

Pandemic Preparedness & Homelessness

International Lessons from COVID-19

Edited by

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INTRODUCTION

Pandemic Preparedness and Homelessness, International Lessons from COVID-19

Dr. Kristy Buccieri

In May 2023 the Director-General of the World Health Organization held a press conference on the state of COVID-19. After more than 3 years, he told the gathered crowd, *“It is with great hope that I declare COVID-19 over as a global health emergency,”* although it still remained a pressing global health threat (BNN Bloomberg, 2023, n.p.). In his statement to the press, Dr. Adhanom Ghebreyesus opined, *“COVID has changed our world and it has changed us.”* (BNN Bloomberg, 2023, n.p.). It is difficult to argue with this statement and yet as we write this introduction, less than 1 year after this announcement, we still have very little idea of just how true it could prove to be. The chapters included in this book all grapple with the one very specific yet large issue of how COVID-19 has shaped our experiences, understandings, and approaches to homelessness. We actively sought contributions from around the world, recognizing that homelessness is just as much a global health crisis as COVID-19, but without a hopeful declaration that an end is in sight.

This book has the unfortunate distinction of being the second in a series examining the effects of a pandemic outbreak within the context of homelessness. The first was written in the wake of the H1N1 outbreak, and detailed findings from a pan-Canadian study in the cities of Calgary, Regina, Toronto, and Victoria (Buccieri & Schiff, 2016). Having lived through recent past pandemics, such as SARS and H1N1, we would be justified in asking what lessons were learned and how (or in fact whether) the knowledge we gained was applied. How far have we come – as communities, nations, and a global society – in making the world a more equitable social, economic, legal, and political place? These are the questions we take up throughout this book, by considering the impacts of the pandemic on individuals experiencing homelessness, social service agencies working to provide supports, and beyond to cities, regions, and state-level responses to COVID-19.

Homelessness and COVID-19: Colliding Global Health Emergencies

In a special edition of the *International Journal on Homelessness*, Oudshoorn (2023) wrote, “*The pandemic hit at a time of high rates of housing exclusion globally. This is a call for us as a global community to do better in preventing and ending homelessness*” (pg.1). When we consider the public health messages we hear during a pandemic – to stay at home and to keep a safe distance from others – the need for housing affordability and inclusion becomes clearer than ever. Critical to this call is the need for a rights-based approach. Honig (2020) notes that in light of social, economic, and racial considerations, in addition to far-reaching police powers, we must think critically about what a right to housing means within a broader public context. The world witnessed the importance of this firsthand with the, often violent, removal and displacement

of people from tent encampments.

As Appleyard (2009) has noted, the ways in which emergencies play out are directly rooted in pre-existing social patterns established during non-emergency times. Indeed, the literature supports that those who were already marginalized, such as persons experiencing homelessness, fared even worse during the COVID-19 outbreak. For instance, a systemic review by Green et al., (2021) demonstrated that individuals from vulnerable groups, such as racialized individuals and persons with low incomes, had disproportionately higher COVID-19 mortality rates. Another study showed that people with recent experiences of homelessness in Ontario, Canada experienced disproportionately higher emergency room visits compared with those who were housed (Liu et al., 2022). It is often the reality that in pandemic outbreaks health needs overwhelm the existing systems and resources, prompting the need for difficult decisions about how, where and to whom resources should be allocated (Thompson et al., 2006). Accordingly, Kotalik (2005) argues, discussions about health care planning always contain a moral dimension that presupposes certain ethical values, principles, norms, interests, and preferences. The research supports this assertion, indicating that COVID-19 had the direst outcomes for the most marginalized amongst those experiencing homelessness. Included in these identified populations are Indigenous women and/or those escaping family violence (Parry et al., 2022), individuals with serious mental health disorders (Mejia-Lancheros et al., 2022), veterans (Cusack et al., 2022; Wynn et al., 2021), people living in remote communities (Schiff et al., 2020), and youth, particularly those who identified as Black, 2SLGBTQ+, and/or those new to Canada (Noble et al., 2022).

Beyond the direct impact COVID-19 had on people experiencing homelessness, the pandemic also strained the capacity of homelessness sectors to provide supports. Key challenges were the narrowly directed funding and lack of long-term solutions to homelessness (Roebuck et al., 2022). Secondary traumatic stress, burnout, and a general decline in well-being were significant impacts amongst frontline workers in one UK-based study (Schneider et al., 2022). Interviews with frontline homelessness service providers in Texas indicated that shifting to remote work and virtual service provision, the reduction in client engagement and rapport-building, creating / enforcing health policies, and the constant service disruptions were critical factors that made their work more difficult (Aykanian, 2023). Likewise, a Canadian study of frontline service providers found that the frequently changing job expectations, challenges working with clients, isolating conditions, the lack of organizational clarity were themes, along with positive support and communication, noted in interviews (Goodwin et al., 2022).

At a structural level, COVID-19 highlighted major deficiencies in state responses to homelessness and pandemic response (Skjefte et al., 2022). Some research suggests that in the time since previous outbreaks, such as SARS and H1N1, promising practices have emerged, but that the lack of personal protective equipment, staffing shortages, and communication challenges remain pervasive (Karabanow et al., 2021). In Germany, for instance, researchers studying 135 service institutions found that a lack of collaboration with health authorities during the pandemic resulted in increased costs for personal protective equipment, which most organizations had to pay for with their existing funds (Gräske et al., 2022). In response to systems pressures, some cities adopted quarantine hotels (Feldman & Pérez, 2020; Johnson et al., 2023; Parsell et al., 2022) and isolation shelters for people experiencing

homelessness who were recovering from COVID-19 (Moss et al., 2021). This approach demonstrated the necessity of secure housing as a determinant of health, with residents describing a sense of stability, protection from COVID-19 infection, and a sense of mental freedom to pursue future planning as benefits (Padgett et al., 2022).

Dawes et al., (2022) argue that policy makers and public health officials must learn from people experiencing homelessness to strategically inform future public health approaches. The editorial team of this book agrees wholeheartedly and have designed this book in a way that highlights recommendations within each chapter and within the sections as a whole. We begin with a focus on the impact of COVID-19 on subpopulations of persons experiencing homelessness, and transition with each section outwards from a micro to macro lens. We consider Dr. Adhanom Ghebreyesus' statement that COVID-19 has changed us and our world, with a particular focus on homelessness as a global human rights issue.

Organization of the Book

This book is designed to move readers through different lenses, from the micro- to the macro- levels with each section. We begin with an examination of how the COVID-19 pandemic impacted special populations who are particularly affected by homelessness, including women, seniors, people who use drugs, youth, and Indigenous youth. The second section of the book examines the impact of the pandemic on social service provision and models. This section includes chapters on traumatic stress in frontline staff, workers with lived experience of homelessness, peer partnership programming, efforts to deliver vaccines, and a transitional housing peer vaccine program. In the third section we move

outwards to focus on city, regional, and state level responses. This section includes chapters on the impact of COVID-19 on rural homelessness service operations, opportunities that can arise from crisis, pandemic planning related to homelessness, and results from a community-academic partnership. The final section of the book focuses on macro and global responses to the pandemic. Here we include chapters on social and geographic inequities, exploring 'we' and 'the others' dynamics, a graph analysis of the impacts on emergency housing shelter access patterns, and a pan-Canada study of COVID-19 in rural and remote regions. This book brings together chapters from a range of different locations, including Canada, the United States, Australia, Ireland, and Switzerland to examine pandemic preparedness, homelessness, and the international lessons we have collectively learned from COVID-19.

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SECTION ONE

Populations

Ashley Wilkinson

In so many ways, the COVID-19 pandemic exposed longstanding inequities within our society related to healthcare access, housing, and many more. The impacts of the pandemic were far from uniform, disproportionately affecting specific populations that already face complex challenges. In the first section of this book, we bring together a selection of chapters that examine the unique experiences of specific homeless populations in the context of COVID-19.

As previous research has demonstrated, women experiencing homelessness face unique challenges. Current data on homelessness suggests that women are under-represented in homeless enumerations, thus limiting our understanding of their experiences (Schwan et al., 2020). However, recent research has demonstrated that women navigate homelessness differently, being less likely to access mainstream homeless services due, in part, to fear of violence or previous experiences of violence within these spaces, and often relying on informal personal networks

for support (Schwan et al., 2020). This reflects a broader lack of women-specific supports, safe housing for women, and gaps in policy – particularly related to domestic violence (Schwan et al., 2020).

This section begins with a chapter from Atolagbe entitled *Women’s Homelessness amid the COVID-19 Pandemic: A Case Study of Prince George, BC*. This chapter provides a first-person research account of the challenges faced by women experiencing homelessness within the context of a shelter in northern British Columbia. The study emphasizes the need for effective public systems and supportive policies that address the structural factors contributing to women’s homelessness in Canada. In the chapter that follows entitled *Fast Fixes but Failed Fit: Shining a Light on Older Women’s Experiences of Sheltering Hotels during COVID-19* Cloutier and colleagues examine ways in which the homeless service sector could be tailored to meet the needs of older women, with a focus on safety, and well-being. They conclude with suggestions on how to address the unique needs of this group using person-centered, trauma-informed, and culturally safe approaches.

The next chapter in this section by Milliken and colleagues entitled, *Developing a Safer Drug Use Space During the Pandemic at YWCA Hamilton*, outlines the process of developing an integrated safer drug use space for women, trans, and non-binary people experiencing homelessness during the COVID-19 pandemic. Milliken and colleagues present challenges and key lessons learned through this process, while reflecting on their collaborative approach to harm reduction. The important insights from this chapter provide a starting point for other homeless-serving agencies.

Indigenous Peoples also face unique challenges with regard to homelessness. As previous research has demonstrated, Indigenous Peoples are overrepresented amongst those experiencing homelessness in communities across Canada, with rates as high as 93% of respondents in some communities (Schiff et al., 2022). The reasons for this are complex and multi-faceted, but as Thistle (2017) explains,

Indigenous homelessness is not defined as lacking a structure of habitation...but is best understood as the outcome of historically constructed and ongoing settler colonization and racism that have displaced and dispossessed First Nations, Métis and Inuit Peoples from their traditional governance systems and laws, territories, histories, worldviews, ancestors and stories (p.6).

