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Work-related grief and bereavement experiences of social and community service workers working with people experiencing social disadvantage: a rapid scoping review

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Abstract

Background While an extensive body of research in palliative care exists on the experiences of grief and bereavement among family caregivers, much of this research is based on normative assumptions of who family caregivers are – housed, financially stable, and with extended family and/or friends to draw on for support. Research shows that in contexts of social disadvantage(e.g., homelessness and poverty, mental health and substance use concerns, racism and discrimination), social and community workers can become 'defacto' family and provide caregiving support at the end of life. Yet, there is little known about the grief and bereavement experiences of this worker group.

Methods This study aimed to review the available literature on the experiences of grief and bereavement among workers working with people experiencing social disadvantage. A rapid scoping review was conducted following the JBI scoping review methodology. Six sources (Medline, CINAHL, APA PsycInfo, Web of Science Core Collection, Sociological Abstracts, and Social Work Abstracts) were searched to identify relevant articles published until June 30th, 2023. From the systematic search and screening process, 9 studies met the eligibility criteria and were selected for the analysis.

Results Nine studies were included in this review that employed various qualitative approaches. Three main themes emerged from the narrative synthesis and thematic analysis: (1) Working in contexts of inequities, (2) Distress and its attributing factors, (3) Support needs and strategies.

Conclusions Caring for socially disadvantaged individuals poses unique challenges, compounded by repeated loss, premature deaths, and societal stigma. Social and community service workers lack formal recognition for their pivotal palliative care role, necessitating organizational support, palliative education, and collective responses to address their unmet grief and bereavement needs. Further research is essential.

Keywords Grief, Bereavement, Social disadvantage, Social and community service workers

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Background

Within contemporary palliative care, bereavement has been conceptualized as the loss of someone important and is characterized by grief [1, 2]. Studies of grief and bereavement in palliative care are prominent, particularly focused on the bereavement experienced by family caregivers [3, 4]. Indeed, bereavement is considered to be one of the most stressful life events [5] with family caregivers particularly affected. Research has shown that physical, mental, social, and financial burdens can affect the grief and bereavement experiences of family caregivers [6, 7] leaving them socially isolated, physically exhausted, mentally drained, and financially depleted following the death of the person they are caring for [8, 9].

While an extensive body of research in palliative care exists on the experiences of grief and bereavement among family caregivers, much of this research is based on normative assumptions of who family caregivers are – housed, financially stable, and with extended family and/or friends to draw on for support [10]. Caregivers, however, are not all the same and recent research on caregiving in the context of inequities suggest there is great variability in how family caregivers and caregiving is conceived and enacted [10, 11]. In the context of providing care to people who are socially disadvantaged, for instance, caregiving sometimes occurs in contexts of housing instability, challenging relationships, poverty, substance use, and severe persistent mental illness [10]. In these situations of social disadvantage – defined here as people being “socially, culturally or financially disadvantaged compared to the majority of society” [12] (p.2) – much of caregiving work has been reported to be provided by housing and outreach workers who take on family like caregiving roles, and like many traditionally conceived family members, may not be recognized nor supported in these important roles [10]. Recent research has shown that compounding distress, grief and loss are everyday experiences for these de facto caregivers [10, 11, 13–15] especially amid a devastating drug overdose epidemic caused by the toxic drug supply in countries such as Canada and the United States [16–21].

Studies of harm reduction and housing workers show that caregiving in the context of inequities is stressful and traumatizing with lasting social and mental health effects [22]. The sheer volume of preventable overdose-related deaths, and deaths due to other unjust causes, have also been shown to exacerbate work-related burnout and compassion fatigue among workers who care for people experiencing social disadvantage [23]. A recent participatory community-based action research study found participants who held dual caregiving and worker roles reported compounding distress, grief, and multiple loss akin to emergency responders [13]. Yet, the impact on these social and community service workers who often perform family caregiver type work – such as medication management, helping with getting dressed, mobility assistance, and bathing and grooming – is equally profound but rarely considered within palliative care literature [10–13]. The overall aim of this rapid scoping review was to review the available literature on the experiences of grief and bereavement among social and community service workers working with people experiencing social disadvantage.

Methods

A rapid scoping review was undertaken to collect and synthesize current literature about the experience of grief and bereavement for workers who support people experiencing social disadvantage. The Interim Guidance on the conduct of Rapid Reviews [24] and the chapter on scoping reviews in the JBI Evidence Synthesis Manual [25] were used to guide this review. The review is reported following the PRISMA extension for Scoping Reviews (PRISMA-ScR) since the methods in this rapid review resemble a scoping review more closely than a systematic review. The specific question guiding this review was: What literature exists about the experiences of grief and bereavement in social and community service workers working with people experiencing social disadvantage?

The population of focus are workers who meet the job description of social and community workers (see below). The concept of interest is experiences of work-related grief and bereavement of these workers who work with adult populations who face social disadvantage (e.g., housing instability, poverty, mental health and substance use concerns, racism and discrimination, etc.). The objective was to identify literature that captures the intersection of work-related grief and bereavement experiences with the stated occupational and supported population criteria.

