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# The impact of client death on frontline workers in homelessness services: a systematic review and narrative synthesis

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**ABSTRACT**

Frontline workers in homelessness services are frequently exposed to unexpected death. While burnout and compassion fatigue have been documented, there is a lack of exploration into the impact of these deaths on homelessness workers. This review aims to understand stressors faced by homelessness workers exposed to premature death, and to identify evidence-based interventions providing support to workers managing the psychological impact of these experiences. Six databases were searched using predefined terms (CINAHL, Health Source, MEDLINE, PsychINFO, SocINDEX, Web of Science). Titles, abstracts, and full texts were screened by two reviewers, with disagreements resolved by a third. Data were extracted and thematically analyzed using NVivo, with findings synthesized narratively. Six studies met inclusion criteria. Workers reported various impacts, including psychological distress, grief complicated by stigma, heightened stress/burnout, and the effect of professional identity. No formal interventions beyond organizational support were identified. Workers utilized formal and informal organizational support, as well as personal coping strategies including boundary setting, finding closure, reframing death, and anticipating death. Repeated exposure to client death psychologically impacts homelessness workers. Lack of structured, evidence-based support highlights an urgent need for targeted interventions to support staff wellbeing.

**Abbreviations:** CASP: Critical Appraisal Skills Programme; CPR: cardiopulmonary resuscitation; PRISMA: preferred reporting items for systematic reviews and meta-analyses; PROSPERO: international prospective register of systematic reviews; UK: United Kingdom; US: United States

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## Background

Staff working in the homelessness sector often experience extremely stressful events, including high rates of client substance use, overdose, violence, and premature death (Winstanley, 2025). Working within this sector is particularly challenging because clients often present with complex physical and mental health needs. Those experiencing homelessness are more likely to report adverse childhood events and trauma in adulthood in comparison to housed populations (Irving and Harding 2025; Klarare et al., 2025), adding a layer of psychological complexity to service delivery. Furthermore, people experiencing homelessness are at a heightened risk of premature death in comparison to those without experience of homelessness (Tweed et al., 2022). Homeless populations are also more likely to report challenges with substance use, as well as issues accessing resources that improve quality of life, contributing to heightened mortality rates (Coombs et al., 2024; Roberts et al., 2023). Those experiencing homelessness tend to die at a much younger age than the general population (Tweed et al., 2022; White et al., 2025), with a mean age of death of 42 years for men and 37 for women (Morrison, 2009). As such, those working in the homelessness sector are likely to regularly experience the premature death of clients. The impact of these events may be further intensified by the fact that staff themselves also often have their own lived experience of adverse childhood events

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and trauma, increasing their vulnerability and the potential to be impacted by trauma in the workplace (Aykanian et al., 2025; Aykanian & Mammah, 2022; Camp et al., 2025).

Several studies exist that explore the wider impacts on workers providing support to the socially disadvantaged, including burnout, compassion fatigue, stress, and trauma, both in terms of witnessing traumatic events themselves and/or secondary trauma resulting from indirect exposure through clients sharing experiences with workers (Baker et al., 2007; Cocker & Joss, 2016; Maslach, 1993; Waegemakers Schiff & Lane, 2019). These impacts are further exacerbated by the need to navigate organizational and systematic pressures while making decisions about client care (Wirth et al., 2019). Burnout, compassion fatigue, stress, and trauma can lead to low job satisfaction, disillusionment, and emotional distress, negatively impacting the quality of care that staff provide to clients (Lenzi et al., 2021). In some cases, this has been exacerbated by ongoing funding cuts within the homelessness sector, with high workforce turnover and higher caseloads impacting staff wellbeing (Perez et al., 2024; Rogers et al., 2020). Training, supervision, and opportunities for team development have been identified as a means for organizations to limit the negative implications which repeated exposure to traumatic events and social disadvantage may have (Olivet et al., 2010; Zalc et al., 2025). Homelessness workers also report relying upon personal coping strategies, including mindfulness and engaging in hobbies to cope with the implications of their job (Peters et al., 2021).

Despite the evidence to suggest that burnout and compassion fatigue negatively impact worker quality of care, there remains a lack of understanding of the implications of repeated exposure to premature, and the expectation of, death. In this context, expectation refers to the anticipatory strain experienced by staff who work with high-risk populations where death is frequent yet often occurs as a sudden or unexpected event (e.g. via overdose or by accident). Furthermore, there is a lack of understanding whether appropriate interventions exist to effectively support staff who experience premature death (Ng et al., 2025). This highlights a need to examine the experiences of those working within the homelessness fields who may be at a heightened risk of exposure to these deaths. This review aims to address these gaps through a synthesis of the existing literature, as understanding workers' experiences can help to inform the development of interventions for managing the stressors unique to the role. While the broader occupational strains, such as stress and burnout, are relatively understood in the sector, this review specifically isolates the impact of death to determine how this shapes professional lives and support needs.

## Methods

A systematic review and narrative synthesis were conducted to explore the impact of premature death on homelessness workers to answer the following research questions:

1. What are the experiences and impacts of frequent exposure to sudden client death among frontline workers in homelessness services?
2. What evidence-based interventions are effective in supporting these workers in managing client deaths?

### *Search strategy*

A systematic review aims to "*systematically search for, appraise and synthesis[e] research evidence*" (Grant & Booth, 2009), and was chosen to explore all known evidence on the impact of unexpected client death on homelessness workers. The review protocol was developed and registered with PROSPERO (CRD42025626242). Systematic literature searching was conducted to identify all relevant literature relating to the review research questions (see inclusion and exclusion criteria below in Table 1).