In the fourth chapter in this section entitled *Endaayaang Indigenous Housing First for Youth: Exploring Service Provision and Planning During the Global Pandemic*, Naidoo and colleagues describe their Indigenous-led Housing First for Youth program. Drawing from the narratives of Indigenous youth and service providers, Naidoo and colleagues present the impacts of COVID-19 on the program, as well as challenges and benefits. This chapter highlights the importance of cultural connection, teachings, and ceremony in programming for Indigenous youth experiencing homelessness.

This section concludes with a chapter by Stewart and Townley entitled, *A Qualitative Exploration of Community Supports, Well-Being and Goals During the COVID-19 Pandemic among Youth Experiencing Homelessness*. Seeking to address a gap in the literature, Stewart and Townley examine the ways that COVID-19 impacted well-being, mental health, community experiences and social support, and goals of youth experiencing homelessness. The study underscores the importance of understanding

and addressing the unique challenges faced by homeless youth during a global crisis, providing valuable insight for future supportive interventions.

All of the chapters in this section present the unique experiences of a specific group and challenge us to acknowledge the differential impacts of structural, socioeconomic, and cultural barriers. By highlighting these unique perspectives, each chapter underscores the need to develop nuanced and targeted strategies that address the specific challenges faced by each group, fostering a more inclusive and equitable approach to homelessness.

CHAPTER ONE

Women's Homelessness Amid the COVID-19 Pandemic: A Case Study of Prince George, BC

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Abstract: This study used an intersectional feminist approach to investigate the impact of the COVID-19 pandemic on homeless women in Northern BC, and examine the state of homelessness in Canada. Gender, race, class, and sexuality were recognized as influential factors shaping individuals' experiences. Homelessness was identified as a significant risk factor for mortality, accompanied by higher rates of physical and mental health issues, substance abuse, and limited access to healthcare. In response to the COVID-19 pandemic, the Canadian government implemented various policy measures aimed at curbing its spread and reducing fatalities. The research focused on the city of Prince George in Northwestern BC, where 40% of the homeless population consisted of women and 68% identified as Indigenous. The findings revealed that homeless women experienced a reduction in available support services, leading to an increased risk of contracting the virus, more severe infections, and higher fatality rates. The

study emphasizes the need for policymakers and stakeholders in the homeless services sector to prioritize effective public systems and address the structural factors contributing to homelessness in Canada. It calls for a comprehensive approach to end homelessness, including the elimination of societal and political barriers, and the development of supportive policies that address the unique needs of homeless women.

Ethics Statement: Informed consent was obtained verbally and in writing by email from all participants before interviews commenced. This research study underwent ethical review, and the study protocol was approved by the Research Ethics Board of the University of Northern British Columbia (E2020.0824.040.00).

Conflict of Interest Statement: The author confirms that there were no financial and non-financial relationships or activities that could be perceived as a conflict of interest related to this research study.

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Introduction

The COVID-19 pandemic posed a unique set of challenges for homeless populations. It was first reported in China in December 2019, and by March 2020, the virus was officially declared a pandemic. For people experiencing homelessness, the threat of COVID-19 is real and immediate, as homeless populations are less able to implement public health directives and cope with the changes in societal behaviours brought on by the pandemic. They are also more likely to be managing pre-existing health issues and chronic diseases. Furthermore, they are unable to practice physical distancing, which is proven to reduce virus spread, and

they have no access to the hygiene supplies, face masks, or shower facilities that help us adhere to WHO guidelines of mask use and frequent hand washing (Wu & Karabanow, 2020; Tsai & Wilson, 2020).

Since mass homelessness entered the Canadian public discourse in the 1980s, stakeholders in the sector have worked to deliver solutions to what is undoubtedly a complicated problem. To provide a common ‘language’ for addressing homelessness in Canada, the Canadian Observatory on Homelessness (COH) held national consultations that culminated in a definition of homelessness as *“the situation of an individual, family, or community without stable, safe, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it”* (Gaetz, et al., 2012).

Richard et al. (2021) found that people with a recent history of homelessness in Ontario, Canada, were particularly vulnerable to COVID-19 infection. They were more likely to test positive, be admitted to hospital, develop complications, and die of COVID-19 compared to the general population. Overdose deaths also more than doubled among the homeless population (Gomes et al., 2021). Although a housing and homelessness crisis was declared in January 2020 in Ottawa, Roebuck et al. (2023) argue that societal responses to the pandemic were shaped by the homelessness industrial complex and did not significantly contribute to ending homelessness.

Historically, older single men were the face of homelessness in North America, however, the population is now more diverse. At least 235,000 Canadians experience homelessness yearly, and women make up 27.3% of that population (Gaetz et al., 2016). 9,078 women and girls experienced homelessness on a given day during the 2018 national Point-in-Time count (Schwan et al., 2021). The number of women and girls, families, seniors,

youths, and gender diverse people experiencing homelessness has risen in recent decades. These sub-populations have distinct needs and experiences that are often overlooked in policy and planning (Schwan et al., 2021; Martin & Walia, 2019; Reeve 2018). For example, almost 30% of women-led households in Canada have been found to be in core housing need (CERA, 2021) and 90% of families using emergency shelters are headed by single women (Boutilier, 2023).

Current scholarship has shown that gender plays a significant role in the experience of homelessness. Despite this, homeless women are more likely to be underestimated and improperly categorized, while their distinct needs remain overlooked. Women experiencing homelessness are more likely to be ‘invisible’, eschewing mainstream shelters and homeless services for more informal, precarious, and dangerous support systems (Gaetz et al., 2016; Schwan et al., 2020). As of 2019, 68% of shelter beds were co-ed or dedicated to men, compared to just 13% dedicated to women (Schwan et al., 2021; Boutilier 2023). As a result, women usually exhaust all informal supports and resources by staying with friends and family, romantic partners (oftentimes abusive), and even strangers until they are no longer able to (Schwan et al., 2021; Bretherton 2017). They are often researched as victims of domestic violence and not as women experiencing homelessness (Bretherton, 2017).

The purpose of this research paper is to explore how the globally traumatic COVID-19 pandemic impacted the lives of women experiencing homelessness using the city of Prince George (PG) in Northern British Columbia (BC) as a case study. I believe that research focusing on one of the most marginalized sections of the homeless population holds the key to ending homelessness for all.

Drawing on Crenshaw’s (1991) intersectional feminist approach,

this research paper aims to describe how varied intersecting identities and social locations interact with homelessness, examine homelessness and the COVID-19 pandemic at national, provincial, and local government levels, and determine the extent to which the COVID-19 pandemic affected homeless women in Prince George.

Women and Homelessness in Prince George

The city of Prince George, often called the “Northern capital” of the province, has about 80,000 residents and limited homeless services and resources. 2021 figures estimated at least 186 individuals experiencing homelessness in PG and 12 of those surveyed experienced housing loss due to the COVID-19 pandemic (Florey, Pateman, & Thandi, 2021; Homelessness Services Association of BC, 2021).

While Indigenous Peoples make up only 15% of the PG population, they are considerably overrepresented among those experiencing homelessness at 68% (Statistics Canada, 2023). Indigenous individuals experiencing homelessness face isolation and alienation from their communities, their lands, their languages, and their identities. They are unable to reconnect with their Indigeneity culturally, spiritually, emotionally, or physically (Thistle, 2017).

In Canada, the prevalence of deep poverty and financial instability among women has ended up facilitating women’s homelessness (Boutilier, 2023; Martin & Walia, 2019). Women often survive on lower incomes and remain overrepresented in minimum-wage and part-time jobs while assuming the majority of the housework and childcare (Schwan et al., 2020). Canadian women have seen proportionately steeper job losses than men as a result of the COVID-19 pandemic (Wright, 2020; Boutilier, 2023).

Schmidt et al. (2015) investigated the trajectories of women’s

homelessness in the Canadian North and found that up to 90% of homeless women in the North are of Indigenous descent. They identified low rental vacancy rates, the legacy of colonialism, and subsequent intergenerational trauma as being central factors influencing Northern Indigenous women's homelessness (Schmidt et al., 2015).

Government Response to COVID-19

Canada's response to COVID-19 included various social policy initiatives to mitigate economic effects and control the virus's spread. While the federal government led recovery efforts, specific policy guidelines were enforced by provinces and territories. The federal government implemented a three-month temporary 10% wage subsidy to increase liquidity for eligible businesses, the Canada Emergency Wage Subsidy, as well as financial support programs like the Canada Emergency Response Benefit (CERB). Most people experiencing homelessness were not eligible to receive the CERB but people who did qualify received \$2000/month between March 2020 and December 2020 (Béland et al., 2020; Government of Canada, 2021). Federal and provincial governments also increased spending and relaxed eligibility criteria for social assistance programs, such as those for Indigenous communities, women's shelters, homeless populations, food banks, and youth and low-income seniors' centres.

The BC government introduced the Emergency Benefit for Workers and a Temporary Rental Supplement Program to assist affected residents as well as a ban on evictions for non-payment of rent. These interventions only lasted for four months and were therefore not as impactful as expected. Considering that on any given night, 9,000 citizens are estimated to be experiencing homelessness in BC, the government also worked to secure 1,700

hotel and community centre spaces across the province (Rech, 2019; Vennavally-Rao & Bogart, 2020). Homeless encampments in Vancouver and Victoria were dismantled and residents were moved into vacant hotel rooms, but it is unclear whether this target was met.

In Prince George, COVID-19 outbreaks at Jubilee Lodge claimed 17 lives, and 8 deaths were recorded at the University Hospital of Northern BC (Balzer, 2021; Northern Health, 2021). The city closed its facilities including parks, playgrounds, libraries, and recreational centers in March 2020. Local businesses, religious organizations, the Treasure Cove casino, the Famous Players 6 cinema, restaurants, galleries, and shopping centres around the city all closed while essential services remained open and educational institutions transitioned to online learning (Payne, 2020; Balzer, 2020). When the city realised that the closure of civic facilities and businesses in downtown PG had reduced the washroom options available for marginalized individuals and homeless populations, it reopened public washrooms in the civic centre to address hygiene challenges faced by marginalized individuals.