Inclusion /exclusion criteria

Definitions

The National Occupation Classification (NOC) 2021 Version 1.0 is a nationally accepted framework to organize categories of occupations in the Canadian labour market [26]. Due to the variety of job titles and roles implied by social support work, we used the NOC 2021 Version 1.0 42,201-Social and Community Service Workers unit group [27] to better capture the context and setting of work being done by the population in this review:

> *Social and community service workers administer and implement a variety of social assistance programs and community services, and assist clients to deal with personal and social problems. They are employed by social service and government agencies, mental health agencies, group homes, shelters, sub-*

Table 1 Eligibility criteria

	Inclusion Criteria	Exclusion criteria
Population	Paraprofessionals classified in the Statistics Canada National Occupational Classification NOC 42,201 - Social and community service workers Workers working with adults (excluded are the school boards, disability categories)	Workers who do NOT fit the definition of the Statistics Canada National Occupational Classification NOC 42,201 - Social and community service workers. Workers who work primarily with children
Concept	Explicit mention of grief or bereavement in work-related experiences.	Does not explicitly mention grief of bereavement, or mentions grief or bereavement but it is not experienced by the workers themselves within their work or due to their work
Publication characteristics	Published in English (either originally, or as an existing translation)	Publication in languages other than English

stance use centres, school boards, correctional facilities and other establishments [27].

Information sources and search strategy

Six scholarly sources were searched for this review. The names, platforms and dates of coverage are shown in Table 2 below.

A systematic search was designed by a librarian (ZP) trained in evidence synthesis methods, in collaboration with the review team. It comprised two search concepts: Grief/bereavement, and social and community service workers. An extensive scoping search was carried out and informed the design of the final search, which was first piloted in APA PsycInfo before being translated to the other databases. Each search strategy comprised subject headings (where available) and keywords searched in the title, abstract and author-keyword fields. The search terms were combined using operators to enhance the sensitivity of the search. The complete search strategies for all databases can be found in Appendix 1.

Forward and backward citation chaining was conducted for all included articles. Due to the rapid nature of the review, separate grey literature searching was not conducted. However, grey literature that was retrieved from the existing bibliographic databases was not excluded due to publication type. Conference articles or dissertations located through the systematic search that met the inclusion criteria and had sufficient detail were included.

Study selection

Study selection was done in two stages, with each stage being piloted among reviewers in order to ensure an initial inter-rater agreement level of >80%. Study screening was facilitated by Covidence software [28]. Two reviewers independently screened each record (containing the title and abstract) and discrepancies were resolved by discussion and consensus. A similar process was undertaken for full-text screening.

1380 initial records were screened independently by two reviewers (KW and CF). After title/abstract screening, 55 records remained for full-text retrieval. Two full-texts were not accessible, and therefore 53 articles were screened in duplicate (KW and CF). The inter-rater agreement level between the two reviewers for the title/abstract screening was 94% and for full-text screening was 95%. The final result of screening was the inclusion of 9 articles. The results of study selection can be seen in the PRISMA flow diagram below (Fig. 1).

Data extraction

Data extraction was conducted by two individuals (KW and CF) independently in accordance with Cochrane Rapid Reviews Methods Group (2020) guidance [24]. The included articles underwent comprehensive data

Table 2 List of scholarly sources searched

Database Name	Platform	Dates of coverage
APA PsycINFO	EBSCOhost	1800 – June 30, 2023
CINAHL	EBSCOhost	1981 – June 30, 2023
MEDLINE All	Ovid	1946 – June 30, 2023
Sociological Abstracts	ProQuest	1952 – June 30, 2023
Social Work Abstracts	EBSCOhost	1965 – June 30, 2023
Web of Science Core Collection including:	Web of Science	
o Arts & Humanities Citation Index		(1975 – June 30, 2023)
o Book Citation Index – Social Sciences & Humanities		(2005 – June 30, 2023)
o Book Citation Index - Sciences		(2005 – June 30, 2023)
o Emerging Sources Citation Index		(2017 – June 30, 2023)
o Conference Proceedings Citation Index – Social Sciences & Humanities		(1990 – June 30, 2023)
o Conference Proceedings Citation Index - Sciences		(1990 – June 30, 2023)
o Science Citation Index-EXPANDED		(1900 – June 30, 2023)
o Social Sciences Citation Index		(1900 – June 30, 2023)