Six electronic databases (CINAHL; Health Source; MEDLINE; PsycINFO; SocINDEX; Web of Science) were searched by JG and MT between February and March 2025. Key search terms were specifically selected to target the intersection of homelessness, the workforce, and death. The full search strategy is as follows: "homeless*"; "work*"; "death" or "grief" or "anticipated grief"; and "experience" or "intervention" or "effect" or "impact". These terms were selected to maintain a primary focus on death-related experiences rather than highlighting studies that show broader occupational strain, hence why the term "grief" was included due to its common association with death. The searches were limited to any study type, published in English language. Reference lists of included studies were also reviewed.

**Table 1.** Inclusion and exclusion criteria.

| Inclusion criteria | Exclusion criteria |
|---|---|
| Adults (18+) working in homelessness settings/with people experiencing homelessness and problematic substance use | Individuals working in wider social care and medical sectors, i.e. care homes, A&E, hospitals, etc. |
| Those working in frontline roles (such as support workers, healthcare professionals, social workers, outreach workers, etc.) | Those receiving support in homelessness settings (i.e. service users) |
| Unexpected/sudden deaths (for example due to overdose, trauma, violence) | Studies focusing on populations outside of social care homelessness services (e.g. care-homes, general healthcare workers, unrelated social service sectors) |
| Research that examines coping strategies, interventions, or support mechanisms for managing psychological stress and burnout in these settings | Research that does not address exposure to sudden death |
| Primary research and systematic reviews. | Opinion pieces, commentaries, editorials. |

### *Selection criteria and quality appraisal*

Papers were imported into Rayyan, an online software that facilitates reviewer collaboration. Duplicate papers were removed, then JG and MT independently screened the titles and abstracts against the proposed inclusion criteria. Disagreements were resolved through discussion, with a third reviewer (HC) making a final decision where necessary. Following this, JG and MT independently screened the full texts of included papers, with any disagreements resolved by HC. Literature searching and screening results were reported using PRISMA (Page et al., 2021). Studies meeting the inclusion criteria were quality assessed using the Critical Appraisal Skills Programme (CASP) systematic review and qualitative study checklists. Both JG and MT independently appraised each study and then discussed the results with HC. Scores were then combined to create the final CASP table (Supplementary files 1 and 2). The decision to include all papers regardless of their quality score was pre-determined to ensure a comprehensive capture of available evidence. Quality appraisal allowed for the systematic consideration of study strengths and weaknesses but was not used to exclude studies (Centre for Reviews and Dissemination, 2008). This approach is consistent with qualitative synthesis guidelines which suggest that even methodologically limited studies can contribute valuable conceptual insights (Carroll et al., 2012). Only one of the included studies was deemed as "weak" and therefore was included in synthesis alongside the more robust papers.

### *Data extraction and analysis*

Data was extracted from the included papers by JG and MT and input into an Excel spreadsheet. This included: location; setting/context; study participants' demographics; recruitment; data collection and analysis methods; and key findings. As the data in the included papers could be deemed qualitative, the studies were entered into NVivo version 20. A narrative synthesis was utilized as it is a method frequently used to summarize and explain findings of multiple studies focusing on the relationships between them and the influences of different contexts (Popay et al. 2006). Within this, a thematic analysis approach was used as the specific tool for analysis. These methods are often combined as thematic analysis enables common patterns from textual data to be extracted, providing the base needed for a narrative synthesis which structures the findings into a cohesive summary (Snilstveit et al., 2012). The analysis followed an inductive process with JG and MT performing coding of both participant quotes and author interpretations to identify recurring concepts. To group these initial codes into broader themes, JG, MT and HC engaged in a collaborative iterative process which involved reviewing coded data extracts to identify patterns. Any disagreements regarding theme definitions were resolved through team discussion and consensus, ensuring that the final narrative was a robust reflection of the collective data. Descriptive quotes are used throughout to support key points and provide transparency.

## Results

Six studies were identified as meeting the inclusion criteria (see Figure 1).

Two studies were conducted in Ireland (Lakeman, 2011; O'Callaghan & Lambert, 2024); one in the United States (US) (Shepard, 2013); one in the United Kingdom (UK) (Valoroso & Stedmon, 2020); one in