Using funds provided by the federal government, the city funded six local agencies to *“enhance service provision in critical areas, including food security, mental health support, neighbourhood cleanup, and drop-in support”* (City of Prince George, 2020). However, many agencies, services, and programmes catering to the homeless population in downtown PG including soup kitchens, clothing rooms, childcare facilities, laundry services, dental clinics, Indigenous community events, youth centers, seniors’ services, and mental health and substance addictions groups—were either completely closed or operated within strict guidelines with limited hours and accessibility (Balzer, 2020).

Methods

This research paper employs a qualitative research methodology using primary and secondary data sources. Primary data was collected using semi-structured interviews with purposively selected participants. The Research Ethics Board of the University of Northern British Columbia approved the study protocol (E2020.0824.040.0) and informed consent was sought before interviews and confirmed through email.

Interviews were conducted between February 2021 and March 2021, at a time when public health orders and the threat of the COVID-19 virus prohibited in-person data collection. Because women experiencing homelessness do not typically have the technology resources required for virtual interviews, participants were female service providers at agencies serving people living on or close to the streets of downtown PG.

Participants were recruited via direct telephone and email contact to ten homeless service agencies, and at the end of the process, three service providers were interviewed. Participants met the expert consensus method (Minas & Jorm, 2010) criteria of professional expertise, with their lived and working experience spanning several decades across different agencies within the homeless services sector in Prince George.

Interview questions explored participants' backgrounds and roles, the services they provide women experiencing homelessness specifically, and the service interruptions they were working through due to the pandemic. Participants shared their experiences providing services to homeless women and shared feedback they had received from their female clientele on the impacts of the pandemic and its attendant societal changes on their lives. The interviews were digitally recorded and manually transcribed,

and data was analyzed using thematic analysis. The data analysis process included four rounds of coding and data reduction that identified five major themes.

Findings

This study identified five major themes that chronicle the impact of COVID-19 on homeless women in Prince George. Firsthand experiences narrated by service providers coupled with feedback received from female clientele, as well as findings from previous literature, helped to uncover how the COVID-19 pandemic affected women experiencing homelessness.

1. Fear and Uncertainty

Women experiencing homelessness and service providers in PG expressed growing concerns about safety, particularly regarding the risk of contracting COVID-19. Homeless women reported increased fear and anxiety, as did the service providers themselves, who faced added stress from measures of constantly wearing protective gear, frequent handwashing, and sanitizing and disinfecting spaces between each client. They also reported their fear of taking the virus home to their family.

Some female clients reported choosing to sleep on the streets to avoid being in contact with many people, which is inevitable if one stays in emergency shelters. Unfortunately, this comes with the associated increased risk of physical and/or sexual assault and hypothermia.

I've noticed there has been an increase in being scared to go to the shelters due to fear of COVID, so there have been increased people sleeping on the streets. It's been harder to get inside and get warm, specifically during winter, because there are boundaries to the

amount of people that can be in any given location.

We had a young lady freeze to death here not too long ago. It was put down as an OD [referring to a drug overdose] but she froze to death.

Another service provider reported clients' fear of contracting COVID-19 because of an already compromised immune system. People experiencing homelessness are more susceptible to illness and death due to the prevalence of underlying physical and mental medical conditions and a lack of reliable and affordable health care (Wu & Karabanow, 2020). Women experiencing homelessness had expressed a greater level of fear around contracting the virus since it could be a death sentence for them. They also expressed anxiety about using public transportation due to the risk of COVID-19 exposure.

2. Service Changes and Lack of Access

Service providers reported that other agencies in PG as well as their own, instituted service changes such as reduced hours, elimination of drop-in services and a switch to appointments only, longer wait times, screening for COVID-19 symptoms before entrance, virtual service either by phone or online video conferencing, cancellation of group and/or in-person sessions, stricter—and in some cases, looser—eligibility criteria for accessing services, etc. Providers decried a lack of support that stripped homeless populations of resources and left them to make do with “*the bare minimum and even less than that*”.

Often when I'm working with someone who is chronically homeless, they do not have access to a lot of technology that we're now depending on because of COVID. For example, cell phones, laptops, and different things like that. Because of COVID, a lot of services have changed— although some services are still offering in-person

options, but it's preferred sometimes to do over the phone or Zoom appointments and I think that has been especially hard for individuals who are chronically homeless and do not have access to that kind of technology. How are they going to get services and get that support and feel connected?

I've had at least 5 different clients come to me scared because they thought they had COVID. They have no access. In order to get tested for COVID, you have to sit on the phone [to book an appointment] and sometimes that is a long process. We've had to sit in my office and wait for a nurse to tell a client whether she had symptoms [and could be booked in for a test] for an hour and a half.

Service changes were not uniform but varied by agency and the types of services offered. One outreach worker at a women-focused agency could no longer provide support services like driving women to and from appointments, food banks, rental listings, and court appearances, while another was able to keep providing such supports because her employer installed a partition in the vehicle, and face masks and hand sanitizer were required before trips.

Additionally, there is a lack of access to resources necessary for maintaining good personal hygiene and following the public health recommendations of wearing face masks when interacting with others, frequent handwashing, and sanitizing high touch surfaces regularly.

Within this theme, there is also the issue of drug and substance accessibility. Homeless populations lack access to the technology needed to attend safe-supply virtual appointments and also do not have a fixed address at which to receive such medication. In PG, this meant that people who had tested positive for COVID-19 were forced to leave their isolation location to pick up their

prescriptions. Of course, safe supply prescriptions serve a different purpose from street drugs as they are only intended to prevent withdrawal symptoms and overdose. A service provider explained that people ended up leaving isolation to “buy street drugs instead of the safe supply... and, in that case, will possibly be spreading COVID even more”.

And people that have addiction issues, right now, I drive 2 people that were both in at the isolation hotel, they'd both tested positive, and they had to go each and every day to get their Methadone. So, they have to go through a drugstore, and I don't know if you've ever been down to the 3rd Avenue drugstore but go down there around noon and watch how many people are going in and out of that drugstore to get their Methadone. They can't self-isolate because if they do, where are they going to get their drugs from? They've got a safe drug supply but the only way they can access it is by going into the public.

This ongoing theme of lack of access also captures a turning point in the downtown PG homeless services sector. Out of the three year-round adult emergency shelters in town, the one women-only minimal-barrier shelter expanded its operations to serve male guests shortly after the pandemic began, leaving women experiencing homelessness without a dedicated shelter space. Although it is unclear whether this service change was instituted due to the pandemic, women experiencing homelessness were frustrated by the change. “...there's now no place that just women can go, unless that's a transition house but that's a very different form of support compared to minimal barrier [shelter]. I think that's another struggle under all of this.”

In October 2023, the shelter was confirmed to be once again women-only.

3. Change in Societal Organization

Service providers reported a loss of connection due to the closure of, or limited services at, cultural centers and drop-in centers. Previously, people could gather at food banks and soup kitchens to share meals and chat, but physical distancing measures prevented this. Open centers only offered window service for pre-packaged meals without communal dining. Waiting rooms for socializing were also closed due to occupancy restrictions.

Providers faced challenges in building meaningful connections with clients as drop-in sessions were replaced by appointment-based interactions. Clients had to buzz or communicate through barriers before gaining entry. These COVID-19 screening and symptom confirmation protocols, while necessary, ended up dehumanizing and potentially traumatizing individuals in crisis.

There is a lot more isolation. There is a lot more tension too between the population on the streets. People are getting more aggressive. They're getting angrier at each other because this whole situation is frustrating, and people end up taking it out on each other.

Homeless populations were reported to have experienced increased isolation due to the closure of group gatherings like Alcoholics Anonymous, Narcotics Anonymous, religious meetings, mental health and brain injury groups. The community support and social connections usually formed and sustained at group gatherings were lost due to closures because of public health orders to limit the spread of COVID-19.

4. Physical Effects

Homeless individuals uniquely felt additional physical impacts due to the virus. Prolonged mask use caused discomfort for everyone, but homeless populations experienced additional pain from

using hand sanitizers with alcohol content on their already cold, dry, and/or cracked hands with numerous cuts, common issues among those unhoused.

Another facet of this theme involves how COVID-19 symptoms compound challenges for people experiencing homelessness. They had to deal with the viral symptoms while also facing a higher likelihood of pre-existing medical conditions, substance use, and systemic health and social inequities.

I tested negative, but I was recommended to stay at home for 14 days and self-isolate. The people that had the positive result, that were in the isolation unit, were isolated for 10 days and released unto the street. What is the difference between me and them? One young lady was very sick, and she came in to see me sobbing and said, 'I'm so sick. They told me I couldn't stay there [referring to the hospital], they told me to go to a shelter'. She did go to a shelter, but others knew that she had tested positive for COVID-19. She was still showing symptoms but no longer contagious. Other shelter guests made up things until they got her restricted, so she had to sleep on the streets for two nights.

In PG, homeless individuals who reported COVID-19 symptoms through the Northern Health phone line and were able to book tests were quarantined in a downtown hotel while awaiting their results. However, the hotel was reluctant to accept individuals who had previously isolated, suspecting that they were seeking testing solely for the sake of finding a place to stay.

5. Restrictions and Harsher Penalties

The study identified a recurring theme regarding more stringent rules and penalties encountered by women experiencing homelessness while accessing services. Amid the COVID-19 response,

various organizations adopted new guidelines, but the severity varied. Service providers reported stricter regulations regarding check-in times, harsher consequences for disruptive behavior, mandatory mask and sanitizer usage, and stricter eligibility criteria for certain programs.

[A homeless woman] went to spend a night at a shelter in town... They told her she could not bring her stuff in. And she said, "but I can't leave it out here, it'll get stolen." They said "well, you'll have to stay outside with it because it's not coming in here." And that's happening a lot more than the public realizes. We've got a new shelter that's just opened up for emergencies. However, if they don't check in at 11 o'clock at night, they lose their bed.

Screening measures at agencies resulted in service denials to anyone with noticeable COVID-19 symptoms. Occupancy limits were also a source of frustration, as even essential needs like restroom access or a safe resting place could be denied once limits were reached. Service providers reported frustration with having to restrict or deny services. This is consistent with service providers in Ottawa, who decried having to function as street-level bureaucrats to operationalize and implement COVID-19 public health policies (Roebuck et al., 2021).

I work with women and children who are leaving abusive situations but sometimes that is also individuals who are at risk of homelessness so our transition house will work with both. With COVID-19, that has changed. Typically, there was a bit more flexibility in that but with COVID we have to be firmer in terms of who is able to access at this time.