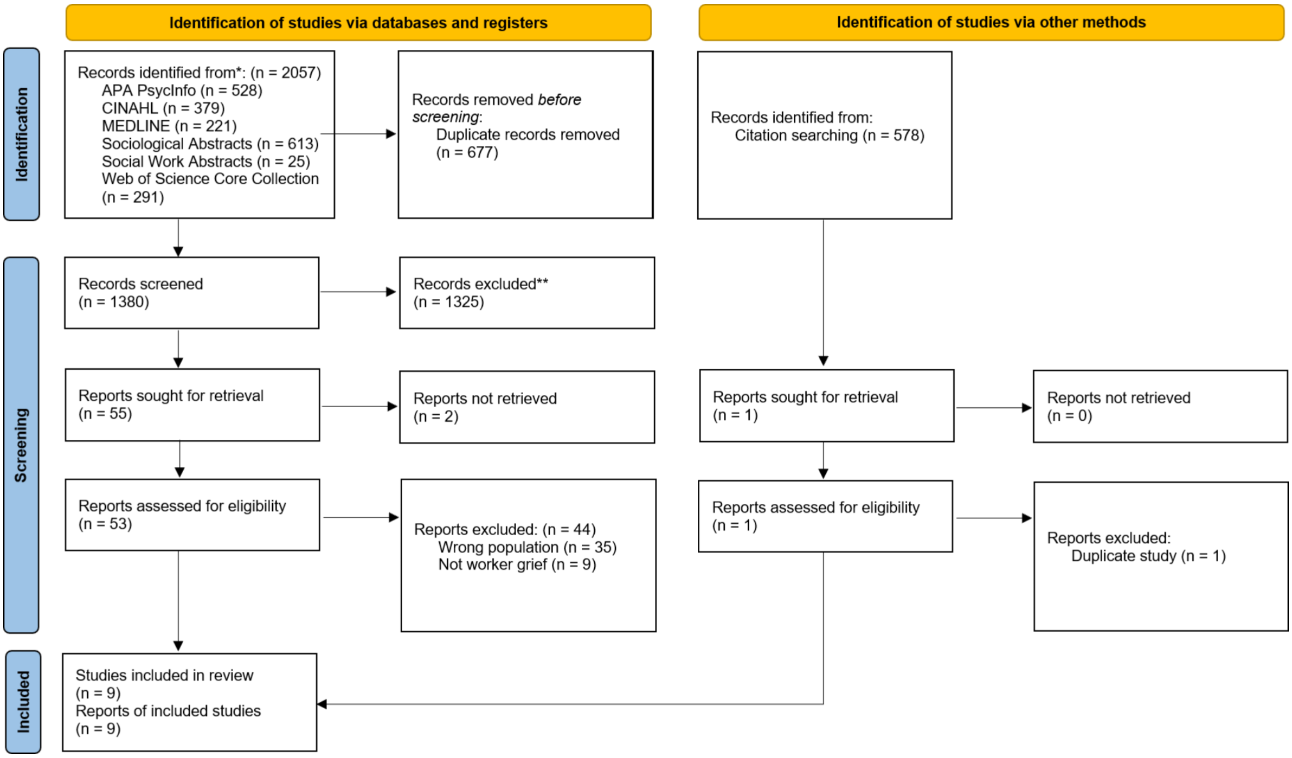

Fig. 1 PRISMA flow diagram

extraction, covering 17 categories including title, purpose, population, design, sample design, research context, main results among others. A sample data extraction form can be found in Appendix 2. The results of data extraction were compared, and discrepancies were resolved via discussion and consensus.

Analysis/synthesis

Narrative synthesis methods and thematic analysis was used to identify relevant topics in the included articles. Following general guidelines for narrative synthesis described by Pope et al., [29] analysis entailed reading the material several times, extracting and organizing verbatim quotes and text pertaining to grief and bereavement, and summarizing it in tabular form. A thematic framework was created by synthesizing and organizing this information into themes in accordance with the current review's research aims by comparing and contrasting similarities and differences across categories. To ensure the relevance and applicability of the final interpretive themes, the synthesis and analysis was conducted iteratively with frequent consultation among the co-authors.

Results

Characteristics of included studies

Nine studies were included in this review that employed various qualitative approaches. The studies took place in the United Kingdom ($n=1$), Northeast India ($n=1$), United States of America ($n=1$), Ireland ($n=2$), Canada ($n=3$), and Australia ($n=1$) between 2011 and 2022. The qualitative methods varied across studies and utilized a variety of methodological approaches: Four studies used ethnography and secondary analysis of critical ethnographic data; three studies were focus groups/group interview studies; one a literature review; and two studies each used storytelling and reflective narrative approaches. The central inclusion criteria for the literature in this review is the mention of work-related experiences of grief and/or bereavement. All included studies described worker grief and/or bereavement as work-related distress and broadly framed as emotional reactions to distress at work. Table 3 includes a summary of included studies.

The included studies were organized by three overarching themes relevant to the research aim of the current review: (1) working in contexts of inequities; (2) distress and its attributing factors; and (3) support needs and strategies. Each theme contained three sub-themes, outlined in Table 4.

Working in contexts of inequities

The population of focus in this review was paraprofessional, social and community service workers who are employed by non-profit organizations and government social service agencies to support people experiencing social disadvantages. Although the occupational titles,