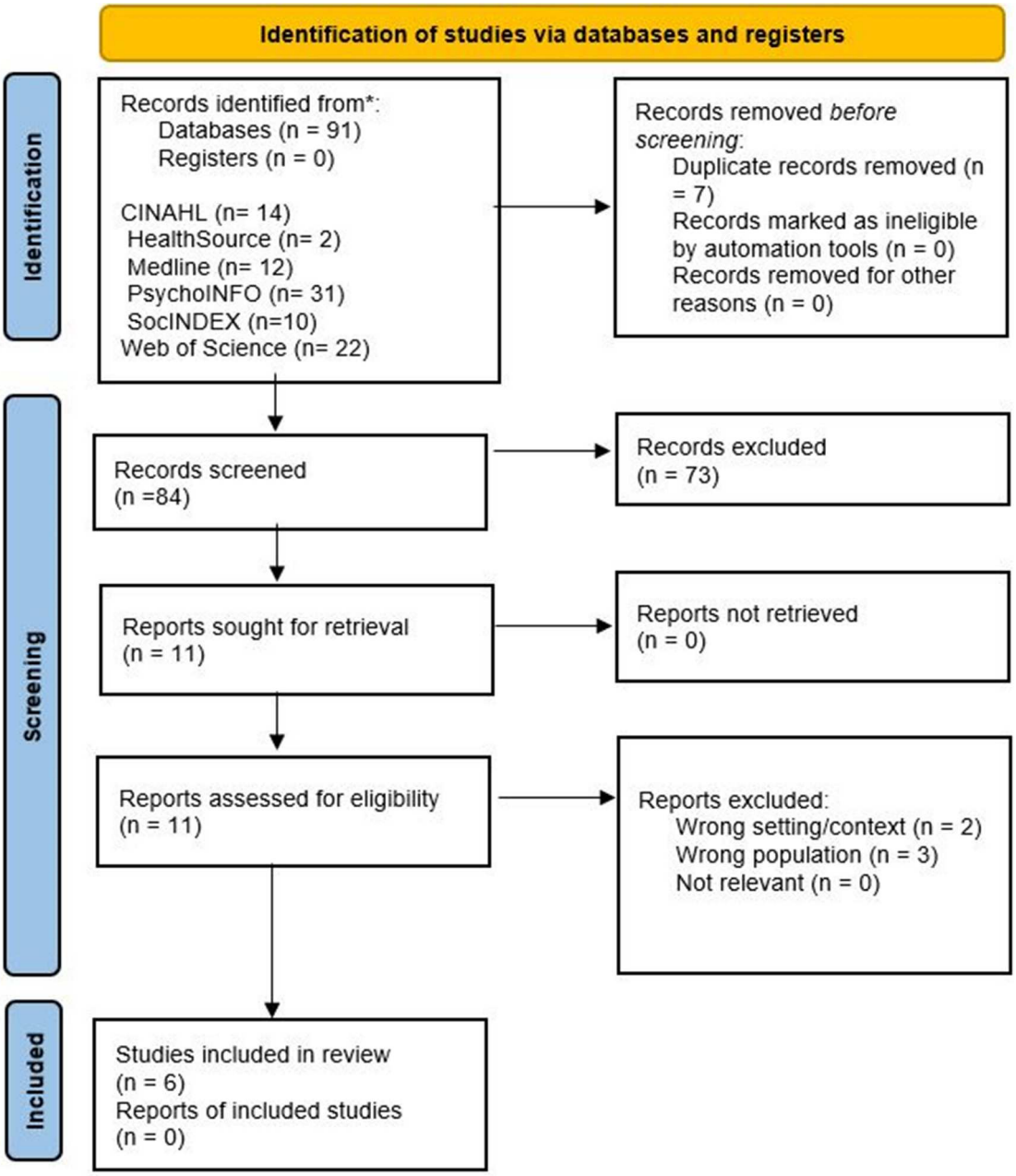


**Figure 1.** PRISMA flow diagram.

Canada (Mamdani et al., 2021); and one covering several nations in an international scoping review (Whitlock et al., 2025). Studies were published between 2011 and 2025, with a total of 437 participants. Data was collected using individual interviews, participant observations, quantitative surveys, reflective journals, focus groups, and through a rapid scoping review. Staff were in roles that interacted with people experiencing homelessness, including within hostels, shelters, group homes, and harm reduction and healthcare services (including emergency medicine and addiction). In some studies, not all participants worked in frontline homelessness settings but were included due to their relevance to the review. Table 2 highlights the characteristics of the included studies in terms of settings and participant demographics.

The focus of this review was to explore the impact of experiencing the sudden death of a client for those working with people experiencing homelessness as well as the availability and effectiveness of evidence-based interventions and support strategies. The synthesized findings are described below in response to the two research questions.

**Table 2.** Characteristics of included studies.

| Author(s) | Country | Setting | Study aim | Participant characteristics | Methods | Key findings |
|---|---|---|---|---|---|---|
| Lakeman (2011) | Ireland | Homeless sector across Dublin, Ireland. | To investigate workers' responses to service user deaths. | Homeless sector workers who had experienced the death of a service user ($n = 16$). | In-depth interviews and fieldnotes; grounded theory. | Coping with death depends on how it is encountered, how the death is marked, and how worker's grief is recognized. |
| Shepard (2013) | USA | Harm reduction services. | To review harm reduction workers' losses and literature focused on loss. | Participants were workers in the fields of harm reduction, healthcare, and human services who operate in high-stress environments and are directly/indirectly exposed to poverty, drug use, fatal and non-fatal overdose, blood borne viruses, structural violence, premature death, and trauma. | Ethnographic and reflective methods including personal stories, observations, secondary sources, and professional recollections. | Workers within harm reduction roles experience occupational stress and trauma. Workers develop coping mechanisms as a response. Harm reduction and human services should promote sustainability, health and pleasure to support workers. |
| Valoroso and Stedmon (2020) | UK | Homelessness hostels within nine areas of the UK. | To explore the emotional and psychological impact of finding the body of a deceased resident in a homelessness hostel. | Homeless sector workers ($n = 8$) with experience of finding a deceased body. | Semi-structured interviews; interpretative phenomenological analysis. | Workers experience emotional distress and trauma upon discovering a deceased resident, including intrusive memories. Workers felt unprepared to deal with death and made independent attempts to make sense of death. |
| Mamdani et al. (2021) | Canada | Two organizations, including a peer worker-led organization in Vancouver Island and a housing-first organization in Vancouver Coastal and Fraser regions. | To highlight stressors faced by peer workers, and to identify/implement supports designed for and by peer workers in overdose response settings. | Workers within overdose response settings ($n = 31$ for focus groups and $n = 50$ for survey). | Peer researcher-led focus groups and survey; thematic analysis and frequency distributions. | Peer workers face significant emotional strain due to constant exposure to trauma, grief and the blurring of personal and professional boundaries. Despite high levels of burnout and stress, most peer workers report a strong sense of pride, satisfaction and purpose in their role. |
| O'Callaghan and Lambert (2024) | Ireland | Health sector includes homelessness, emergency medicine, addiction and social work across the Republic of Ireland. | To explore the impact of drug-related client loss on healthcare practitioners. | Healthcare practitioners ($n = 15$) working in addiction, homelessness, emergency medicine, social care and public health. | Semi-structured interviews; reflective thematic analysis. | Three core themes emerged encapsulating the experience of drug-related bereavement for workers who support people experiencing addiction: 1) Grief Beneath the Surface, 2) The Cost of Caring, and 3) Finding Closure. |
| Whitlock et al. (2025) | UK, India, USA, Ireland, Canada and Australia. | Social service, government and mental health organizations. | Reviewing literature on the experiences of grief and bereavement amongst workers. | Social and community service workers ($n = 317$). | Rapid scoping review; narrative synthesis and thematic analysis. | Caring for socially disadvantaged individuals, including those experiencing homelessness, poses challenges, compounded by repeated loss, premature deaths, and societal stigma. |

### 1. What are the experiences and impacts of frequent exposure to sudden client death among frontline workers in homelessness services?

