *Best practice in professional supervision: a guide for the helping professions,* Jessica Kingsley, London.

Davys, A., May, J., Burns, B. and O'Connell, M. (2017) 'Evaluating social work supervision', *Aotearoa New Zealand Social Work*, vol. 29, no. 3: 108–121.

Devilly, G.J., Wright, R. and Varker, T. (2009) 'Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals', *Australian and New Zealand Journal of Psychiatry,* vol. 43 no.4: 373–385.

Dolan, E. D., Mohr, D., Lempa, M., Joos, S., Fihn, S. D., Nelson, K. M. and Helfrich, C. D. (2015) 'Using a single item to measure burnout in primary care staff: a psychometric evaluation', *Journal of General Internal Medicine*, vol. 30, no. 5: 582–587, https://doi.org/10.1007/s11606-014-3112-6.

Ewing, R., Waugh, F. and Smith, D.L. (2021) 'Introduction: what is reflection and reflective professional practice?' in R. Ewing, F. Waugh and D.L. Smith (eds), *Reflective Practice in Education and Social Work: Interdisciplinary Explorations,* Routledge: 1–12, https://doi.org/10.4324/9781003155010.

FEANTSA (2015) *Peer support: a tool for recovery in homelessness services*, Policy paper, FEANTSA, Brussels.

Ferguson, H. (2018) 'How social workers reflect in action and when and why they don't: the possibilities and limits to reflective practice in social work', *Social Work Education*, vol. 37, no. 4: 415–427.

Griffin, B. J., Purcell, N., Burkman, K., Litz, B. T., Bryan, C. J., Schmitz, M., Villierme, C., Maguen, S. and Maguen, S. (2019) 'Moral injury: an integrative review', *Journal of Traumatic Stress,* vol. 32, no. 3: 350–362.

Guarino, K., Soares, P., Konnath, K., Clervil, R. and Bassuk, E. (2009) *Trauma-informed organizational toolkit,* Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation, Rockville, Maryland, accessed 4 June 2025, https://www.air.org/sites/default/files/downloads/report/Trauma-Informed_Organizational_Toolkit_0.pdf.

Hartanto, S. and Mackelprang, J. (2019) 'Traumatic brain injury and homelessness: the case for research to optimise service provision for brain injury survivors', *Parity*, vol. 32, no. 7: 20.

Henderson, A., Jewell, T., Huang, X. and Simpson, A. (2024) 'Personal trauma history and secondary traumatic stress in mental health professionals: a systematic review', *Journal of Psychiatric and Mental Health Nursing*, vol. 31, no. 4: 7–19, https://doi.org/10.1111/jpm.13082.

Henderson, C., Everett, M. and Isobel, S. (2018) *Trauma-informed care and practice organisational toolkit (TICPOT): an organisational change process resource, stage 1–planning and audit*, Mental Health Coordinating Council, Sydney.

Herman, J. L. (1992) *Trauma and Recovery,* Basic Books, New York.

Hoell, A., Kourmpeli, E. and Dressing, H. (2023) 'Work-related post-traumatic stress disorder in paramedics in comparison to data from the general population of working age: a systematic review and meta-analysis', *Frontiers in Public Health,* vol. 11: art. 1151248, doi:10.3389/fpubh.2023.1151248.

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

Isobel, S. and Thomas, M. (2022) 'Vicarious trauma and nursing: an integrative review', *International Journal of Mental Health Nursing*, vol. 31, no. 2: 247–259, doi:10.1111/inm.12953.

James, A., Dunlop, P.D., Gilbert, C., Gilbert, J., Gagné, M., Parsell, C., Cawthray, J. and Farid, H. (2023) *Investigative panel into building and retaining an effective homelessness sector workforce,* AHURI Final Report No. 409, Australian Housing and Urban Research Institute Limited, Melbourne, https://www.ahuri.edu.au/research/final-reports/409, doi:10.18408/ahuri8128901.

Kapoulitsas, M. and Corcoran, T. (2015) 'Compassion fatigue and resilience: a qualitative analysis of social work practice', *Qualitative Social Work*, vol. 14, no. 1: 86–101, https://doi.org/10.1177/1473325014528526.