Table 3 Characteristics of included studies

Study	Country	Population	Study design	Aim	Key Findings
Lakeman, 2011 [32]	Dublin, Ireland	Homeless sector workers who had experienced to the death of a service user (*n* = 16)	Qualitative Modified grounded theory, comparative analysis, theoretical sampling, interviews	Investigate workers' responses to service user deaths	Coping with death depends on how it's encountered, marking the death, and recognizing / responding to vulnerability
Roche et al., 2013 [33]	Australia	Indigenous AOD and general health workers (*n* = 121)	Qualitative Focus groups, thematic analysis, purposeful sampling	Explore Indigenous worker well-being, stress, burnout	Main stressors are excessive workload, proximity to communities, loss/grief, lack of recognition, inadequate rewards, stigma/racism, and Indigenous working ways.
Stajduhar et al., 2020 [10]	Victoria, B.C., Canada	Inner city workers (ICWs) (*n* = 16) and key informants (e.g., executive directors and managers in health and social services) (*n* = 15)	Qualitative Secondary thematic analysis of observational and interview data from larger critical ethnographic study	Explore ICWs' experiences in providing care to dying clients, integrating a palliative approach, and improve access	Palliative care in inner city often provided by ICWs. Key themes: approaches, awareness, training, workplace policies, grief, bereavement, and supports.
Kennedy et al., 2019 [20]	Vancouver, B.C., Canada	Peers working in Overdose Prevention Sites (OPS) (*n* = 72)	Qualitative 185 h observational fieldwork at OPS 72 in-depth qual interviews, thematic data analysis	Characterize peer involvement in OPS programming	OPS operations rely on peer involvement which improves engagement and promotes harm reduction. However, peers often face trauma, burnout, and grief.
Kanno & Giddings, 2017 [30]	United States	Mental health professionals and trauma workers, social workers	Qualitative Review of literature worldwide from (1974– 2015)	Review traumatic stress and discuss prevention strategies	Understanding traumatic stress nature is critical. Traumatic stress can significantly impair workers and should be addressed with prevention and remediation strategies.
Dutta et al., 2022 [34]	Northeast India	Miya community workers	Qualitative Storytelling, critical resilience praxis, decolonial theories	Name workers' resistance efforts, suggest implications for decolonial liberatory praxis, and critique "inclusion"	Identified reclaiming theory, moving beyond "inclusion", resisting commodification, and the centrality of community in resistance.
Watson, 2016 [35]	United Kingdom	Outreach/peer support worker in mental health and recovery setting (*n* = 1)	Qualitative Reflective narrative approach	Describe a day in the life of a peer support worker in an NHS trust to reflect on recovery-focused practices and peer support	Reflection related to boundaries, grieving, and the experience of endings within peer support.
Giesbrecht et al., 2023 [13]	Canada	Community worker action team (*n* = 18); Palliative care, social care, and housing support workers (*n* = 48)	Qualitative Community-based participatory action research, Focus groups (*n* = 5) evaluative interviews (*n* = 13), observational field notes (*n* = 34)	Explore workers' experiences of grief, identify support strategies	Identified workers grieving as "de-facto" family, complex layers of compounded grief, fear of confronting grief.
Tobin et al., 2020 [31]	Ireland	Traveller community health workers (*n* = 10)	Qualitative 3 semi structured group interviews, Interpretative phenomenological analysis (IPA).	Explore grief experiences in Traveller community	Identified extensive, profound, and enduring loss; difficulties in coping with suicide deaths; silence and strategies for managing tragic deaths disclosure.

roles, and responsibilities differed across the worker groups and sectors, two sub-themes related to work-related distress were found: (1) workplace environments and role ambiguity; and (2) client context and inequity.

Workplace environments and role ambiguity

The included studies describe experiences of distress among those providing services to people who "fall through the cracks of fractured housing, health, and social care systems" [10] (p.673) in various (predominantly urban) settings in the UK, India, Canada, Ireland, and Australia. Workers encompassed a range of job descriptions including mental health peer support workers, Indigenous alcohol and other drug (AOD) workers, overdose prevention service (OPS) peer workers, trauma and mental health workers, inner city workers (ICWs), traveller community health workers, front-line workers in the homeless sector, and Miya community workers.

Table 4 Summary of interpreted themes and sub-themes

Overarching themes	Sub-themes
Working in contexts of inequities	Workplace environments and role ambiguity Caring for clients in contexts of disadvantage
Distress and its attributing factors	Psychological responses and negative emotions Bearing witness to injustice and service delivery failures Compounding and complicated grief
Support needs and strategies	Self-care, boundaries and meaning making Working conditions, policies, and procedures Collective support

While the included research describes workplace environments that are generally consistent across sectors and cultures, there are strong variations in how worker distress is defined and contextualized. Several studies characterize distressing work environments through their proximity to service user trauma and to the psychological impacts of "assisting traumatized populations" [30] (p.333). Others cite the tension produced when workers in settings ostensibly designed to "improve access to care and reduce health inequities" [20] (p.65) witness the "poorer health status and lower life expectancy" [31] (p.131) that results from social or structural exclusion as the primary mechanism of worker distress. Workplace exposure to death is identified in the majority of included studies as an important contributor to worker distress, but several studies state that it is in fact the repeated encountering of sudden, unexpected, often preventable death—especially when it "takes place against a backdrop of expectation that harm may befall service users" [32] (p.931) that leads to worker distress.

The majority of included studies also note role ambiguity where the roles and responsibilities of work that has been previously restricted to health professionals [20] (p.64) is now often redistributed to peer and community support workers. These workers' distress stems from the fact that they are "less likely to share clear professional identities and role demarcations as people who work in hospitals or emergency services" [32] (p.926), yet they face more "risk and uncertainty" [32] (p.927) in low-threshold settings. Study participants describe their work as "a world of unmet needs, multiple losses, and persistent grief" [10] (p.674) characterized by low pay, heavy workloads, lack of formal recognition and support, extensive demands and expectations, stigma, racism, and a lack of culturally safe ways of working [33] (p.533). Studies that report role ambiguity among workers [10, 13, 20, 32–34] discuss how the need to fill gaps in chronically under-resourced work environments mean workers often take on multiple roles [34] and endure expansive workloads, yet typically receive little organizational support [10, 13, 20, 33]. However, not all characterizations of this ambiguity are entirely negative. Roche et al., highlight the tension "between holistic Indigenous ways of working and the need for 'boundary setting' in regard to individual workers' roles and 'being on call' for community/family members" [33] (p.533) as a source of both stress and support for workers. While imbued with tension, these positionings can allow workers to gain deeper understandings of the communities and individuals they serve [33] by placing the community itself over formal institutions or organizations in ethical considerations and accountability [34] (p.364).