Across the six studies there were a range of experiences and impacts due to workers' exposure to sudden deaths. These were described in terms of the psychological responses to death; grief as being complicated by stigma; stress and burnout; and the impact of workers' role identity on their experiences.

#### Psychological responses to death

Participants reported complex psychological responses to unexpected death, including feelings of self-blame and culpability when a client has suffered, reflecting on missed opportunities to improve their client's well-being (O'Callaghan & Lambert, 2024; Whitlock et al., 2025). Participants discussed questioning previous decisions and whether they had done enough for clients (O'Callaghan & Lambert, 2024; Whitlock et al., 2025). In the event of unexpected death, workers compared their decision-making to the procedural expectations of their workplace and questioned their professional competence. This led to further feelings of self-blame, as workers internalized feelings of responsibility for the death of their client, and concern that they had not followed protocol (O'Callaghan & Lambert, 2024).

Participants in three studies also spoke of needing to suppress their feelings when exposed to sudden death to meet the demands of their workplace, as addressing these feelings may complicate their ability to conduct their work in the aftermath of exposure to premature death (Lakeman, 2011; O'Callaghan & Lambert, 2024). The nature of working with those experiencing homelessness within organizations that are often impacted by limited resources, particularly in terms of staffing and funding, may lead workers to "*prioritise their work and create a silent, unprocessed, and unrecognised grief that, as professionals, is their own burden to bear*" (O'Callaghan & Lambert, 2024). Some participants believed "pushing back" their emotions to be an important way of coping with the ability to compartmentalize complex emotions allowing participants to maintain stability and therefore, continue their roles without disruption (Valoroso & Stedmon, 2020):

> In order to carry on with necessary work, and perhaps also to prevent one from being overwhelmed with emotion, several people spoke of putting their emotions, ambiguous or disturbing images, or thoughts and memories 'in boxes' or 'pushing them back'. (Lakeman, 2011)

#### Grief as being complicated by stigma

Workers acknowledged their feelings of grief and bereavement when faced with working in an environment where unexpected deaths are common (O'Callaghan & Lambert, 2024). The cumulative weight of repeatedly witnessing ongoing, potentially preventable, decline in clients' health was challenging (Whitlock et al., 2025). This form of grief differed from traditional experiences of loss, with some workers describing it as "disenfranchised" (Valoroso & Stedmon, 2020) or "complicated" (Whitlock et al., 2025) due to the ways in which it can be experienced in their professional roles. Workers' grief was strongly impacted by the stigma associated with the client group with those experiencing homelessness and related challenges, such as substance use, being highly stigmatized and this extends to when they die. Frustration was also expressed at societal narratives that frame substance use as a matter of personal choice rather than due to structural inequality or trauma, thereby diminishing the value of these lives and their deaths:

> … such losses are loaded with social and moral stigmas, as well as intense feelings of frustration, guilt, anger, shame, helplessness and questions about whether those in the community could have done more (Shepard, 2013)

For some workers, there was little emotional response to death, whereas others felt overwhelmed (Lakeman, 2011). The stigma associated with those experiencing homelessness and related challenges impacted the way in which workers processed the death and experienced grief. Often grief was not fully felt or processed, and would often become internalized and "*had to remain beneath the surface*" (O'Callaghan & Lambert, 2024). This was seen as invalidating workers' experiences and was exacerbated by a lack of wider recognition of grief, such as within the workplace, when faced with the unexpected death of a client. The situations surrounding these deaths impacted how socially acceptable it was to grieve these individuals:

> It's not the most straightforward thing. It's not like the sudden death of a 60-year-old that dies of a heart attack either. Like, when you're trying to explain to somebody else, you have the whole stigma around drug use. (O'Callaghan & Lambert, 2024)

Related to this, workers described uncertainties as to whether they would be welcome at clients' funerals due to shame or perceived impropriety. In some cases, funeral details were deliberately withheld or altered by families to conceal the deceased's substance use (O'Callaghan & Lambert, 2024). The pressure to maintain a front of professionalism often discouraged help-seeking and contributed to self-stigma for individuals working in these contexts (O'Callaghan & Lambert, 2024). Studies called for a shift toward relational and trauma-informed care frameworks that normalize grief and shift stigmatizing perceptions to help validate the emotional impact of client loss (Lakeman, 2011; Mamdani et al., 2021 O'Callaghan & Lambert, 2024; Valoroso & Stedmon, 2020 ). Recognizing this grief, both within services and across wider society, was described as essential to fostering dignity, compassion, and long-term sustainability in frontline roles (Valoroso & Stedmon, 2020).

### *Stress and burnout*

Across five studies, participants discussed the daily stressors they faced, and described their day-to-day encounters with potentially traumatic experiences, such as violence and sudden death (Lakeman, 2011; Mamdani et al., 2021; Shepard, 2013; Valoroso & Stedmon, 2020; Whitlock et al., 2025). This expectation to live through loss contributed to long-term emotional stress (Mamdani et al., 2021). The process of dealing with potential and confirmed death, including finding a body, attempting lifesaving care through cardiopulmonary resuscitation (CPR), contacting emergency services, and moving a body, was particularly stressful for workers (Valoroso & Stedmon, 2020). Participants highlighted the visceral and traumatic nature of these encounters, with particular emphasis on overwhelming sensory details. These experiences were described as traumatic, and participants believed the memories would be difficult to forget and could result in unpleasant flashbacks when they had to repeat these tasks, such as room checks, in the future (Lakeman, 2011; Valoroso & Stedmon, 2020):