Discussion

Safety measures adopted to reduce the spread of the COVID-19 virus fostered significant social implications for women experiencing homelessness in Prince George. They had their already limited options for social gathering and community connections even more restricted. This study found that there is more isolation among the homeless population. People experienced loss of supports, resources, friends, and family. Women who are experiencing hidden homelessness living in unsafe and/or precarious housing situations have faced increased incidences of domestic violence because of the stay-at-home/lockdown orders (Piquero et al., 2021).

People experiencing homelessness who contract COVID-19 have had to deal with adverse symptoms of the virus while also facing a higher likelihood of pre-existing medical conditions, substance use, and systemic health and social inequities (Luft, 2021; Huang et al., 2021).

Drug and substance users experienced increased incidences of overdose because of a contaminated drug supply due to a disruption in global supply chains brought on by COVID-19. The province of BC had previously declared a public health emergency in 2016 because of the opioid overdose crisis. Despite this, 193 overdose deaths were reported in PG by the BC Coroners Service between 2016 and 2021. In Ontario, the average weekly overdose death rate increased by 38% in the first 15 weeks of COVID-19 compared to the 15 weeks before (Ali et al., 2021).

The health inequities already being experienced pre-COVID-19 were felt more intensely by homeless women in Prince George. They were faced with testing, treatment, and isolation procedures not uniform with the rest of the general population. The

consensus is that homeless women in PG have been left to fend for themselves during these unprecedented times.

We now know that chronic homelessness is more common in Canada's Western and Northern communities than in the East (Employment and Social Development Canada, 2021). Future research is needed to investigate variations in the experience and location of homelessness in Canada. We also need further research on solutions to Indigenous Peoples' overrepresentation within homeless populations in Canada.

Homeless data and demographics in Canada lack granularity, making specific data on women's homelessness unavailable. This study aimed to address a notable gap in academic research on the subject. While the study design was specifically tailored to women experiencing homelessness, the resulting findings offer broader insights. Future feminist research is needed to explore regional and ethnic variations in the prevalence of women's homelessness in Canada. To generalize the findings to a wider population, more studies in various cities across Canada will be imperative for comparative analysis.

Recommendations

The COVID-19 pandemic has revealed the inadequacies of emergency readiness protocols around the world. Adverse weather conditions like wildfires, extreme cold, and heatwaves as a result of climate change are becoming more frequent. It is important to plan for the most vulnerable populations in our societies to ensure that everyone is protected. Protocols should be established to ensure that marginalized individuals can continue to access services in extraordinary situations. For example, Northern Health staff could have been deployed to emergency shelters to conduct

COVID-19 testing for people with no access to a phone line.

Policy makers and civil society organizations that serve the homeless population in general, and homeless women in particular, must first believe that it is possible to dismantle the current homelessness industrial complex (Dej, 2020). Public health interventions should adopt a human rights approach to housing and to homeless encampments (Olson & Pauly, 2021). Canadian society must commit to addressing the structural issues and failures in public systems that lead to homelessness and provide increased supports for individuals and families during emergencies. These measures will prevent homelessness and alleviate the burdens faced by marginalized individuals during extraordinary situations.

Table 1 below provides a high-level snapshot of findings from this study and outlines recommendations for government, policy makers, and stakeholders in the homeless sector.

Table 1 - Research Findings and Recommendations

Findings	Recommendations
Reduction in the number and types of support services available to homeless women	Design and funding of emergency protocols to ensure homeless women can still access support during extraordinary situations
Increased risk of contracting COVID-19 due to living in emergency shelters or on the street	Increased funding for affordable and supportive housing units
Worsening health inequities and unequal treatment protocols	Mandatory sensitivity training for staff across government and private institutions that provide health services for the homeless population Strengthening of regulatory mechanisms and institution of fair complaint processes Increased mental health funding
Increased risk of overdose for PWUD	Decriminalization of drug use Increased funding and supports for addiction treatment

Conclusion

It is possible to end homelessness. Canada must seek to consistently decrease (with a view to eliminating) the number of people who end up experiencing homelessness due to the failure of other public systems. Policy and funding initiatives should prioritize child protection, corrections, social housing, mental and physical health, and addiction treatment programs. This, in addition to well-funded support systems that step in when individuals are faced with personal crises, breakdown of family, interpersonal violence, etc., will ensure that nobody experiences homelessness for more than a few weeks. Eradicating homelessness in Canada requires the implementation of comprehensive

measures that tackle underlying structural issues like poverty, discrimination, the scarcity of affordable housing, and the adverse effects of colonialism on Indigenous Peoples, all of which contribute to the prevalence of homelessness in Canada.

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CHAPTER TWO

Fast Fixes but Failed Fit: Shining a Light on Older Women's Experiences of Sheltering Hotels during COVID-19

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Abstract: COVID-19 spurred a rapid infusion of resources into a fractured homeless-serving sector (HSS), but also exacerbated many longstanding service challenges. In this chapter, we acknowledge the right to appropriate housing as a primary determinant of health. But the primary goal of our research is to highlight avenues for intentional, positive system-level changes

to improve HSS services for older women with lived expertise of homelessness (WLEH). These individuals represent a generally overlooked, as well as 'hidden' segment among the unhoused. WLEH numbers are increasing due to disadvantages that have accumulated over time through wage inequities, lack of access to pensions, penalties accrued from unpaid domestic labour, and intimate partner violence. Motivated by safety and security first and foremost, older women exhaust informal supports such as friends and family by couch-surfing and sleeping in cars before they engage with formal services.

Data from 20 interviews with WLEH and 22 with service providers gathered during the first year of the pandemic explore the impact of COVID-19. While the pandemic introduced new emergency and transitional housing, sheltering hotel arrangements often intensified threats to safety and wellbeing, reduced available service options due to distancing and other safety protocols, and deepened social isolation for women. If there is any 'silver lining' from the pandemic, however, it lies in recognizing the need for transformative system change. To better support health and healing for WLEH and exits from homelessness, more housing is an inarguable need. In addition, a re-imagined system needs both adequate resources and room for innovative solutions to improve service integration and support system navigation to better meet the diverse needs of WLEH. Such a system must be focused on person-centered, trauma-informed and culturally-safe values, principles and models of care.

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Introduction

The COVID-19 pandemic has had a major impact on the world at large. Among those most affected in virtually all communities are individuals and families with less access to the financial, physical, emotional, and social resources and services that are essential to support a healthful life. Since the 1980s, and therefore long before the COVID-19 pandemic, homelessness was an emerging phenomenon stemming from disinvestments in social housing and social welfare supports that continue today (Gaetz et al., 2016). The pandemic brought into sharp relief many of the day-to-day challenges faced by those with lived and living experience of homelessness and housing insecurity, and the organizations, service providers and governments invested in trying to care for them (Kaur et al., 2022; Pleace, 2023).

While two-thirds of those who experience homelessness historically have been single, older men, now older women (age 50+) are among

the fastest growing segment in this population today (Flike et al., 2023; Gaetz et al., 2016; Grenier, 2022). Unfortunately, a lack of age and gender-specific research creates a critical gap that prevents proper attention from being given to the supports, services and programs necessary for older women to live independently in the community as they age. They are caught between a lack of effective housing and support-service models for those who are homeless and female on the one hand, and limitations and pressures on assisted living and long-term care alternatives on the other (Petersen, 2015).

According to Milany et al., (2020) and Whitzman (2006), older women with lived expertise of homelessness (WLEH) who have been or continue to be homeless experience both 'spatial' and 'policy' invisibility. This refers to the fact that they avoid the Homeless Serving (HS) and Violence Against Women (VAW) systems (henceforth called 'HS/VAW') until they exhaust their informal resources of friends, family, neighbours and others first through means of couch-surfing, sleeping in their cars, or sleeping on the street (Grenier et al., 2016; 2020; Milaney et al., 2020; Tung & Cloutier, 2023). And, because they are invisible to the system, they tend to be both undercounted and underserved in terms of the range of services and supports available to them (Gaetz et al., 2016; Milaney et al., 2020).

Reasons why women and gender diverse persons defer engagement with the HS/VAW systems include lack of awareness, fear of safety and security within the system, shame and self-blame, fear of theft, and past histories of intimate partner violence which encourage them to stay away from HS/VAW environments that are male-dominated, or that otherwise pose a threat to their well-being (Collins et al., 2018; Grenier et al., 2020). At a personal level, this means that WLEH's diverse needs and unique health challenges are often unmet.

At least two pathways characterize WLEH experiences of housing insecurity: entering homelessness in later life or experiencing chronic or episodic homelessness over many years (Grenier et al., 2020). In the case of the latter, the growing prevalence of women among the unhoused is a function of multiple and overlapping forms of disadvantage that have accumulated over a lifetime through wage inequities, lack of access to adequate pensions, penalties accrued from unpaid domestic labour, and increased risk of intimate partner violence (Darab et al., 2018; Grenier et al., 2020). These disadvantages are related to intersecting gender, class, and other social identities including race, Indigeneity, and disability. Indigenous persons are notably and significantly over-represented among homeless populations in Canada given the history of colonialism, limited access to housing and clean water, breakdown of families, and the perpetuation of intergenerational trauma (Schwan et al., 2020).

Health conditions experienced by older homeless persons can include tuberculosis, HIV/AIDs, respiratory illness, and other infectious disease (Zlotnick et al., 2013). Whether beginning later in life or across the lifespan, the experience of housing insecurity and homelessness produces accelerated physical and cognitive decline, compromised health, multiple co-morbidities, and premature aging (Brown et al., 2017; Dickens et al., 2020). Similar to older men, common chronic conditions for older women include hypertension and heart conditions, asthma, diabetes and chronic obstructive pulmonary disease (Canham et al., 2020; Collins et al., 2018; Flike et al., 2023). However, older women are more likely to experience chronic pain and greater psychological distress and trauma due to brain injury caused by partner violence (Canham et al., 2020; Flike et al., 2023). A recent nationwide survey of WLEH reported that 79% lived with physical or mental disabilities (Schwan et al., 2020). Additionally, research by Brown et al., (2022) reported that mortality

was higher for women who experience homelessness at or after age 50 compared to younger women, thereby emphasizing particular vulnerabilities arising from entering housing insecurity later in life.