Caring for clients in contexts of disadvantage

All the studies included in this review describe work that supports those who experience social and structural inequities. Service users are likely to live in poverty or socio-economic disadvantage [10, 13, 20, 31–34], are unhoused or precariously housed [10, 13, 20, 31–34], experience trauma and violence [10, 13, 20, 30–34], have mental health or substance use concerns [10, 13, 20, 30–35], have interactions with the criminal justice system [10, 13, 20, 33, 34], and experience racism [10, 13, 31, 33, 34], discrimination [10, 13, 20, 31–34], and cultural dislocation [10, 13, 20, 33, 34].

Several researchers articulate these disadvantages through identification and description of service user characteristics such as Lakeman's [32] statement: "Homeless people tend to have high rates of alcohol and drug dependence and associated problems, communicable diseases, psychiatric disorders, and exposure to violence and trauma" [32] (p.926). Others describe disadvantage and inequity as the product of structural or systemic factors [10, 13, 20, 33, 34]. For example, Dutta et al., state that "women at the margins of the nation state experience violence generated by structures, institutions, and histories that make their experiences irreducible to discrete categories (e.g., livelihood, health, domestic violence)" [34] (p.362).

Among the systemic disadvantages and inequities experienced by those who access support is the inequity of access to services. Stajduhar et al., identify that the population served in these settings – those experiences homelessness, poverty, racism, criminalization, and stigma – are more likely to experience barriers in accessing mainstream health care and the "disproportionate burden of ill-health and social suffering" [10] (p. 670). Many authors report that workers may also experience some of the same spaces of inequity as service users, compounding the effects of inequity in their own lives [10, 13, 20, 32–34]. This means, for example, that community support workers can often find themselves in "proximity to trauma whether it is embedded in the lives and stories of those they accompany, or their own inherited legacies of intergenerational trauma" [34] (p.360).

Distress and its attributing factors

All the studies in this review describe worker grief and/or bereavement as work-related distress. However, the authors' discussions of distress and its attributed factors varied significantly. Specifically, they attribute work-related distress as a result of: (1) psychological responses and negative emotions, (2) bearing witness to injustice and service delivery failures, and (3) the compounding of existing distress, grief, and loss.

Psychological responses and negative emotions

Describing work-related distress in terms of the psychological responses of individual workers is a common theme in the included studies, with the most mentioned outcome being disorders such as traumatic stress, vicarious trauma, burnout, post-traumatic stress disorder and compassion fatigue 10,30,31). However, the discussion of the mental health impacts of work varies from a brief mention to the study's entire focus.

In their review of 41 years of empirical evidence on the history and definitions of traumatic stress, Kanno and Giddings [30] highlight that mental health workers may experience traumatic stress as a result of their repeated exposure to traumatized clients. They define traumatic stress as the "occupational distress faced by helping professionals working with traumatized populations" (p. 333). One more recent study [10], while acknowledging the "connections between helping professions and issues, such as secondary traumatic stress, vicarious trauma, burnout, and compassion fatigue" [10] (p.673), largely locates distress in the context of the work such as organizational policies and systemic injustices.

Bearing witness to injustice and service delivery failures

A major aspect of how the included studies frame work-related distress is in workers "bearing witness to and caring for people who they perceive to be suffering or living with unmet health and social care needs" [10] (p.673) and of the "perception of government inaction" [10] (p.673). This is described as leading to workers further compromising boundaries around their employment: "many ICWs (inner city workers) explained how they saw their clients falling through the cracks of fractured housing, health, and social care systems, and as a result, felt morally compelled to 'fill the gaps'" [10] (p.673). And further, "Encountering death of a service user can in turn lead to a heightened sense of expectancy in the future, and if death is not worked through adequately or framed positively, a sense of futility may ensue" [32] (p.933).

Several studies note that this form of worker distress is particularly acute when service users die [10, 13, 20, 32, 33]. Lakeman describes the anger felt by workers when they perceived that formal services had failed the person who had died, such as "failing to provide shelter, not trying hard enough to engage with the person, or not marking the death in a respectful way" [32] (p.935). Giesbrecht et al., describe how study "participants shared multiple traumatic accounts of their dying clients and peers falling through the cracks of the systems, receiving little to no support, suffering until the moment of their death, to after death witnessing bodies and belongings being treated in undignified ways" [13] (p.564). Lakeman further reported that the emotional responses of workers were typically triggered by encountering an event that reminded them of the deceased or was particularly stressful, citing that workers sometimes carry hopes or aspirations for service users that are shattered when the service user dies [32].

Some authors note that significant worker distress is caused by the routine witnessing of preventable death, particularly among drug users dependent on toxic criminalized markets [10, 13, 20]. Workers discuss "how the grief and trauma they experienced as a result of routine exposure to overdose events and the significant loss to overdose death in the community contributed to burnout in regards to their role as peer workers" [20] (p.65). Tobin et al., also describes the "sense of fear that pervades communities in which multiple losses—and particularly deaths by suicide—can seem commonplace. The fear is felt in a constant watchfulness, particularly in the immediate aftermath of a tragic death, but also for extended periods of time" [31] (p.137).