> Maybe it was about a week and a half (later), I had my first panic attack … I would be physically sick every morning knowing that I had to go and knock on people's doors, because as soon as I went to open that door all I could see, hear, and smell was that day. (Valoroso & Stedmon, 2020)

Participants also described feeling unprepared when encountering client death, particularly in cases where they discovered the deceased themselves. This unanticipated exposure has lasting emotional consequences, particularly without psychological or situational readiness (Whitlock et al., 2025). In some cases, the unpreparedness was amplified by a mismatch between the client's recent health status and the suddenness of their death. These instances challenged workers' assumptions and highlighted the unpredictable nature of death in homelessness services (Lakeman, 2011):

> People noted that opiate overdoes often occurred when people seemed to be doing well and perhaps has been abstinent for some time. (Lakeman, 2011)

Repeated experiences of stress and exposure to trauma, such as sudden deaths often resulted in workers experiencing burnout, which had a negative experience on their health and wellbeing and their productivity (Lakeman, 2011; Mamdani et al., 2021 O'Callaghan & Lambert, 2024; Valoroso & Stedmon, 2020;; Whitlock et al., 2025). As one peer worker in Mamdani et al.'s (2021) study, notes "*I am running myself ragged. The burnout."* Similarly, Lakeman (2011) highlights that the death of clients can lead to burnout as workers may question their professional confidence and effectiveness, with Valoroso and Stedmon (2020) noting feelings of powerlessness. There was a view that dealing with death was not a part of the job that they had signed up for:

> Staff in hostels come to work with people to ultimately get them to live independently. They don't come in … to find dead bodies, deal with dead bodies. (Valoroso & Stedmon, 2020)

Without adequate debriefing, supervision, and trauma-informed policies, workers are left to manage their responses to traumatic situations in isolation, impacting their long-term wellbeing and increasing emotional burden (Mamdani et al., 2021; Shepard, 2013; Whitlock et al., 2025).

### *The impact of professional role identity on dealing with death*

Participants across five of the included studies faced an internal conflict while working in homelessness settings where sudden death is apparent and emotionally charged (Carroll et al., 2012; Carroll et al., 2012; Lakeman, 2011; O'Callaghan & Lambert, 2024; Shepard, 2013). While the demands of the role often require emotional distance from clients to ensure continued functionality, this distancing does not fully shield workers from the impact of client loss. Many expressed that despite professional roles, meaningful connections were developed with clients, making their death emotionally taxing (Valoroso & Stedmon, 2020). Several of the studies described workers forming strong relationships with their clients, often extending beyond conventional professional boundaries. Peer workers particularly felt the weight of these losses, given their shared lived experiences (Mamdani et al., 2021). Clients were often also friends or "*chosen family*," blurring the lines further:

> … unlike most other first responders, peer workers have a unique understanding of the lives of PWUD [people who use drugs] and can relate deeply to stories of trauma, which can amplify the stress they feel. In this same vein, peer workers are not supporting mere clients but often clients who are friends and family members. Losing a client, therefore, is so much more difficult. (Mamdani et al., 2021)

While rooted in empathy and therapeutic intent, bonds were often shaped by sustained contact, shared experiences of adversity, and a genuine understanding of the client's life story (Mamdani et al., 2021 O'Callaghan & Lambert, 2024;), as described by Whitlock et al. (2025):

> Several authors discuss how personal and professional roles can become entangled in these environments: Inner city workers described how they often become "de facto" … family as they are "often the most consistent and reliable people in their clients' lives". (Whitlock et al., 2025)

In relation to their role identity, workers felt unable to address the wider societal risks that impact their clients' health and wellbeing. Structural inequality appeared to affect the type of death an individual has, potentially leading to more traumatic experiences:

> The homeless sector workers (even those with conventional professional identities) are also to a large extent invisible and are relatively powerless to address or control the circumstances that lead people to be at risk of death. The homeless sector worker must sometimes confront the death of the service user that is coloured by violence, gross injustice, and death with little dignity in which the worst fears of individuals are sometimes realized. (Lakeman, 2011)

Despite an awareness of the risks associated with homelessness, especially in terms of substance use, studies discussed that professional readiness did not protect workers from the emotional weight of a client death with whom they have strong relationships (O'Callaghan & Lambert, 2024). The resulting grief experienced is complex, shaped by the worker's knowledge of the client's history and the perceived loss of future potential (Lakeman, 2011). Rather than a clear separation between feeling and function, a more complex negotiation is faced by individuals working in these settings in that they must stay, to some degree, emotionally available enough to offer compassionate care, while distancing enough to handle repeated experiences of loss (O'Callaghan & Lambert, 2024).

## *2. What evidence-based interventions are effective in supporting these workers in managing client deaths?*

Interestingly, none of the studies included in the review described formal interventions for staff in dealing with death other than formal support from their employers. These may include interventions specifically developed to support staff impacted by client death including grief-specific training programs or specialized mental health workshops designed to help staff process client deaths. There were, however, several coping strategies employed by individuals, and these are described below in terms of setting boundaries; finding closure; reframing death; anticipating death; and formal and informal support.