Keane, C.A., Magee, C.A. and Kelly, P.J. (2016) 'Is there a complex trauma experience typology for Australians experiencing extreme social disadvantage and low housing stability?', *Child Abuse and Neglect*, vol. 61: 43–54, https://doi.org/10.1016/j.chiabu.2016.10.001.

Kerman, N., Ecker, J., Gaetz, S., Tiderington, E. and Kidd, S. A. (2022a) 'Mental health and wellness of service providers working with people experiencing homelessness in Canada: a national survey from the second wave of the COVID-19 pandemic', *Canadian Journal of Psychiatry,* vol. 67: 371–379, https://doi.org/10.1177/07067437211018782.

Kerman, N., Ecker, J., Tiderington, E., Aykanian, A., Stergiopoulos, V. and Kidd, S. A. (2022b) '"Systems trauma": a qualitative study of work-related distress among service providers to people experiencing homelessness in Canada', *SSM-Mental Health,* vol. 2, https://doi.org/10.1016/j.ssmmh.2022.100163.

Kerman, N., Ecker, J., Tiderington, E., Gaetz, S. and Kidd, S.A. (2023) 'Workplace trauma and chronic stressor exposure among direct service providers working with people experiencing homelessness', *Journal of Mental Health*, vol. 32, no. 2: 424–433, doi:10.1080/09638237.2021.2022629.

Kimerling, R., Allen, M. C. and Duncan, L. E. (2018) 'Chromosomes to social contexts: sex and gender differences in PTSD', *Current Psychiatry Reports*, vol. 20, no. 12: 114–114, https://doi.org/10.1007/s11920-018-0981-0.

Kulkarni, S., Bell, H. and Hartman, J. (2013) 'Exploring individual and organizational factors contributing to compassion satisfaction, secondary traumatic stress, and burnout in domestic violence', *Journal of the Society for Social Work and Research*, vol. 4, no. 2: 114–130.

Kyron, M. J., Rikkers, W., LaMontagne, A., Bartlett, J. and Lawrence, D. (2022) 'Work-related and nonwork stressors, PTSD, and psychological distress: Prevalence and attributable burden among Australian police and emergency services employees', *Psychological Trauma: Theory, Research, Practice, and Policy*, vol. 14, no.7: 1124–1133, https://doi.org/10.1037/tra0000536.

Lawson, J., Denham, T., Dodson, D., Flanagan, K., Jacobs, K., Martin, C., Van den Nouwelant, R., Pawson, H. and Troy, L. (2019) *Social housing as infrastructure: rationale, prioritisation and investment pathway*, AHURI Final Report No. 315, Australian Housing and Urban Research Institute Limited, Melbourne, http://www.ahuri.edu.au/research/final-reports/315, doi:10.18408/ahuri-5314001.

Lemieux-Cumberlege, A. and Taylor, E. P. (2019) 'An exploratory study on the factors affecting the mental health and well-being of frontline workers in homeless services', *Health & Social Care in the Community*, vol. 27, no. 4: e367–e378, https://doi.org/10.1111/hsc.12738.

Lemieux-Cumberlege, A., Griffiths, H., Pathe, E. and Burle, A. (2024 Vo 33 no.2) 'Post-traumatic stress disorder, secondary traumatic stress, and burnout in frontline workers in homelessness services: risk and protective factors', *Journal of Social Distress and Homelessness*, vol.33, no.2: 329-340, https://doi.org/10.1080/10530789.2023.2191405.

Lenzi, M., Santinello, M., Gaboardi, M., Disperati, F., Vieno, A., Calcagnı, A., Greenwood, R. M., Rogowska, A. M., Wolf, J. R., Loubiere, S., Beijer, U., Bernad, R., Vargas-Moniz, M. J., Ornelas, J., Spinnewijn, F. and Shinn, M. (2021) 'Factors associated with providers' work engagement and burnout in homeless services: a cross-national study', *American Journal of Community Psychology,* vol. 67, no. 1–2: 220–236, https://doi.org/10.1002/ajcp.12470.

Leung, T., Schmidt, F. and Mushquash, C. (2023) 'A personal history of trauma and experience of secondary traumatic stress, vicarious trauma, and burnout in mental health workers: a systematic literature review', *Psychological Trauma: Theory, Research, Practice, and Policy*, vol. 15, suppl. 2: S213–S221, https://doi.org/10.1037/tra0001277.

Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C. and Maguen, S. (2009) 'Moral injury and moral repair in war veterans: a preliminary model and intervention strategy', *Clinical Psychology Review,* vol. 29, no. 8: 695–706.

Louth, J., Mackay, T., Karpetis, G. and Goodwin-Smith, I. (2019) *Understanding vicarious trauma: exploring cumulative stress, fatigue and trauma in a frontline community services setting,* The Australian Alliance for Social Enterprise, University of South Australia, Adelaide.

Maheen, H., Dimov, S., Spittal, M.J. and King, T.L. (2021) 'Suicide in welfare support workers: a retrospective mortality study in Australia 2001–2016', *Occupational and Environmental Medicine*, vol. 78: 336–341, https://doi.org/10.1136/oemed-2020-106757.

Mann, K. (2023) *Experiences of social workers who work with the victims of intimate partner violence in Aotearoa New Zealand,* The University of Auckland, New Zealand.

Marshman, C., Hansen, A. and Munro, I. (2022) 'Compassion fatigue in mental health nurses: a systematic review', *Journal of Psychiatric and Mental Health Nursing*, vol. 29, no. 4: 529–543, https://doi.org/10.1111/jpm.12812.

McNelis, S. (2006) *Rental systems in Australia and overseas,* AHURI Final Report No. 95, Australian Housing and Urban Research Institute Limited, Melbourne, https://www.ahuri.edu.au/research/final-reports/95.

Menschner, C. and Maul A. (2016) *Brief: key ingredients for successful trauma-informed care implementation,* Center for Health Care Strategies, accessed 4 June 2025, https://www.chcs.org/resource/key-ingredients-for-successful-trauma-informed-care-implementation/.

Morris, A., Robinson, C., Idle, J. and Lilley, D. (2024) 'Ideal bureaucracy? The application and assessment process for social housing in three Australian states', *International Journal of Housing Policy,* vol. 24, no. 2: 224–245.

Natalier, K., Cortis, N., Seymour, K., Wendt, S. and Kind, D. (2020) 'Workplace violence against domestic and family violence and sexual assault workers: a gender, setting-based approach', *British Journal of Social Work,* vol. 51: 2301–2320.

Newcomb, M. (2022) 'Self-care rhetoric in neoliberal organisations: social worker experiences', *Practice,* vol. 34, no. 3: 223–238, https://doi.org/10.1080/09503153.2021.1998414.

O'Donnell, M., Varker, T., Cash, R., Armstrong, R., Di Censo, L., Zanatta, P., Murnane, A., Brophy, L. and Phelps, A. (2014) *The trauma and homelessness initiative,* Australian Centre for Post-traumatic Mental Health in collaboration with Sacred Heart Mission, Mind Australia, Inner South Community Health and VincentCare Victoria.

Ogińska-Bulik, N., Gurowiec, P.J., Michalska, P. and Kędra, E. (2021) 'Prevalence and predictors of secondary traumatic stress symptoms in health care professionals working with trauma victims: a cross-sectional study', *PLOS ONE,* vol. 16, no. 2: e0247596, https://doi.org/10.1371/journal.pone.0247596.

Olivet, J., McGraw, S., Grandin, M. and Bassuk, E. (2010) 'Staffing challenges and strategies for organizations serving individuals who have experienced chronic homelessness', *The Journal of Behavioral Health Services & Research*, vol. 37, no. 2: 226–238, doi:10.1007/s11414-009-9201-3.

Payne, M. (2002) 'Social work theories and reflective practice', in R. Adams, A. Dominelli and M. Payne (eds), *Social Work: Themes, Issues and Critical Debates,* 2nd. ed., Palgrave: 123–138.

Peters, L., Hobson, C. W. and Samuel, V. (2021) 'A systematic review and meta-synthesis of qualitative studies that investigate the emotional experiences of staff working in homeless settings', *Health and Social Care in the Community*, vol. 30, no. 1: 58–72, https://doi.org/10.1111/hsc.13502.