The authors in our review did not all share the same perspective on the impact of bearing witness. Against a backdrop of systemic harm, bearing witness was noted to play a role in community resistance to colonial or carceral systems. Dutta et al., state: "We engage in radical and emancipatory ways of bearing witness, which do not replicate fraught gendered, raced, and classed asymmetries that perpetually position some people as onlookers while others are always gazed upon" [34] (p.357).

Compounding and complicated grief

Work-related distress can also serve to compound the effects of grief and loss felt in other areas of workers' lives and communities. Workers who serve populations with a high prevalence of premature and unexpected deaths and high levels of grief in the community [33] (p.530) may experience complicated grief, identified as "grief which prevents a person from accommodating to their bereavement and which does not lessen over time" [31] (p.133). Complicated grief can, in turn, create the potential for bereavement overload [31] (p.133). Tobin et al., explain that in these situations, "the first bereavement is compounded by subsequent ones and each loss cannot be fully mourned" [31] (p.133). These dynamics may also expose the lack of culturally safe work practices further compounding workers' distress. Roche et al., describe how, from an Indigenous perspective, loss and grief are interwoven with broader concepts like ancestral, intergenerational, suppressed, and unresolved grief [33]. These concepts are often misunderstood by mainstream peers who may treat grief as an individual and linear experience [33].

The distress workers experience from the intersections of personal, workplace, and community grief is further compounded by the social stigma and discrimination their service users face. "Grief is understood to be triggered by losses such as personal bonds, valued relationships, the nonrealization of professional goals, realization of one's own mortality, and the emergence of past unaddressed losses" [32] (p.943). Lakeman [32] states that the grief experiences of workers are influenced by the marginalized social position of the homeless individuals they work with, as well as their own status as workers in the sector. Giesbrecht et al., reinforce this point indicating that despite acting like family caregivers, workers face differential treatment from health, legal, and social systems that "had profound impacts on the grieving process" [13] (p. 563). Both "the nature of the death encounter as well as the worker's identification with the deceased impacts on the response to the death" [32] (p. 944). Grief was described as "intertwined with feelings of guilt" [13] (p. 564) as workers question if enough was done to alleviate "a lifetime of suffering" [13] (p. 564) for those nearing end of life.

These experiences also lead to distress within workers' living relationships: "How possible is it to [grieve] and at the same time give something of yourself to a relationship? I think is a lot to ask of a workforce to hold countless miniature grief cycles within us while continuing to create new relationships" [35] (p.20). Several authors [10, 13, 33] discuss how personal and professional roles can become entangled in these environments: Inner city workers described how they often become "de facto" [13] (p.563) family as they are "often the most consistent and reliable people in their clients' lives" [10] (p.673). And further how, "Dying and death is medically contained, and the worker is in a similar position to those who may work in palliative care or aged care. The emotional labour of caring for the person is or ideally should be acknowledged by colleagues through gestures of support" [32] (p.933).

Support needs and strategies

All the included studies discuss strategies for supporting workers in mitigating or improving their experience of work-related distress from complicated and compounding grief and bereavement. While these strategies vary considerably, they can be discussed in terms of three main sub-themes: (1) self-care, boundaries and meaning making; (2) working conditions, policies, and procedures; and (3) collective support.

Self-care, boundaries and meaning making

Several authors identify workers' practices of self-care and their ability to set and maintain positive boundaries around their work as important factors in alleviating distress. Making a "boundary demarcation" [32] (p.944) allows homeless sector workers to positively frame their relationship to the deceased as professional rather than personal, in pursuit of maintaining their own mental health [30]. Access to people and environments that allow workers to successfully reconcile the role of death in their lives and communities are important means of support that help workers to acknowledge the sometimes tragic and undignified ways in which their clients die while also preserving the hope that they can make a difference in the lives of those clients that remain [32] (p.946).

The reviewed studies also described the meaning that workers made of their experience of distress though this varied significantly. Tobin et al. [31], for example, described how the use of silence, or not talking about death, was a way to keep grief hidden from public view and mask a vulnerability associated with the work of caring for people experiencing inequities. Silence, in this sense, is viewed as having "protective value" [31] (p. 14), sparing people from the difficulty of talking about distressing circumstances while also protecting others from the potential harm that this knowledge might evoke. More broadly, Stajduhar et al., [10] note that distress is manifest in homeless service environments because organizations (e.g., housing, community support, substance use support) do not encourage discussions about death and dying. These organizations' service mandates may fail to acknowledge death, dying, grief, and loss as relevant to their work, and thus, do not recognize the value of a palliative approach to care as part of their core responsibilities within inner-city settings [10]. Studies [13, 35] also describe the emotional conflict produced by work that holds professional expectations of developing close client relationships yet expects workers to carry on as usual in the event of a client's death.

Working conditions, policies, and procedures

Within this body of literature, authors recommended a variety of solutions for improving workers' experience of distress. Providing adequate workplace supports through formal psychotherapy and counselling, supporting formalized mechanisms for peer support, and identifying strategies to mitigate risk factors associated with trauma-related stress were common recommendations [30] (p.340). Drawing on broad-based conceptualizations of harm reduction and recognizing the alignment between harm reduction and palliative care principles was found to provide workers with new understandings of death and dying in the context of inequities [10]. This approach had the potential to minimize bias and judgements within the health sector more broadly and allowed workers to recognize that death, from a variety of causes, including substance use, was something to be acknowledged and discussed [10].