### *Setting professional boundaries*

Setting professional boundaries was highlighted as a key approach to manage the emotional toll of working with individuals experiencing homelessness, particularly in the aftermath of client death (Lakeman, 2011;

O'Callaghan & Lambert, 2024). As mentioned previously, there can often be a lack of clear emotional and professional boundaries with clients, which complicates the grieving process (Whitlock et al., 2025). For many, drawing a line between their personal and professional lives was not only a matter of self-care but also a way to sustain long-term engagement with emotionally taxing work:

> Some more experienced workers spoke about maintaining clear boundaries in their working relationships and between their working and home lives. (Lakeman, 2011)

Lakeman (2011) focused on the importance of framing relationships with service users as professional rather than personal. This practice of "boundary demarcation" helped workers cope with death by maintaining a clear emotional stance, balancing compassion with the protection of their own wellbeing (Whitlock et al., 2025). Emotional restraint was described as a necessary strategy, not due to lack of care, but due to the emotional demands of the role:

> If every time something happens you allow yourself to feel the full force of the emotional impact … you would probably be quite unwell. (O'Callaghan & Lambert, 2024)

Workers said that when they viewed their connection to the deceased through a professional lens it helped serve as a mental health buffer, allowing staff to stay compassionate without being emotionally overwhelmed. Additionally, participants described more deliberate emotional distancing as a protective strategy. Avoiding emotionally triggering details helped contain distress, with participants maintaining "*emotional distance and professional boundaries*" to protect themselves (Valoroso & Stedmon, 2020):

> I didn't see her face … I think if I'd have seen her face it would have been completely different. (Valoroso & Stedmon, 2020)

### *Finding closure*

Lakeman (2011) highlighted that for professionals working to support people experiencing homelessness, finding closure following a client's death can be a complicated process. Participants explained how the sudden and often traumatic nature of these deaths, especially in cases of overdose, suicide, or homicide, left a lingering sense of ambiguity and unresolved emotion, especially when the cause of death remains unclear (Lakeman, 2011; Valoroso & Stedmon, 2020). Healthcare professionals in O'Callaghan and Lambert's (2024) study reported that professional obligations such as completing documentation and adhering to policy frameworks offered participants a structure through which to maintain composure and help to move forward (O'Callaghan & Lambert, 2024):

> The policy did provide me with support, I suppose it gave me a practical lens because from an emotional standpoint I was really angry … The policy was a good way to keep my rational mind. (O'Callaghan & Lambert, 2024)

Attending funerals was also seen as a route to closure, however, as discussed previously, were not always accessible or welcoming spaces for workers (Lakeman, 2011; O'Callaghan & Lambert, 2024; Valoroso & Stedmon, 2020). These tensions made the act of finding closure more emotionally complex, sometimes adding guilt or fear of overstepping to an already difficult grieving process. Even when families' decisions were respected, there was a recognition that such exclusion could hinder workers' own emotional resolution. The absence of social or cultural ways to mourn clients can leave individuals grieving in isolation, often without formal support or communal recognition of their loss (Lakeman, 2011; Mamdani et al., 2021 O'Callaghan & Lambert, 2024;). Participants viewed finding closure not as a singular event but as a personal and often fragmented journey. Acts of remembrance and personal rituals formed part of how workers attempted to reconcile grief with the realities of their roles (O'Callaghan & Lambert, 2024; Shepard, 2013; Whitlock et al., 2025). They found that these symbolic, ritualistic, or practical acts of remembrance were a way in which workers coped with client death. Workers sought to mark a death in a way that felt respectful and appropriate. This was particularly relevant when institutional responses were seen as inadequate or when deaths were acknowledged only in a clinical manner:

> People were aggrieved if they perceived that death was not marked respectfully, for example, when the death of a service user is announced at a team meeting and immediately followed by discussion of more mundane matters. (Lakeman, 2011)

Individuals and teams often developed personal or collective strategies for memorialization. These ranged from lighting candles, quiet moments of reflection, and the creation of shrines, to organizing communal events like tree plantings or annual remembrance services:

> I remember walking downstairs one day and seeing that one of our case managers had made a shrine at his workstation in honour of those on his caseload who had died that year. It was an intricate collage of photos, poems, and memorabilia. (Shepard, 2013)

### *Reframing death in a positive light*

Another coping strategy for homelessness sector workers was the intentional reframing of service user deaths in a way that enabled emotional processing and continuity in their roles. This could include focussing on positive memories of the client, or any positive progress they were making. By making sense of death through a positive lens, workers could manage distress without becoming overwhelmed (Lakeman, 2011; Mamdani et al., 2021 O'Callaghan & Lambert, 2024;; Whitlock et al., 2025):

> A positive frame enables people to continue working in their roles or with vulnerable populations with enthusiasm, optimism, and compassion. Positively framing the death of a service user entails both a general way of viewing oneself in relation to service users generally and to the deceased person specifically. (Lakeman, 2011)

For some staff, this framing became a source of renewed purpose and motivation to continue working toward reduced risk and harm for their clients (Lakeman, 2011). In cases of traumatic or violent deaths, workers channeled their emotional responses into a deeper commitment to their work. Others managed the emotional toll by cognitively distancing themselves, often rationalising the deaths as inevitable or unpreventable (Valoroso & Stedmon, 2020). This helped reduce feelings of guilt or responsibility. Reframing deaths functioned as a flexible tool for preserving both emotional wellbeing and professional commitment in the face of recurring loss (O'Callaghan & Lambert, 2024; Valoroso & Stedmon, 2020):

> In the absence of closure, some attempted to reassure themselves that the death was unpreventable, perhaps defending themselves against self-blame. (Valoroso & Stedmon, 2020)

### *Anticipating death – expecting the unexpected*

Participants described an awareness of the heightened mortality risks amongst the populations they serve (Lakeman, 2011; Mamdani et al., 2021). This knowledge often led to a form of anticipatory processing, with some workers entering clients' rooms braced for the worst. This included visualising possible traumatic scenes before they unfolded:

> I like expect to see someone hanging … I'm just thinking about all the things that could go wrong and all the gruesome things I could find. (Valoroso & Stedmon, 2020)

This mental preparation may be used as a protective strategy to help workers plan for potential trauma experiences, but it does not necessarily always translate into emotional protection (Lakeman, 2011; Valoroso & Stedmon, 2020). Repeated exposure to sudden death could lead to a heightened sense of expectancy and emotional burnout. Some participants framed death as "part of the job" (O'Callaghan & Lambert, 2024; Shepard, 2013), yet this rationalization often masked deeper distress:

> Contending with sudden loss against a backdrop of anticipatory grief inhibited efforts to make sense of the loss, and participants explicated that the traumatic shock from such events is profound. (O'Callaghan & Lambert, 2024)

Without appropriate processing or organizational support, anticipatory grief and the shock of unanticipated losses can combine into workers doubting their own professional conduct (O'Callaghan & Lambert, 2024). The paradox of knowing death is likely yet never being fully prepared underscores a complex occupational stressor for those working in high-risk frontline roles (O'Callaghan & Lambert, 2024; Valoroso & Stedmon, 2020).