Petrovich, J., Twis, M.K. and Evans, S. (2021) 'Practice with people experiencing homelessness: an analysis of secondary traumatic stress in the workplace', *Journal of Social Distress and Homelessness*, vol. 30, no. 2: 116–125, doi:10.1080/10530789.2020.1763574.

Portillo-Van Diest, A., Vilagut, G., Alayo, I., Ferrer, M. et al. (2023) 'Traumatic stress symptoms among Spanish healthcare workers during the COVID-19 pandemic: a prospective study', *Epidemiology and Psychiatric Sciences*, vol. 32: e50, https://doi.org/10.1017/S2045796023000628.

Raunick, C.B., Lindell, D.F., Morris, D.L. and Backman, T. (2015) 'Vicarious trauma among sexual assault nurse examiners', *Journal of Forensic Nursing*, vol. 11, no. 3: 123–128, https://doi.org/10.1097/JFN.0000000000000085.

Ravalier, J., Jones, D., Truell, R. and McFadden, P. (2022) 'Global social work working conditions and well-being', *International Social Work*, vol. 65. no. 6: 1078–1094, https://doi.org/10.1177/00208728221112731.

Reamer, F.G. (2022) 'Moral injury in social work: responses, prevention, and advocacy', *The Journal of Contemporary Social Services*, vol. 103, no. 3: 257–268, https://doi.org/10.1177/1044389421105102.

Robinson, C. (2014) 'Trauma: a cause and consequence of homelessness', in C. Chamberlain, G. Johnson and C. Robinson (eds), *Homelessness in Australia: An Introduction,* UNSW Press, Sydney: 233–252.

Robinson, C. (2022) *Bigger, better, stronger: responding to the mental health care needs of unaccompanied homeless children in Tasmania,* Social Action and Research Centre Anglicare Tasmania, Hobart, Tasmania.

Rohland, B. M., Kruse, G. R. and Rohrer, J. E. (2004) 'Validation of a single-item measure of burnout against the Maslach Burnout Inventory among physicians', *Stress and Health*, vol. 20, no. 2: 75–79, https://doi.org/10.1002/smi.1002.

Rosenberger, R., Fowler, R.L., Mona Robbins, M. and Gardner, A. (2019) 'Burnout among EMS professionals: incidence, assessment and management', *Journal of Emergency Medical Services*, accessed 4 June 2025, https://www.jems.com/mental-health-wellness/burnout-among-ems-professionals-incidence-assessment-and-management/.

Rothschild, B. (2000) *The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment*, Norton, New York.

Safe Work Australia (2022) *Managing psychosocial hazards at work: code of practice*, Safe Work Australia, accessed 6 May 2024, https://www.safeworkaustralia.gov.au/sites/default/files/2022-08/model_code_of_practice_-_managing_psychosocial_hazards_at_work_25082022_0.pdf.

Safe Work Australia (2023) *Model Work Health and Safety Bill 2023,* Safe Work Australia, accessed 6 May 2024, https://www.safeworkaustralia.gov.au/sites/default/files/2023-12/model-whs-bill-23_november_2023.pdf.

Safe Work Australia (2024a) *Duties under WHS laws,* Safe Work Australia, accessed 31 July 2024, https://www.safeworkaustralia.gov.au/law-and-regulation/duties-under-whs-laws.

Safe Work Australia (2024b) *Role of WHS regulators,* Safe Work Australia, accessed 31 July 2024, https://www.safeworkaustralia.gov.au/law-and-regulation/whs-regulators-and-workers-compensation-authorities-contact-information/role-whs-regulators.

Safe Work Australia (2024c) *How do the regulators enforce WHS laws*, Safe Work Australia, accessed 31 July 2024, https://www.safeworkaustralia.gov.au/law-and-regulation/whs-regulators-and-workers-compensation-authorities-contact-information/how-do-regulators-enforce-whs-laws.

Safe Work Australia (2024d) *WHS representatives and work groups*, Safe Work Australia, accessed 31 July 2024, https://www.safeworkaustralia.gov.au/safety-topic/managing-health-and-safety/consultation/health-and-safety-representatives-and-work-groups.

Salter, M. and Hall, H. (2022)' Reducing shame, promoting dignity: a model for the primary prevention of complex post-traumatic stress disorder', *Trauma, Violence, & Abuse*, vol. 23, no. 3: 906–919. https://doi.org/10.1177/1524838020979667.