The mitigation of worker distress through more equitable financial compensation, ongoing education and training related to palliative approaches to care, and mentorship and self-empowerment were also reported [10, 20, 30]. For example, acknowledging that social and community service workers are often much lower paid than their professional counterparts, Kennedy et al., [20] suggest that fair compensation could help to address concerns about workers' potential devaluation and exploitation, and support their sustained retention in the workforce. Supporting social and community service workers through education on a palliative approach to care was reported to have the potential to create work environments that explicitly valued palliative care work as a key feature of inner-city work with people who experience structural inequities [10]. Establishment of peer support groups or support systems to address the needs of traumatized employees was also reported as a potential strategy to mitigate and create proactive strategies to manage high levels of workplace-related distress [30].

Collective support

All the included studies demonstrate some awareness of the structural and systemic factors that lead to social and community service workers' grief and distress. This includes inequities and other forms of structural violence faced by both service users and providers. Authors of studies included in this review offered suggestions for decreasing distress highlighting varied conceptualizations of support needs, strategies, and goals. Several authors framed the goal of identifying and intervening in worker distress for keeping organizations operating and effective. These authors framed support for workers as necessary for organizations seeking to "enable people to keep working effectively in their work despite confronting trauma and death" [32] (p.941) to sustain their larger mandate of service delivery. Traumatic stress can negatively impact the job performance of trauma workers, leading to resignations and high turnover rates [30] (p.346). These perspectives tend to align with support strategies that respond to the emotional and psychological burden of care seeking to prevent and combat compassion fatigue, PTSD, and vicarious trauma.

Authors who make a direct link between social and structural inequities and work-related distress advocate for support approaches that view workers as embedded in the broader context of inequities where their work occurs [10, 13, 20, 34]. This perspective values the knowledge and roles that workers hold in their communities, asserting that workers deserve supports that allow them to remain healthy both inside and outside the workplace while caring for people who experience inequities across the life course, including the end of life [10, 13]. Some authors go further to emphasize the interconnectedness of care and community and the utility of grief as a critical aspect of care work for those who are *both* workers *and* community members. For example, Giesbrecht and colleagues [13] suggest that rather than "pathologizing grief as individual experiences reflective of poor professional boundaries it should be recognized and valued as a likely outcome from quality care provision" [13] (p. 565).

This latter perspective on grief and work is particularly pertinent to peer workers who may occupy dual roles as workers and peers/caregivers/community members. Kennedy et al., [20] highlight the unique knowledge of peer workers, especially in drug-related expertise, as vital for effective services for people who use drugs. This view supports the perspective that the specialized skills of workers who support people facing social disadvantage are vital to their success [33]. The valuing of peer worker knowledge as legitimate expertise can involve addressing the additional support needs for people who are part of the communities that they serve. Dutta and colleagues expand upon the concept of challenging discourses that perpetuate "colonial, state, and epistemic violence" [34] (p.356), obscuring "complex relationships, alliances, shared histories, and commitments" [34] (p.356). They argue that "damage-centered narratives" [34] (p.356) of community suffering and grief undermine their critical resistance to inclusion in structural violence and instead emphasize the importance of collective responsibility and shared consequences.

Discussion

The aim of this rapid scoping review was to determine what is known in the literature about the experiences of grief and bereavement among social and community service workers working with people experiencing social disadvantage. Using narrative synthesis methods and thematic analysis of retrieved literature, focusing on work-related experiences of grief and/or bereavement, we identified three overarching themes that characterize the grief and bereavement experiences of social and community service workers: (1) working in contexts of inequities; (2) distress and its attributing factors; and (3) support needs and strategies.

In the current review, our analysis suggests that grief and bereavement, and accompanying worker distress, are characterized by environments where workers commonly encounter repeated and often unjust preventable deaths and often bear witness to declining health in their clients in contexts of profound health and social inequity. Workplace exposure to death was identified as an important contributor to worker distress and, within the context of extensive work demands and the lack of recognition given to workers for the 'palliative care' work they do, further contribute to feeling undervalued and a perception that grief is to be silenced in the name of getting the job done. Such experiences may aptly be considered an example of disenfranchised grief, a phrase coined by Doka [36] to define those losses that are not openly acknowledged, socially mourned or publicly supported. Working within organizational cultures that do not acknowledge or support emotional expressions of grief or recognize 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 organizations as well [37, 38]. Dutta et al., [34] suggest that workers may also experience similar forms of inequity to their clients, putting them at further risk for trauma responses that are often unrecognized and unacknowledged within their work settings.

Social and community service workers in this review described work settings in which they are continually exposed to high levels of work-related distress. Premature and unexpected deaths of their clients coupled with preventable overdose deaths due to a toxic criminalized drug market within North America and other jurisdictions further exacerbates an already emotionally charged situation. The level of distress and grief expressed could be considered akin to those of first responders who have been found to have higher rates of mental health problems and are more likely to experience depression than the general population [39]. Depression and anxiety among ambulance personnel have been reported, with 27% experiencing psychological distress [40]. Frequent exposure to traumatic events has been shown to lead to high levels of post-traumatic stress disorder among firefighters [41]. Unlike first responders, however, social and community service workers are rarely provided with paid time off or supports. Instead, as this review demonstrates, high levels of grief in this community and the lack of supportive structures to facilitate moving through grief leave workers in a situation where bereavement overload, physical and mental health consequences, and complicated grief reactions are normalized as part of the everyday work.