Addressing homelessness requires coming to terms with intersecting structural vulnerabilities of poverty and trauma (Butler et al., 2022). Growing evidence suggests that it may be more expensive to house individuals in transitional and emergency environments than it is to find permanent housing solutions for them from the outset (Gajari, 2018). Moreover, while access to appropriate housing is undeniably important and often characterized as a first step, there is also an irrefutable need for both episodic and long-term whole-person care and support to address the trauma and discrimination that individuals who have experienced housing insecurity and homelessness have usually known (Chaland, 2021; Gajari, 2018). Restoring dignity and personhood, according to van Leeuwen (2018), requires reconnecting individuals so they get to experience meaningful social connections to help them heal from the alienation and stigma of homelessness.

When COVID-19 hit the world, uncertainty was rampant. In British Columbia, Canada, provincial health orders and organizational rules and regulations evolved rapidly, causing individual clients and service providers to have to adjust quickly and accordingly. The HS/VAW was no exception. In this chapter, we explore how COVID-19 affected precariously housed older women by drawing on interviews with service providers and older women themselves.

Methods

Guided by a community based participatory research (CBPR) approach, this chapter highlights findings from a larger study that explored the stories of older women with lived experiences

of homelessness (WLEH) and housing insecurity to assess ways to improve access to resources and services, and support exits from homelessness. The arrival of COVID-19 was coincident with the receipt of grant funding from two of Canada's Tri-Council Funding agencies, the Social Sciences and Humanities Research Council (SSHRC), and the Canadian Institutes of Health Research (CIHR), for this project. Due to COVID-19, the original projects had to be altered to a degree. One of the primary impacts was that all interviews had to be undertaken over online platforms rather than in person. The core research team included four WLEH as co-researchers, leadership engaged in ending homelessness at the Alliance to End Homelessness in the Capital Region (AEHCR), the Community Social Planning Council, the principal investigator, project coordinator, and two social science trainees (Masters' and PhD). Other team members who supported the project included five other academic researchers with social science and nursing backgrounds.

Ethics approval for the study was obtained by the Research Ethics Board at University of Victoria. Qualitative interviews were undertaken with 22 service providers (SP) as well as 20 WLEH (ages 48-78). Service providers ranged from frontline support staff to managers. Interviews with the four community co-researchers (CRLEH) were included among the 20 WLEH. All interviews were conducted during a one-year time frame between November 2020 and November 2021, after the first wave and into the second wave of the pandemic.

All study participants were currently living or working in Victoria. Recruitment of SPs was accomplished by emailing contacts at service provider organizations within the HS/VAW sectors. WLEH recruitment was primarily undertaken through posters and contacts at homeless serving organizations and with the aid

of SP participants. Potential participants were directed to email or call the project coordinator for additional information on the study and to establish an interview time.

Informed consent was obtained prior to each interview. WLEH received a small honorarium while SPs were not remunerated as interviews were conducted during working hours. Interviews typically lasted between 50-75 minutes with several extending past 90 minutes. All interviews followed a semi-structured interview guide developed by the core research team. Interviews were conducted by two core academic team members following the semi-structured interview guides with follow-up questions as needed to build understanding of experiences.

Interviews were conducted via Zoom or telephone in accordance with both COVID-19 and ethics protocols. They were audio-recorded (through Zoom) and then transcribed by a professional transcriptionist. WLEH interviews were coded using NVivo 12 software by the two students (AT+KF). Interviews with SPs were hand-coded (DC+RK). To undertake the thematic analysis, codes that mentioned 'COVID' or the 'pandemic' were extracted from WLEH and SP interview transcripts and reviewed. A coding structure was then developed based on manifest and latent codes discussed and validated by DC + RK. In many cases, full interview transcripts were then revisited to consolidate the analysis to identify key themes for the paper, which were then reviewed and validated by all authors (DC+RK+AT+KF) in accordance with the six well-tested principles for thematic analysis articulated by Braun and Clarke (2022).

Findings

Our findings to explore the impacts of COVID-19 are organized into two thematic sections, the first representing the system level, “Fast Fixes, but Failed Fit” and the second, the individual level, “Older Women’s Journeys: Making the Hidden Visible,” respectively. Subthemes under the two main themes are also outlined with respect to impacts and service system navigation challenges during the first year of COVID-19.

1. Fast Fixes, but Failed Fit

Fast Fixes

One of the most large-scale changes in the HS/VAW systems serving unhoused persons in the months following the advent of COVID-19 was the lease and later purchase of five sheltering hotels by the provincial government as temporary supportive/transitional housing in the community. The sheltering hotels also fulfilled a need to address public safety and reduce the spread of the virus in the ongoing provincial state of emergency. People living in tent encampments or on the street were prioritized over those already staying in temporary emergency shelters. However, this action was not well understood or appreciated by people using housing services who felt they had been displaced from social housing (BC Housing) lists they had been waiting on for years.

Yeah, there’s a lot of tension, a lot of frustrationthe ‘scoop-up’ kind of, as they call it, what happened in April in Victoria where there was large, large, numbers of homeless people on the block and they got rapidly put into those hotels because of the pandemic. In all fairness it was a pandemic. Nobody knows what to do. But there was a lot of people who had been waiting on that list for years and they got jumped. Like they just got skipped and whoever was on

the block that day got housed. And so, for those people great, like that's awesome, but for the other people that's extremely upsetting and frustrating. [SP 6]

Another service provider expressed a more hopeful view that COVID-19 actions were enhancing the visibility of the homeless population and therefore promoting increased awareness of the general vulnerability of unhoused persons:

But I think the good part is that it's opened the eyes more to like funding bodies and government, and you know just really showcasing how many people are homeless and are experiencing homelessness and what that looks like, and some of the extra struggles that are going along with it, and of course the whole overdose crisis and mental health. So, things are being highlighted and they're getting more attention. So, that's positive. [SP 13]

Not surprisingly, however, these rapid provincial and federal resource infusions were not adequate to address longstanding structural barriers and pressing needs for increased housing alternatives and better all around, whole-person care:

[While] The silver lining of the pandemic for this sector is that it forced the federal government to open a lot of funding up to be distributed to work towards housing people, the problem in our region is that we simply don't have the housing units. So, that's where we're still running into a barrier. [SP 11]

On another positive note, in some cases, uncertainty due to COVID-19 spurred increased collaborations and new networking opportunities among service organizations as they scrambled to react and meet needs. Additionally, congregating people into the sheltering hotels meant that services could also be consolidated, that is, delivered there more easily (e.g., COVID-19 vaccines

were brought directly to the hotels for those who wanted to be vaccinated).

Some organizations took on new roles as one provider explained:

So, in all the hotels we [organization] had our own space. Some of the spaces we shared with other agencies so we would have clothing, food, like I mentioned harm reduction supplies and you know access to paperwork and all that stuff. And then we would kind of be on site. ... people would come to us and then we would participate in safety checks, wellness checks, going around people's rooms, knocking on their doors, any kind of overdose response.... So, it was kind of like a combination of support and safety. [SP 13]

Existing peer support workers with lived expertise maintained their critical role in helping clients navigate the service system. In addition, newly injected COVID-19 funds spurred an increase in training and opportunities for new peer support workers to enter the system and manage and assist with the movement of people into the temporary sheltering environments, and to support them once settled. One co-researcher now securely housed and acting as a peer support worker shared the following:

I had been volunteering with [organization] for about two years and hoping one day to be employed with them because they're my second family... It [peer support work] was exactly what I needed at the time...I jumped at the chance and I'm glad I did. I have been happy. I've been enjoying the work that I do. [CRLEH 2]

Service losses were also an inevitable part of the COVID-19 landscape with reductions or complete shutdown of some services and supports for fear of transmission of the virus. Encouraging workers to stay at home if they felt poorly helped to reduce transmission rates, but also meant that services and programs were

operating with fewer staff than usual, and typically fewer staff than needed. As a result, staff who came to work were often working more hours to cover the loss of personnel, and levels of burnout increased.

Another loss to overall system capacity arose to accommodate COVID-19 distancing protocols. One manager indicated, “Okay so, we had 25 beds before COVID, and we had four emergency beds. So, 29. Now with COVID, we’re just 18 (beds)” [SP 1]. Although bed numbers decreased in some areas, one response was to increase lengths of stay in certain places to enhance stability and reduce movement. This provided some security for already housed individuals but reduced the pool of available shelter and housing options for others.

Failed Fit?

Fast fixes that opened new spaces for individuals, may or may not have had the staff or programming complement in place to adequately support new mixes of individuals. This is arguably a feature of the HS/VAW sectors under the best of circumstances, but one aspect that was amplified as a consequence of rapid movements and groupings of complex clients together.

I think the sheltering sites are fantastic. I think the rush of COVID, and we’ve seen poor decisions being made on all levels, but you really have to in my opinion kind of slow things down, be thoughtful and kind of plan things out and be prepared. So, for instance [organization] opened the Tower which is part of [place name]. So, we partner with [organization]. And we were literally asked to open that shelter in three days. How can you do that? How can you have qualified, educated, staff who know the building, who know all our safety protocols? When you bring in 30 people that you... clients that you’ve never met before, you don’t know, and then you’re like here’s your room, good luck, you know? [SP 2]

Sheltering hotels were a rapid, emergency response to COVID-19 and not a planned strategy to support and assist individuals, meet their needs, and support their exits from homelessness where possible. To a degree, this speedier placement of people out of necessity, offered a roof and a bed, but without much forethought given as to where individuals should be placed for the best fit as SP 2 elaborates:

So, I think they're [sheltering hotels] absolutely needed, but you kind of have got to look at who's the demographic? What kind of support services do you really need? Yeah, there's just so much... People's lives are just so complex. Things that you'd never even think of the things they have to do on a day-to-day basis so that kind of extra support needs to be there.