Scanlan, J.N. and Still, M. (2019) 'Relationships between burnout, turnover intention, job satisfaction, job demands and job resources for mental health personnel in an Australian mental health service', *BMC Health Services Research*, vol. 19: 62, https://doi.org/10.1186/s12913-018-3841-z.

Scharg, R., Fantus, S., Leat, S., Childress, S. and Wood, L. (2023) 'Experiencing moral distress within the intimate partner violence & sexual assault workforce', *Journal of Family Violence*, doi:10.1007/s10896-023-00567-x.

Senreich, E., Straussner, S. L. A. and Steen, J. (2020) 'The work experiences of social workers: factors impacting compassion satisfaction and workplace stress', *Journal of Social Service Research*, vol. 46, no. 1: 93–109, doi:10.1080/01488376.2018.1528491.

Shay, J. (2014) 'Moral injury', *Psychoanalytic Psychology*, vol. 31, no. 2: 182–191.

Smith, S. and Hanna, S. (2021) 'Does helping hurt the helper? An investigation into the impacts of vicarious traumatisation on social work practitioners in Hawke's Bay, Aotearoa New Zealand', *Aotearoa New Zealand Social Work*, vol. 33, no. 3: 48–60.

Somani, R., Muntaner, C., Hillan, E., Velonis, A.J. and Smith, P. (2021) 'A systematic review: effectiveness of interventions to de-escalate workplace violence against nurses in healthcare settings', *Safety and Health at Work*, vol. 12, no. 3: 289–295, https://doi.org/10.1016/j.shaw.2021.04.004.

Steenekamp, B.L. and Barker, S.L. (2024) 'Exploring the experiences of compassion fatigue among peer support workers in homelessness services', *Community Mental Health Journal*, vol. 60: 772–783, https://doi.org/10.1007/s10597-024-01234-1.

Steering Committee for the Review of Government Service Provision [SCRGSP] (2025) *Report on Government Services 2025,* Productivity Commission, Canberra.

Taylor, K. M., Thielking, M., Mackelprang, J. L., Meyer, D. and Flatau, P. (2022) 'Trauma involving violation of trust and mental health help seeking among homeless adults', *Australian Psychologist,* vol. 57, no. 3: 174–185, https://doi.org/10.1080/00050067.2022.2059337.

Tehrani, N. (2010) 'Supporting employees at risk of developing secondary trauma and burn-out', in N. Tehrani (ed.), *Managing Trauma in the Workplace: Supporting Workers and Organisations,* Routledge.

Thibodeau, P., Arena, A., Wolfson, H., Talamantes, M. and Albright, K. (2024) '"Working within broken systems": social workers bridge the fractures of US healthcare: a qualitative inquiry on moral injury', *Social Science & Medicine*, vol. 358, art. 117262: 1–9.

Tiderington, E. (2019) 'Practice dilemmas, successes, and challenges in the delivery of homeless services: voices from the frontline', in H. Larkin, A. Aykanian and C. L. Streeter (eds.), *Homeless prevention and intervention in social work: policies, programs, and practices,* Springer: 379–394.

Tsantefski, M., Humphreys, C., Wilde, T., Young, A., Heward-Belle, S. and O'Leary, P. (2023) 'Worker safety in high-risk child protection and domestic violence cases', *Journal of Family Violence*, doi: 10.1007/s10896-023-00551-5.

Tually, S., Tedmanson, D., Habibis, D., McKinley, K., Akbar, S., Chong, A., Deuter, K. and Goodwin-Smith, I. (2022) *Urban Indigenous homelessness: much more than housing*, AHURI Final Report No. 383, Australian Housing and Urban Research Institute Limited, Melbourne, http://www.ahuri.edu.au/research/final-reports/383, doi:10.18408/ahuri3222701.

Twis, M., Petrovich, J., Cronley, C., Nordberg, A. and Woody, D. (2022) 'A mixed methods analysis of case manager stress at a homelessness services center', *Journal of Evidence-Based Social Work*, vol. 19, no. 1: 19–41, https://doi.org/10.1080/26408066.2021.1989355.