Along with the aforementioned self-care strategies that can be helpful for some workers, broader organizational supports that recognize death and dying as integral aspects of work with people experiencing social disadvantage are vital for transcending the mere recognition of inequities. Acknowledging the significant roles that social and community workers play in providing palliative approaches to care not only places value on the work they do but also profoundly enhances their capacity to address the health and social needs of the community. This approach goes beyond identification of health and social inequities; it actively works towards meeting the tangible and material health, and social needs of individuals.

Finally, this review underscores the importance of access to people and environments that allow workers to reconcile the role of death in their lives and communities. However, for this support to be meaningful to those facing social and structural disadvantages, it is critical to acknowledge how the collective grief arising from ongoing structural inequities and violence as more than individualized experiences; it should also be understood as a result of quality, relational care. This could be an area where palliative care services can contribute by fostering a better understanding of grief and bereavement as a response to loss and part of the human experience, rather than solely as individual pathology.

Although all the articles in the review mentioned the impact of work on the grief experiences of workers, the varied conceptualization of what causes work-related distress in social and community service workers directly informed the available recommendations. This conceptual influence speaks to the importance of solutions that simultaneously locate the problem in broader systems and structures while recognizing the visceral impacts of this work on individuals. A multi-faceted approach such as this aligns with a palliative approach to care in the ability to promote holistic support systems, acknowledging the complex interplay between personal grief and the societal conditions that shape it. While it is essential that these strategies are adaptable, culturally safe(r), and responsive to the unique needs of social and community service workers who frequently navigate the compounded effects of socioeconomic and health disparities, it is important to realize that "community—and not institutions/organizations—is the center and the basis of ethics and accountability" [34] (p.364). Much like how a palliative approach to care reorients the priorities of end-of-life care to center the person and their community, it can also teach valuable insights for research and actions that prioritize and support the actual struggles of communities instead of merely studying them as subjects [34].

Implications for social policy and practice

This review highlights several implications for social policy in practice for both the homelessness sector and palliative care. While individualized responses to grief (e.g., self care strategies, counselling) can be important for some, our review highlights the importance of material and collective responses to grief in the homelessness sector such as paid time off and making space for collective grief (e.g., remembrance activities; memorials) inside and outside the workplace. For palliative care, there is a need to step outside of traditional responses to grief (i.e., one-to-one grief counselling primarily oriented towards family members and close friends) toward models that recognize and value the important caregiving role of unrelated and paid workers, and community members more broadly, that can support the enfranchisement of grief.

Limitations

This study has provided important insights into the work-related bereavement experiences of social and community service workers, but we acknowledge several limitations. First, we would like to highlight that even though we did some qualitative analysis from the included sources of evidence, as this was a rapid scoping review, no quality appraisal of each included source was conducted. Secondly, while we attempted to follow a robust methodological approach, guided by the JBI Scoping review methodology, it is possible that some studies may have been missed due to the choices we made in conducting this review as a rapid scoping review. However, we have reported our methods transparently; and our team benefited from the expertise of a highly experienced health sciences librarian, who provided informational retrieval and methodological support. Despite these limitations, this review is, to our knowledge, one of the first to explore in-depth the work of those supporting individuals experiencing social disadvantage through grief and bereavement. Social and community service workers are in a unique position to contribute to a palliative approach to care, yet there is very little evidence on what this work entails and how it is experienced.

Conclusions

Providing support and care for people who experience social disadvantage is challenging at the best of times, but in the contexts of repeated loss, premature death, ongoing stigmatization and discrimination of clients, and a lack of formal recognition that palliative approaches to care play a key role in work, social and community service workers are left to manage emotional impacts that are traditionally well supported within mainstream palliative care services. While further research is required to determine the full extent of the grief and bereavement experiences of these workers, results from this rapid scoping review suggest that support from organizations, education and training related to a palliative approach to care, as well as supporting collective responses to the grief experienced in these settings, may be a starting place to consider. As Dutta and colleagues argue, the extent to which worker's work-related distress and grief from caring for those who experience social disadvantage, "is meaningful only when relationally, politically, and ethically tethered to varied struggles for justice" [34] (p. 13).

Supplementary Information

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Supplementary Material 1

Supplementary Material 2

Author contributions
K.S. and K.W. conceived the study. Z.P. designed the systematic search and supervised K.W. in conducting the literature search and data collection. K.S., C.P., M.A-R., and Z.P. piloted each stage of the study selection process and resolved conflicts arising during the article screening, which was carried out by K.W. and C.F. K.W, A.M., K.S., and C.F. contributed to the data analysis, which was subsequently approved by all authors. K.W., A.M., Z.P., and K.S. drafted the initial manuscript, with M.A-R. and C.F. providing critical feedback and revisions. All authors reviewed and approved the final manuscript. K.S. secured funding and, together with Z.P., provided guidance and oversight throughout the research process.

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Data availability
The datasets used and/or analyzed during the current study, including the full search strings for the literature search, are available in the supplementary materials.

Declarations

Ethics approval and consent to participate
Not applicable.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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