Unmet needs of older women

The particular needs of older women and specific kinds of support to help with their mobility and other health challenges were often not recognized, again reflecting their vulnerability and invisibility within many aspects of the HS/VAW system. This is illustrated in several of the following quotes:

...everybody wants a forever home, but it's really important when you're almost 70 years old; like 3 more years I'll be 70. It's like, oh my God, I just want to be in one place and not have to move again. Like to stay put is good, and that would be so nice and comforting not to have to just uproot myself. I can't do it. I'm too old for that. I'm not resilient enough. My health isn't good. And I'm not the only one. There's tons of us on the streets right? [WLEH 14]

One housing worker discussed how in an “ideal world” there would also be more options for clients:

Most people weren't given a choice of where they're going to live though. They're like here you go. You have to leave this tent city. We're putting a fence around your yard. Your yard is gonna become smaller and smaller. We're forcing you out. Here's your alternative. Go. And so.... there wasn't a lot of choice. Having said that though there's people that had actually been in the shelters for a long time, and this is the first time they've ever had a permanent roof over their head...I'm just really recognizing it took away a lot of rights or personal choice from people. [SP 1]

A similar view was expressed by another WLEH participant making a case for the need for a different kind of sustained engagement with whole-person care for clients:

Getting people off the street due to COVID is not the same as looking after them and getting them housed...they need more shelters that are not thrown up as a result of COVID which is like those cardboard little rooms at the arena or spots on the gym floor. It's a way to get people off the street and out of tents absolutely, but it ...doesn't help people get better, and a lot of the people that are in there are [not] going to be able to get housed and live a productive life. [WLEH 15]

One tenant's experiences featured challenges with increased costs of living in the COVID world because she had been living in her car previously. In addition, she found that the food options in the sheltering hotels did not comply with her diabetic dietary needs:

My life was wonderful when I was living in my car. I got sick when I got to [place]. My blood sugars are always 20 up here. The food they feed here... they do not feed the diabetic diet. So, I have to spend all my money on my food...I had more money to live on when I lived in my car and was able to make ends meet. It is more difficult now. [WLEH 7]

Communication and Information

Communication and information channels were other contentious areas in the COVID-19 environment for SPs and clients. While public health officials shared information with the general public via the media, within the HS/VAW hierarchy information flows between managers, staff, and clients were not as fluid. When they broke down, it created an erosion of trust. Many clients felt that new information about COVID-19 illnesses and deaths was available but not being shared with them in a transparent way. One participant said, “*Yeah, we just hear rumours amongst us, between us, how many there are.... The workers don’t tell you anything. It’s all being kept very hush, hush.*” [WLEH 12]. Public libraries that had previously offered sanctuary to individuals as safe spaces with computer access, and could be relied upon by many unhoused individuals to check their email, stay connected, and apply for services or programs, closed down and were thus unavailable.

In summary, although provincial and federal funding spurred securing hotels to house clients, the ‘one size fits all’ method failed to meet the needs of many, but especially the unique circumstances and complex needs of older women.

2. Older Women’s Journeys: Making the Hidden Visible

Experiences of Violence and Lack of Safety

Among WLEH participants, our interviews revealed that 80% were living with disabling physical or mental health conditions or injuries; 40% had experienced previous intimate partner violence; and 65% had experienced violence in the places where they stayed. As part of their daily lives, 50% percent had experienced sleeping rough; 65% had experienced evictions; and more than two-thirds (70%) noted negative experiences with law enforcement. In terms of cultural identity, 25% identified as

Black, Indigenous or as People of Colour. Health-wise, the range of conditions and challenges they reported included: mobility; mental health challenges including anxiety, depression, and PTSD; diabetes; MS; heart conditions; chronic infections; respiratory issues; degenerative arthritis; broken bones; hip and knee replacement; spinal injuries; and brain trauma.

For some of the women interviewed, staying in a hotel after living in a tent was an improvement:

There was a woman going around through the tents and I happened to talk to her and she saw that I had a broken heel and that was because of an assault by another person on the street. She tried to get me in fairly quickly. So, I was lucky, very fortunate, to get a suite in [sheltering hotel] and it's really helped out a lot with the healing process of the broken heel. [WLEH 12]

Another participant described how the hotel felt safe at first but changed quickly when other tenants arrived: “They were stealing things and their behaviour cost me a lot of money to fix my car with the vandalism.” She illustrated this unsafe environment further by sharing a story about seeing “a woman being beaten downstairs by my room and men fighting and yelling.” [WLEH 7].

Similarly, another participant shared that her safety and comfort were reduced when the building she lived in, originally designated for seniors, was opened to non-seniors. Another WLEH remarked on how the rapid establishment of new COVID-19 spaces meant being [re-]exposed to some past perpetrators of violence as well as potential new threats:

I'm glad to be... behind my door here. I feel like I check my door a lot with hands on both sides of the door to make sure it's shut really tight. And yeah, but the stuff that goes on out in the hall or the loud

music and somebody is fighting it's scary and threatening. But, you know so it's really hard to be here, but it's better than being on the street....So, it's still very threatening right. ...you choose not to go on the elevator at the same time as the other people 'cause you don't know what they're gonna do, especially if it's somebody you recognize has hurt you before. [WLEH 14]

As noted for many older women living with mixed male/female, and older/younger groups of clientele could be highly challenging in terms of their safety and security:

These are all men here who are on drugs, do not wear masks, spit on us if they are close to us and do not do the distancing for COVID-19 protocol since they have moved in here. It is not safe outside my room, on the grounds, because there is no tenancy agreement with drug addicts. They are allowed to be doing pretty much anything inside and outside their rooms. There has been a fence constructed to keep outsiders and people who are not residents out, but this is not very effective. [WLEH 7]

Another client of a sheltering hotel described living with the overhanging threat of eviction, compounded by a history of difficult relationships with staff and police. She retold an event where she tried to support another client who was at risk of overdose, but she felt ignored by staff, who failed to respond to her concerns, and who also had her forcibly removed from the premises. In her story, she indicated she was detained afterward by a police officer who, she said, used unnecessary force and inflicted physical injuries on her despite her visible physical disabilities and use of a walker:

I was totally vulnerable, and they had all this power over me, and oh my God it was horrible... It's not like you own your own home. It's a room in a hotel that's been given to you for COVID shelter. You

don't have a say in it. They could come in in 5 minutes and tell me I have to go. [WLEH 4]

The previous statements provide several examples of how women's safety was compromised in these temporary COVID-19-related environments, with episodes of violence being a common refrain. Women staying in the sheltering hotels not only witnessed violence to others, often feeling powerless to intervene, but also experienced it themselves on numerous occasions. Moving off the street meant giving up some control over their own circumstances. While being housed was meant to be a safer alternative, fear and uncertainty were constant companions and yet another illustration of 'failed fit.'

The Regulation of Social Life: Fragmented Services, Supports and Social Networks

COVID-19 introduced physical distancing protocols in most public places. For one WLEH, this offered a 'comforting' sense of order. *"I like the physical distancing. It's a real good thing.... I love the arrows. This way up; that way down. It keeps it simple. It keeps people moving and flowing properly."* [WLEH 2]

However, for other WLEH, day-to-day life during COVID-19 became increasingly complicated across intersections of age, gender and health. Health conditions, already complex for so many WLEH, worsened during COVID-19, especially for those who had previous experience with life on the street. One participant encountered delays in surgeries and specialist appointments. She developed infections, and even experienced a ruptured appendix:

I still have ongoing health issues from being homeless. So, for me my situation is different than a lot.... as a result of being homeless...I'm dealing with health issues to this day and will be for the next year you know. [WLEH 15]

Support workers tried to help clients wherever possible, but due to masking and distancing they were often positioned at opposite ends of rooms and tables from one another. This made relationship-building with WLEH clients difficult. Helping women to get access to supports like counsellors or harm reduction services, or even just helping them to fill out eligibility forms, was also fraught with challenges.

Services that had provided critically needed social engagement opportunities were among those most likely to be eliminated due to COVID-19. Even though proximity to individuals through higher-density living in the sheltering hotels increased, social isolation also increased due to the need for social worlds to be safer through masking and distancing. One woman shared that while she could now have visitors at her place, she was ‘forbidden’ to have more than three at a time.’ [WLEH 6]. Other facilities did not allow any outside visitors whatsoever, so women’s access to social connections varied by site.

In some places, meal programs were discontinued, reduced, or modified to giving clients take-away boxes to eat in their rooms, to comply with distancing protocols. These circumstances further eroded opportunities for building friendships, relationships, a sense of community and social engagement:

It’s [dinner] another line-up down the hallway with the garbage and the urine. You’re given a Styrofoam container. I’ve eaten out of Styrofoam since COVID began. I can’t remember the last time I had a meal on a plate. Pre-COVID was the last time I had a meal on my plate. [WLEH 11]

Many older women who already often had small or fragmented social networks saw them reduced further, “*In the beginning, my family weren’t sure about COVID and me living with other homeless*

people, so my daughter in-law didn't want me around for awhile, and that was very difficult on me." [WLEH 12].

Discussion and Recommendations

Although the pandemic introduced new resources (in the form of sheltering hotels) into a highly fragmented, complex, and relatively impoverished system of supports in Victoria, social and physical distancing requirements had a general, overall effect of reducing the number of available spaces, rooms, beds, and mats within facilities. Some older women experienced a reduced sense of control compared to their pre-pandemic lives and habits. Indeed, the movement of older women out of tent encampments and into sheltering hotels and other 'makeshift' spaces (e.g. event arena) was problematic for several individuals who expressed increased fear and potential for re-traumatization and violence from law enforcement, staff and other clients in cases (Burns, 2016; Casey et al., 2008). Ultimately, there seemed to be no additional accountability built in to protect some of the most vulnerable in this new COVID environment. Consequently, WLEH participants reflected a view that the newly added COVID sheltering spaces, some featuring "cardboard dividers," barely constituted a room, much less a "forever home."

In these places services were expanded in some cases and reduced in others. The staff complement featured those both old and new to the sector, and longer work hours and pressures related to COVID-19 resulted in higher burnout rates for existing service providers and peer support staff. New rules and regulations were developed to govern daily life, for example, taking meals in your room and eating off of Styrofoam plates. Restrictions on the number of friends or family one could see hindered a sense of social inclusion, belonging, and dignity. Loss of social

activities and programs promoted higher levels of anxiety and loneliness for many, ultimately affecting their emotional and mental health and behaviours. At a basic level, the sheltering hotels were further evidence of a critical system failure to help older women access the physical, mental, social, and emotional care and services needed to support their health and well-being (Burns, 2016; Canham et al., 2020).