Varty, M., Mines, M., DelMonte, J. and Ratliff, B. (2024) 'Implementing evidence-based workplace violence prevention education to support frontline staff at risk for workplace violence', *Journal of Nurses Professional Development*, vol. 40, no. 1: 4–9, https://doi.org/10.1097/NND.0000000000000966.

Voth Schrag, R., Wood, L., Watcher, K. and Kullkarni, S. (2022) 'Compassion fatigue among the intimate partner violence and sexual assault workforce: enhancing organizational practice', *Violence Against Women*, vol. 28, no. 1: 277–297.

Vrijkotte, T.G.M., van Doornen, L.J.P. and de Geus, E.J.C. (2000) 'Effects of work stress on ambulatory blood pressure, heart rate, and heart rate variability', *Hypertension,* vol. 35: 880–888, doi: 10.1161/01.hyp.35.4.880.

Vrklevski, L. P. and Franklin, J. (2008) 'Vicarious trauma: the impact on solicitors of exposure to traumatic material', *Traumatology,* vol. 14, no. 1: 106–118, https://doi.org/10.1177/1534765607309961.

Waegemakers Schiff, J. and Lane, A. M. (2019) 'PTSD symptoms, vicarious traumatization, and burnout in front line workers in the homeless sector', *Community Mental Health Journal*, vol. 55, no. 3: 454–462, https://doi.org/10.1007/s10597-018-00364-7.

Williamson, V., Stevelink, S. A. and Greenberg, N. (2018) 'Occupational moral injury and mental health: systematic review and meta-analysis', *The British Journal of Psychiatry,* vol. 212, no. 6: 339–346.

Wirth, T., Mette, J., Nienhaus, A., Schillmoller, Z., Harth, V. and Mache, S. (2019a) '"This isn't just things, it's about people and their future": A qualitative analysis of the working conditions and strain of social workers in refugee and homeless aid', *International Journal of Environmental Research and Public Health*, vol. 16, no. 20: 3858, https://doi.org/10.3390/ijerph16203858.

Wirth, T., Mette, J., Prill, J., Harth, V. and Nienhaus, A. (2019b) 'Working conditions, mental and coping of staff in social work with refugees and homeless individuals: a scoping review', *Health and Social Care in the Community*, vol. 27: 257–269, https://doi.org/10.1111/hsc.12730.

Worksafe Victoria (2023) *Work-related stress: violent or traumatic events*, WorkSafe Victoria, accessed 3 June 2025, https://www.worksafe.vic.gov.au/work-related-stress-violent-or-traumatic-events.

Zhang, J., Zheng, J., Cai, Y., Zheng, K. and Liu, X. (2021) 'Nurses' experiences and support needs following workplace violence: A qualitative systematic review', *Journal of Clinical Nursing*, vol. 30, no. 1: 28–43, doi:10.1111/jocn.15492.

Zuromski, K. L., Ustun, B., Hwang, I., Keane, T. M., Marx, B. P., Stein, M. B., Ursano, R. J. and Kessler, R. C. (2019) 'Developing an optimal short-form of the PTSD Checklist for DSM-5 (PCL-5)', *Depression and Anxiety,* vol. 36, no. 9: 790–800, https://doi.org/10.1002/da.22942.

Appendix 1: About participants in our national online survey

This appendix contains information about the responses to the national online survey run in the second phase of the research. The data presented is unweighted.

Three-quarters (75%) of the survey participants identified as female, one-fifth (20.9%) identified as male, and 2.4% of participants identified as non-binary/genderqueer/gender fluid. Survey respondent age ranged from 19 years to 80 years old.

Over three-quarters of participants were in the age range 25–54 years old, with an even distribution across three age brackets:

- 26.6% were 45–54 years old
- 25.9% were 35–44 years old
- 25.6% were 25–34 years old.

Some 6.6% of survey participants identified as being of Aboriginal or Torres Strait Islander origin. Survey participants were well educated, with 29.93% holding a Bachelor degree (with or without Honours), followed by 25.26% who had a Diploma or Advanced Diploma (see Table A1).