### *Formal and informal sources of support*

Across five of the included studies, there was acknowledgement of the importance of structures within the workplace to support workers to process their emotions when exposed to trauma and sudden death

(Lakeman, 2011; Mamdani et al., 2021; O'Callaghan & Lambert, 2024; Valoroso & Stedmon, 2020; Whitlock et al., 2025). Lack of access to these support structures can result in "*bereavement overload, physical and mental health consequences, and complicated grief reactions*" (Whitlock et al., 2025). As Mamdani et al. (2021) explain, in the case of peer workers, they are often not given the opportunity to take time for reflection and access support:

> Unlike other professionals, their work is a 24-h job. Peer Workers often do not get to unwind after a stressful day because they are constantly working to support community members in need, even outside the work environment. (Mamdani et al., 2021)

Incorporating resources that provide workers the space to process their experiences when exposed to death can reduce the risk of negative emotional impacts, such as burnout and compassion fatigue.

Some workers described their hesitance to engage with internal, formal support in the aftermath of the discovery of a body, as they were concerned with being perceived as unable to do their job (Lakeman, 2011; Mamdani et al., 2021). Instead, workers expressed preference for support from external resources, such as personally funded therapy sessions, to ensure privacy and confidentiality. Those who did engage with external, formal support spoke positively about their experience:

> Most respondents had refused the offer of formal debriefing or counselling, at least initially, and worried that they might be perceived as "weak" or "unprofessional" if they immediately availed. Those who had experienced formal debriefing, personal counselling, or supervision from someone not in a line-management position reported it as being immensely valuable to express and process ambiguous, irrational, and painful thoughts and feelings about the deceased person. (Lakeman, 2011)

While formal support within their organization was deemed beneficial, participants in some studies expressed frustration around the difficulties in accessing this support when it was required (Valoroso & Stedmon, 2020; Whitlock et al., 2025). In most circumstances, participants felt that the responsibility to seek support lay with workers. However, they believed that support should be automatically offered to staff in a timely manner with enough time and space for workers to process their emotions (O'Callaghan & Lambert, 2024; Valoroso & Stedmon, 2020; Whitlock et al., 2025).

As well as the provision of formal support like counseling, studies described the importance of organizations acknowledging the experiences of workers who provide care to those at risk of sudden death (Lakeman, 2011; O'Callaghan & Lambert, 2024; Valoroso & Stedmon, 2020; Whitlock et al., 2025). Explicit recognition of staff and their continued work to improve the lives of their clients was highlighted as essential to ensure worker wellbeing:

> Working within organisational cultures that do not acknowledge or support emotional expressions of grief or recognise the importance of rituals and informal and formal supports to help social and community service workers cope with ongoing loss run the risk of high worker turnover and instances of emotional build up that are not only unhealthy for workers but for organisations as well. (32; p.10)

Informal support was also recognized as a valuable resource in the aftermath of experiencing client death. Participants described examples of informal support from colleagues and other staff within their organizations, including sitting with a cup of tea or going outside for some air (Valoroso & Stedmon, 2020). These activities ensure those impacted by premature death can discuss thoughts and feelings, without pressure to participate in time-consuming, formal support, such as counseling (Lakeman, 2011).

## Discussion

This paper presents the findings of a systematic review and narrative synthesis exploring the impact of premature death of clients on homelessness workers. Additionally, this paper considered whether appropriate support interventions exist for those exposed to premature death in these settings. The findings of six studies were synthesized and reported against the two main research questions. Workers reported a variety of impacts from their frequent exposure to sudden death. This included psychological responses such as questioning their professional decisions, instances of self-blame, and suppressing their own emotions. Grief was also complicated by stigma, felt both toward themselves as workers in the homelessness field, as well as wider societal stigmatizations experienced by those they support. This stigma can make it hard

for workers to move through the grieving process. Workers also experienced high levels of stress and burnout, heightened by the frequent exposure to death and lack of preparedness for discovering dead bodies. This could have long-lasting effects, with workers experiencing anticipatory grief and further emotional and psychological challenges. Additionally, workers' own role identity impacted their experiences, with some finding it difficult to balance providing compassionate care while maintaining boundaries to protect their own personal wellbeing. While none of the included studies provided evidence of specific interventions, across the six studies a range of coping strategies were identified, in terms of setting professional boundaries; finding closure; reframing death in a positive light; anticipating death; and formal and informal sources of support.

Included studies highlighted that those working with people experiencing homelessness experienced complex psychological reactions including self-blame, guilt, and questioning of their professional competence following sudden client deaths (O'Callaghan & Lambert, 2024; Whitlock et al., 2025). While these reactions parallel those of emergency responders (Lyra et al., 2025; Park et al., 2025), the homelessness context is unique due to the relational nature of the work. Unlike some first responders who may only interact with a patient once, homelessness workers often support the same individuals over extended periods. When a death occurs, therefore, it can lead to feelings of personal loss. Workers internalized responsibility, often suppressing emotions to continue functioning within resource-limited and high-demand environments, resulting in unprocessed and silent grief (Lakeman, 2011; O'Callaghan & Lambert, 2024). Without adequate recognition and support, these unaddressed psychological responses can accumulate over time, increasing risk of burnout, emotional exhaustion, and impaired wellbeing among homelessness workers. This may be particularly relevant for staff who are new to their roles, and given the high staff turnover in these settings, more research is needed to understand how this effects the development of emotional resilience.