Looking toward the future, what lessons can be learned that raise hope for system improvements to enhance the lives of WLEH in a post-COVID landscape? We argue that one large step forward would involve a recalibration or intentional recommitment to ensuring the services available are ‘whole-person’ more than system-centered (Nichols & Doberstein, 2016; Grenier, 2022). Improved access to episodic and ongoing trauma-informed and culturally sensitive training for staff can help to build capacity when it comes to the provision of compassionate, equitable and ethical care that also aims to protect workers themselves from burnout (Casey et al., 2008; Nichols & Doberstein, 2016; Schwan et al., 2020). Such a reimagining would ideally bring new infusions of resources into the system. There is no time to wait, so efforts must also be directed at imagining and shifting how resources are currently being used (Chaland, 2021; Nichols & Doberstein, 2016).

Shining a light on older women’s stories is critical to help them to be more visible in the HS/VAW system. A positive of COVID-19 was that it revealed potential, and willingness, among many organizations to work together in the face of an unprecedented emergency. While lack of housing and services can be viewed as part of an ongoing crisis, the system (HS/VAW and allied supports) needs to capitalize on opportunities for improved integration and coordination at a minimum (Chaland, 2021; Nichols & Doberstein, 2016).

Historically, the needs of older women who are unhoused have been poorly understood and consequently, their needs have gone largely unmet (Flike et al., 2023; Milany et al., 2020). Whether living with housing insecurity or not, every woman needs to have a sense of choice and control over their own destiny, to the extent that is possible. Increasing the availability of purpose-built, affordable housing stock is paramount, but repurposing existing housing stock should also be considered wherever possible to address immediate and longer-term needs. Supports must consider the specific needs of older women with complex comorbidities and their physical, mental and spiritual health challenges. System transformation can be possible but requires the HS/VAW sector to work together and to avoid being pitted against one another in the quest for scarce resources.

What if sheltering hotels could be refurbished to become a new, home-like housing model designed specifically for and with WLEH to address their specific needs based on co-morbidities, physical mobility challenges, and brain injury due to violence? These purpose-built environments could have communal kitchens for eating and cooking, as well as small, galley kitchens for cooking at home. They could feature multipurpose common rooms for crafts and socializing that could facilitate engagement and community-building in a manner that resonates with older women. These are just simple examples of supports that have been identified in nascent literature for housing models for women and gender-diverse people which foreground the importance of relationships for personal healing and social connectivity (Sagert, 2017; van Berkum & Oudshoorn, 2015; Vaccaro & Craig, 2020). While these models are informed by intersectionality considerations, older age typically represents an under-studied identity category within research on women's housing. Our analysis highlights the imperative of expanding age and gender-sensitive

housing models, which remain overlooked by decision-makers, in ways that are safe and inclusive for older women who often hold intersectional identities arising from the pathways into homelessness and experiences surrounding housing insecurity.

Conclusion

The reasons why older women with lived expertise of homelessness experience housing insecurity and poor health outcomes have much to do with intersections of past trauma, interwoven with complex health and financial challenges at the individual level, as well as manifold challenges at the system level. This emphasizes the inadequacy of current resources, and the poorly integrated and coordinated nature of the services currently available (Nichols & Doberstein, 2016). Arguably, the system fails to look at individuals sufficiently in whole-person, rather than system-centered ways.

Beyond the HS/VAW system, long-standing structural barriers rooted in poverty and trauma, as well as historical disadvantages (e.g. wage inequities, child and eldercare responsibilities, lack of adequate pension plans), require sustained attention, intervention and action (Darab et al., 2018; Farha & Schwan, 2020; Schwan et al., 2020). While COVID-19 intensified many long-standing deficiencies research and practice-based knowledge is demonstrating that systemic change is possible and lessons from local, national and international case studies can, and must be mobilized, to prioritize transformative system level integration and coordination (Nichols & Doberstein, 2017 and Falvo, 2020). It is hoped that system renewal is possible from the ground up, and that healing from trauma, and exits from homelessness for WLEH are not just pipe dreams but real opportunities near at hand. An improved HS/VAW system should never lose sight of

the diverse people it serves. In the spirit of dignity, belonging, and resilience, some degree of choice and control is not only necessary, but critical for older women with lived expertise of homelessness to live and flourish.

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CHAPTER THREE

Developing a Safer Drug Use Space During the Pandemic at YWCA Hamilton

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Abstract: Across Canada, fatal drug poisonings increased during the pandemic. This was caused by several factors, including the increasing toxicity of an unregulated drug supply, more people consuming drugs alone because of physical distancing, and limited access to harm reduction supports. At YWCA Hamilton, there was a sharp rise in drug poisonings in our overnight drop-in space and our transitional living program serving women, trans, and non-binary people experiencing homelessness. Many women we supported and cared about passed away from fatal drug

poisonings in the community during the pandemic. In response to our collective grief, YWCA Hamilton, the Hamilton Social Medicine Response Team, and Keeping Six partnered to develop a Safer Drug Use Space integrated into an overnight drop-in space at YWCA Hamilton. During the pandemic, the federal government opened a new avenue for community organizations to operate safe consumption spaces called ‘Urgent Public Health Needs Sites’; we were designated a UPHNS in April 2022. This chapter will explore our key lessons learned during our first year of operations. We will reflect on what it has meant to work together across the housing and health sectors, and in collaboration with people who use drugs, to design, open, and operate this life-saving service. We will reflect on our approach to harm reduction and safer use for women impacted by homelessness and violence and offer pragmatic information about our program model to inform future iterations of this approach in gender-specific shelters and drop-ins across the country.

Ethics Statement: An ethics review was not needed for this chapter because it was not a research paper.

Conflict of Interest Statement: All of the authors for this chapter are employed by the organizations that have partnered to found and run the Safer Drug Use Space at YWCA Hamilton (YWCA Hamilton, HAMSMaRT, Keeping Six).

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Introduction

Canada is going through a toxic drug¹ crisis,² which has coincided with and been exacerbated by the COVID-19 pandemic in various ways (Ontario Drug Policy Research Network, 2020). In particular, periods of government-mandated closures and physical distancing requirements have resulted in lasting, troubling outcomes for people who use drugs and experience homelessness. These outcomes include loss and limiting of social and healthcare supports, isolation, and increased contamination of the street-based, illegal drug supply due to shipping interruptions (Gomes et al., 2021; Gubskaya et al., 2023). This in turn has led to an increased visibility of homelessness and substance use in communities across the country, as well as a surge in drug poisonings³ (Gubskaya et al., 2023; Lew et al., 2022). Consequently, the federal government opened an exemption pathway under the Controlled Drugs and Substances Act called an “urgent public health need site” (UPHNS), allowing for the creation of additional spaces for safer substance consumption (Government of Canada, 2022).

This chapter focuses on the opening of an overdose prevention site through the UPHNS exemption pathway during the COVID-19 pandemic in a low-barrier overnight drop-in and transitional living program for women and non-binary people in Hamilton, Ontario. Throughout this chapter, we bring in the perspectives of the three collaborating partners, YWCA Hamilton, Keeping Six Hamilton Harm Reduction Action League (Keeping Six), and the

1. The words “drug” and “substance” are used interchangeably throughout this chapter.

2. This crisis is commonly referred to as an “opioid crisis.” However, we use the term “toxic drug crisis” in this chapter because approximately half of drug poisonings involve both opiates and stimulants, and the street-based drug supply is becoming increasingly unstable over time (Public Health Ontario, 2020).

3. We will be using the term “drug poisoning” rather than overdose in this chapter to reflect the toxicity of the drug supply (Public Health Ontario, 2020).

Hamilton Social Medicine Response Team (HAMSMaRT) to tell the story of how our Safer Drug Use Space was conceived at the height of the COVID-19 pandemic.

We begin by providing brief overviews of the work each collaborating partner engages in, as well as the expertise and resources they bring to the Safer Drug Use Space. We outline the feminist harm reduction perspective and practice we bring to this work and describe the Safer Drug Use Space's daily operations. We conclude with a reflection on some of the key lessons we have learned about running a safe consumption program for women and non-binary people integrated into a low-barrier overnight drop-in program during a pandemic. We hope that by speaking to our experience, other organizations that support women and non-binary people who use drugs and experience homelessness may have a model to follow to open similar life-saving programs. Furthermore, our story illustrates how it is vital that programs like the Safer Drug Use Space exist for women during extreme events when access to social services and healthcare supports are limited.

Substance Use and the COVID-19 Pandemic

At the beginning of the COVID-19 pandemic, we saw high rates of drug poisoning among the people we support at YWCA Hamilton's Transitional Living Program and the overnight drop-in program, Carole Anne's Place. When businesses, health services, and social service organizations closed to walk-in traffic and "non-essential" work, people who did not have a permanent home experienced a drastic decrease in the number of spaces they could access for support (Lew et al., 2023).

Furthermore, we were all directed to stay away from other people

for our safety. This mandate exacerbated the fraught situation people deprived of housing found themselves in, particularly if they used illicit substances. Due to the unregulated and unpredictable street supply, it can be quite dangerous for people to use their drugs by themselves (Bardwell et al., 2021). If you cannot be sure what is in your drugs, it is hard to gauge consistently how much you can use safely (Canadian Community Epidemiology Network on Drug Use, 2023). For example, sedatives like benzodiazepines and xylazine are increasingly being found in fentanyl and methamphetamine sold on the street (Canadian Community Epidemiology Network on Drug Use, 2023). On top of this, the criminalization of drug use forces people to use quickly and alone for fear of attracting legal trouble. If a person uses alone and there is a sedative in their drugs they had not meant to ingest, they could become unconscious and vulnerable to violence and/or theft (Bardwell et al., 2021).

Health Canada set up a process that allowed provinces and territories to issue exemptions for shelters and other organizations to establish “*urgent public health needs sites*” (UPHNS), otherwise known as overdose prevention sites, to help communities respond to the ways the COVID-19 pandemic and the opioid crisis were compounding with each other (Government of Canada, 2022). The main difference between an overdose prevention site and a consumption and treatment service is that a consumption and treatment service receives provincial funding to operate. The application process is far longer and more involved than with overdose prevention sites, which are usually grassroots-run initiatives (Ministry of Health and Long-Term Care, 2018). The UPHNS pathway allowed YWCA Hamilton, HAMSMaRT, and Keeping Six, with support from faculty and students in McMaster University’s School of Social Work, to mobilize quickly to open an overdose prevention site at the YWCA’s downtown location.