Table A1: Demographic and educational background of survey participants

Responses	Number	Percentage (%)
How do you describe your gender?		
Woman	435	75.3
Man	121	20.9
Non-binary/genderqueer/gender fluid	14	2.4
Intersex	1	0.2
Prefer not to answer	7	1.2
Total	578	
What is your age in years?		
18–24 years	18	3.2
25–34 years	146	25.7
35–44 years	147	25.9
45–54 years	151	26.6
55–64 years	82	14.5
65–74 years	22	3.9
75–84 years	1	0.2
Total	567	
Are you of Aboriginal and/or Torres Strait Islander origin?		
Yes, Aboriginal	29	5.0
Yes, Torres Strait Islander	5	0.9
Yes, both Aboriginal and Torres Strait Islander	4	0.7
No	522	90.3
Prefer not to say	18	3.1
Total	578	
What is your highest education level?		
Doctoral degree	2	0.3
Masters degree	81	14.0
Graduate Certificate or Graduate Diploma	43	7.4
Bachelor Degree with or without Honours	173	29.9
Diploma or Advanced Diploma	146	25.3
Certificate III–IV	81	14.0
Certificate I–II	4	0.7
Year 12 or High School Diploma	36	6.2
Year 11 or below	12	2.1
Total	578	

Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

The majority of survey participants (63.1%) worked within a greater capital city, while 34.3% worked in a regional area and 2.6% worked in a remote area.

Survey participants were asked to indicate how they interact with clients or tenants in their roles and could select all applicable options. The majority reported working directly with clients or tenants. Some said they directly supervised staff working with clients or tenants, or worked in management positions within a service or agency (see Table A2).

Survey participants' job roles varied, with the most commonly nominated titles including after-hours support worker, case manager, case worker, client relations officer, coordinator, team leader, housing officer, outreach worker, intake and assessment worker, tenancy manager or worker, senior client service officer, social worker, support worker and youth worker.

Table A2: Work location and role of survey participants

Responses	Number	Participants (%)
Do you work within a greater capital city or a regional or remote area?		
Greater capital city	364	63.1
Regional	198	34.3
Remote	15	2.6
Participant total	577	
In your role, do you (select all that apply)?		
Work directly with clients/tenants	513	88.8
Directly supervise staff who work directly with clients or tenants	210	36.3
Work in a management position in a service/agency	140	24.2
Work in an administrative (non-client/tenant facing) role	57	9.9
Maintenance officer	17	2.9
Other	24	4.2
Participant total	578	

Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

When asked which client or tenant cohorts they work with, the three most commonly selected groups were individuals experiencing or at risk of homelessness (84.4%), Aboriginal and/or Torres Strait Islander peoples (73.8%), and women (72.8%) (see Table A3).

Table A3: The client/tenant cohorts survey participants worked with in their current roles

Responses	Number	Percentage (%)
Which client cohort do you work with (select all that apply)?		
People experiencing or at risk of homelessness	488	84.4
Aboriginal and/or Torres Strait Islander peoples	427	73.8
Women	421	72.8
Families	356	61.6
Young people	345	59.7
Rough sleepers	341	59.0
Community housing tenants	315	54.5
Public housing tenants	294	50.9
Children	236	40.8
Other	42	7.3
Participant total	578	

Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

Survey participants reported varying lengths of time working in the homelessness, community housing or public housing sectors, ranging from two months to over 40 years. The largest proportion (36%) had been working in these sectors for one to four years, followed by those with five to nine years of experience (25.8%). Most survey participants (78.3%) intended to be in the same job in 12 months' time, although just over a fifth (21.7%) indicated that they did not (see Table A4).

Table A4: The length of time survey participants had worked in the social housing and homelessness sectors and intention to stay in these sectors

Responses	Number	Percentage (%)
For how many years have you been working in the homelessness, community housing or public housing sectors?		
Less than 1 year	15	2.6
1–4 years	206	36.0
5–9 years	148	25.8
10–15 years	91	15.9
16–20 years	57	9.9
21–25 years	28	4.9
26–30 years	11	1.9
31–40 years	15	2.6
More than 40 years	2	0.3
Total	573	
Do you intend to be in the same job in 12 months' time?		
Yes	451	78.3
No	125	21.7
Total	576	

Source: Authors (National Survey of Workplace Trauma among frontline workers in social housing and homelessness, unweighted).

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