Grief was complicated by the stigma associated with clients' marginalized identities. Workers reported frustration at societal narratives framing substance use as personal choice, which diminished the value of clients' lives and deaths (Shepard, 2013; Valoroso & Stedmon, 2020; Whitlock et al., 2025). This stigma impacted how grief was socially recognized, with workers feeling unable to openly mourn and facing barriers such as exclusion from funerals (O'Callaghan & Lambert, 2024). Stigma often complicates grief, amplifying feelings of guilt and isolation. This creates occurrences of disenfranchised grief whereby because society often views the lives of people experiencing homelessness as less valuable, the worker's grief can go socially unacknowledged. Complicated grief in the aftermath of premature death has been documented among caregivers in other marginalized contexts (Pitman et al., 2016; Williams, 2025), however, the layer of stigma experienced by frontline workers in homelessness services can create a barrier to help-seeking that may be more pronounced than in other healthcare and social support environments. The studies included in this review call for relational approaches to normalize grief and reduce stigma, reflecting wider recommendations in trauma and grief care literature (Phillips et al., 2025).

Workers described experiencing stress, burnout, and emotional exhaustion because of the repeated exposure to violence, trauma and death, particularly when deaths were unexpected (Mamdani et al., 2021; Valoroso & Stedmon, 2020 ). Additionally, workers struggled with maintaining professional identities while forming meaningful bonds with clients. Participants described the importance of connecting with their clients to achieve wellbeing outcomes, but this connection emphasized feelings of distress when faced with a client death (Mamdani et al., 2021; O'Callaghan & Lambert, 2024 ). This internal conflict is consistent with literature on moral injury and boundary challenges in caring roles (Doel et al., 2010; Funk et al., 2017). Funding cuts across the homelessness sector and loss of complementary services means there is a lack of systemic support for workers intensifying feelings of responsibility and further contributing to stress and burnout.

Despite the clear emotional toll on those working with people experiencing homelessness, access to formal mental health support was limited. Stigma and professional identity were acknowledged as aspects of working with these individuals that can act as barriers to help-seeking for workers in the face of death (O'Callaghan & Lambert, 2024). In response, workers relied on the coping strategies of maintaining professional boundaries, finding closure, reframing death in a positive light, as well as anticipating death. Informal peer support was identified as a vital coping resource in most of the studies, providing shared understanding and validation (Lakeman, 2011; O'Callaghan & Lambert, 2024; Shepard, 2013; Valoroso & Stedmon, 2020; Whitlock et al., 2025). Similarly, wider evidence advocates for the implementation of peer-involved organizational

strategies to enhance wellbeing and reduce burnout amongst frontline, often trauma exposed, roles (Billings et al., 2021; Carbone et al., 2022; Collins, 2008). To address the lack of formal support, organizations must move toward interventions that recognize managing the death of clients as an occupational reality in frontline homelessness settings. Services should implement structured support sessions and allow space for remembrance of clients. This can help workers transition from acute crisis management to healthy processing of loss. Addressing these challenges requires systemic change that validates grief, strengthens trauma-informed practices, and fosters sustainable care environments for the homelessness workforce. It is important to note that the included studies focused on accommodation-based services such as shelters and hostels. Future research should examine the experiences of street-based outreach workers who may also face exposure to sudden death which may result in differing impacts. Future studies should additionally examine the key factors that may be effective in reducing the distress experienced by frontline workers in homelessness services, which could lead to the development of evidence-based interventions.

### *Strengths and limitations*

This systematic review and narrative synthesis has provided insight into the experiences of those working with people experiencing homelessness when faced with sudden client death. The review was conducted in a rigorous manner, with all authors involved at each stage of the process and provides insight from a range of countries and settings. The findings of this review, however, are based on the views of participants in the included studies and therefore, represent a small sample of those working in frontline homelessness roles. As such, the topic would benefit from further research to consider if findings are applicable across contexts, particularly in terms of effective coping strategies. The quality of the included studies, assessed using CASP, was mostly high, and the one study with the lower score did not contain sufficient detail regarding the quality appraisal components. The searches for study inclusion were undertaken between February and March 2025 meaning newer studies have been published after this time (see Camp et al., 2025). However, we have not identified any studies that would alter the findings of this review thus far.

## Conclusion

This review aimed to explore the experiences and impacts of frequent exposure to sudden client death among frontline workers in homelessness services and whether evidence-based interventions are effective in supporting these workers. The findings reveal that repeated exposure to client death has a significant psychological and emotional impact on workers, manifesting in self-blame, guilt, burnout, and complicated grief. This grief is intensified by societal stigma surrounding homelessness and substance use. These experiences are formed by tensions between professional roles and personal attachments as well as a lack of formal support and cultural barriers to help-seeking.

The review found a notable gap in evidence-based interventions specifically designed for the homelessness workforce coping with death. Instead, workers reported employing a range of informal coping strategies to navigate grief. These strategies reflect the adaptive response of workers operating in resource-limited environments; however, should not be viewed as a substitute for structured, trauma-informed organizational support.

These findings point to a need for the development and evaluation of targeted interventions that acknowledge the unique grief experiences of homelessness workers. Addressing this gap requires systemic changes that validate grief, reduce stigma, and create sustainable, evidence-informed practices to support frontline staff routinely exposed to death.

## Author contributions

JG and HC developed the search strategy for the review, with JG and MT performing database searches, data extraction, and data analysis, while HC acted as a second reviewer for data inclusion. All authors contributed to the drafting of the manuscript, contributing to the interpretation of the findings and the final version of this manuscript.

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No potential conflict of interest was reported by the author(s).

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## Data availability statement

This study was a review of existing data, which is openly available at locations cited in the reference section. No new data were created or analyzed in this study.

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