Working Together Across Women's, Healthcare, and Drug User-Led Organizations

YWCA Hamilton, Keeping Six, and HAMSMaRT have united in shared grief caused by the rising death count in our community of women and non-binary people experiencing homelessness and using drugs. Each partner has a distinct lens, approach, and analysis that they bring to this work. These different perspectives, knowledge, and approaches are what have made our Safer Drug Use Space what it is today.

1. YWCA Hamilton

YWCA Hamilton is well-known for its commitment to supporting some of the most underserved populations in Hamilton. This is achieved through operating from a low-barrier, trauma-informed, anti-racism/anti-oppression, feminist framework. Their mission is to strengthen women's, girls', and non-binary people's voices, broaden their choices, and provide essential and meaningful services that promote safe and equitable communities. As an organization, YWCA Hamilton is also deeply engaged in advocacy work around the issues most pressing for women, girls, and non-binary people in our community, including affordable housing, ending gender-based violence, reproductive justice, supporting women and non-binary people impacted by substance use, involvement with the criminal justice system, and homelessness.

2. HAMSMaRT

HAMSMaRT is an organization of healthcare providers and community organizers working to integrate clinical practice, critical analysis, and political action. They are an interdisciplinary outreach team providing community-centred care to people for whom conventional health service models present too many

barriers to access. They dream of healthcare that is a liberatory force for patients, practitioners, and communities alike and are guided by the core principles of community-centred care, reciprocal learning, harm reduction, and building the community we want to live in.

Many of the patients served by HAMSMaRT are part of the YWCA community and access services, supports, and housing through the YWCA. Knowing firsthand the challenges facing women and non-binary people who use drugs and experience homelessness, HAMSMaRT was thrilled to join the YWCA in launching the Safer Drug Use Space. HAMSMaRT works closely with Keeping Six and knows that people with lived and living experience of substance use respond to the vast majority of overdoses in their communities, and have a depth of experience unmatched by healthcare and social service providers without lived experience (Boilevin et al., 2019).

3. Keeping Six

Keeping Six is a community-based organization that is run by and provides support for people with lived and living experience of substance use. Keeping Six also engages in activism and advocacy within the broader Hamilton community. Keeping Six trains and oversees peer support staff at the Safer Drug Use Space because they believe it is integral for people with lived experience of substance use, in whatever capacity they are able, to be a part of the creation, planning, implementation, and practice of any harm reduction programming. Having peer support staff at the Safer Drug Use Space who know what it is like to navigate systems of care in Hamilton as a person who uses drugs helps us all expand our knowledge around safe substance use practices and plays a critical role in building trust with guests.

Our value-based framework for the Safer Drug Use Space

At the core of all feminist anti-violence work is the assertion that everyone has the right to safety (Bennett, 2012). From our perspective, the right to safety includes the right to use drugs safely, in safe consumption programs, with trauma-informed supports in place. Therefore, as feminist leaders in the community, we sought to develop the second gender-specific overdose prevention site in Canada, and the first program to be integrated into an overnight drop-in space or shelter in Hamilton.

The Safer Drug Use Space is operated through an intersectional feminist lens, with an understanding that the health and social care needs of women and non-binary people who use drugs are uniquely impacted by gender as well as by other facets of their identities (Austin et al., 2023). Women and non-binary people, especially those who experience multiple forms of health and social inequity, are differentially impacted by drug-related risks and harms in comparison to men who use drugs. This includes an increased risk of gender-based violence while using, unique health concerns caused by using, and different ways of engaging in their own harm reduction practices to keep themselves and the people around them safe (HIV Legal Network, 2020).

YWCA Hamilton is a distinctly feminist organization, but the political lenses and organizational values of HAMSMaRT and Keeping Six also have a tremendous influence on our gender-specific approach, shaping the ways in which we come together to offer life-saving services to women and non-binary people. HAMSMaRT believes that health is political and that it is an inherent part of the job of healthcare providers to be actively engaged in advocacy oriented towards change. Their political work became

increasingly visible during the pandemic. As an organization, HAMSMaRT has had a strong voice in local encampment advocacy (The Hamilton Social Medicine Response Team, 2022) and helped to organize testing for COVID-19 in emergency shelter settings, as well as vaccination clinics for populations experiencing barriers to access. Their commitment to the intersection of health and advocacy work promotes a framework for providing community-based responses to the toxic drug epidemic.

Keeping Six champions the importance of meaningfully involving people with lived experience in the design, development, and operation of harm reduction services and supports. Through this lens, we have all learned more about the inherent value and knowledge that people who use drugs can bring to service delivery and advocacy work, if their participation is meaningful and equitable.

A Gender-Specific Approach to Harm Reduction

Traditionally, research on substance use has been narrated through the male perspective and drug policies and harm reduction services developed across Canada in response to the toxic drug epidemic have largely remained gender neutral (Xavier et al., 2021). Taking a gender neutral approach has meant that policies and programs have been designed, developed, and evaluated according to the needs of men who more “visibly” experience homelessness and drug poisonings (Xavier et al., 2021).

Harm reduction services can inadvertently exclude women if social determinants of women’s health, including poverty, violence and trauma, pregnancy and mothering, and social policies surrounding sex work and housing are not accounted for and integrated into service planning, delivery, and evaluation (Hovey

et al., 2020; Jean Tweed Centre, 2013). Furthermore, limited attention has been paid to the ways women who use drugs access services, curtailing the development of gender-informed, culturally safe, and trauma-informed harm reduction services. As a result, the needs of women who use drugs have not had a prominent influence on shaping harm reduction research, policymaking, and on-the-ground practices and services (Austin et al., 2023; Xavier et al., 2021).

Using an intersectional framework to develop and run the Safer Drug Use Space has been paramount to our approach, especially during the COVID-19 pandemic which further intensified gender, racial, disability, and socio-economic inequalities (Lew et al., 2022; World Bank Group, 2020). Responding to the pandemic amidst the intersecting housing and toxic drug crises has required a deep understanding of what is happening for the people we support and the contexts of their lives.

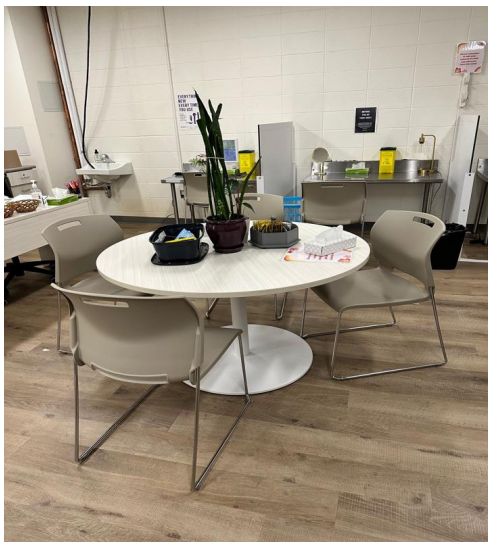
1. Gender and program operation

Since first opening the program, we have strived to develop a staff cohort that reflects the diverse identities of the women and non-binary people we serve in the Safer Drug Use Space. Crucially, women with lived/living experiences of substance use are key members of our team. Building on shared aspects of identity and experiences has allowed our team to build trust and connection with people who have largely been excluded from mainstream health and social services.

Having a space oriented towards allowing for sharing and mutual comfort-seeking with peers has been communicated to us as a vital need for women and non-binary people accessing harm reduction support. With this in mind, we have intentionally designed the Safer Drug Use Space to function like a “*living room*”

(Atira Women’s Resource Society, 2021). We have three reclining chairs people can use to “chill out” post-use while staff monitors them. In the centre of the room, there is a round table with chairs used by staff and guests for art work, crafts, eating, connecting, and socializing.

Figure 1. SUS Activity Table and View of Using Stations



Our room is designed to be accessible to people using wheelchairs and walkers, with plenty of space around the designated tables where people can prepare and use their drugs. The furniture can also be easily rearranged to serve the unique needs of people in the space. The tables are stainless steel, so they can be easily disinfected, and mirrors and lights help people see the areas on their body where they will be injecting. Only two people can use at a time because, with two staff and two oxygen tanks, we only have the ability to respond to two drug poisonings at once.

Figure 2. Using stations at SUS



We hang a red dress in our space as a reminder of the missing and murdered Indigenous women and girls across the country, as well as those in our own community. Urban Indigenous women are disproportionately represented in the population of people who access the Safer Drug Use Space, and many guests have spoken to staff about their experiences of disconnect from their culture. This is a purposeful consequence of colonization (Canadian Aboriginal AIDS Network, 2019). Our intention is to reflect on the Calls for Justice in the National Inquiry into Missing and Murdered Indigenous Women and Girls final report (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019) and to incorporate these actionable teachings into our program model and advocacy work.

In addition to supporting women and non-binary people to use substances safely, the Safer Drug Use Space offers support around issues relating to gender-based violence, reproductive health and pregnancy, survival sex work, and loneliness and isolation.

Responding at the intersection of these unique needs has allowed for the development of gender-specific, trauma-informed, and political harm-reduction services that are responsive to the unique needs of this population.

2. Gender-based violence support

Violence in the context of relationships escalates during pandemics because of economic stress and social isolation. As societal systems break down under pressure, there is reduced access to services and/or the inability to escape abusive partners (World Bank Group, 2020). At the onset of the COVID-19 pandemic, when people were asked to stay at “home”, gender-based violence and exploitation increased, particularly in the context of intimate partner relationships and familial systems. Many shelters serving people fleeing gender-based violence were forced to limit their capacity due to social distancing and staffing shortages. This meant that some people attempting to flee gender-based violence were unable to do so (Canadian Women’s Foundation, Gendered Impacts of Coronavirus, 2020).

As the Safer Drug Use Space is one of the only services open overnight downtown, our program has become a first point of connection for people who experience physical and/or sexual violence. We maintain a close relationship with the Sexual Assault Centre of Hamilton and Area (SACHA), and make referrals to other community-based anti-violence supports for women and non-binary people as needed.

3. Pregnancy and reproductive health support

Societal stigmatization of pregnant people and mothers who use drugs prevents birthing people from talking honestly about their drug use (Jean Tweed Centre, 2013). Consequently, this population

tends to use drugs in hidden and unsafe spaces. Key reproductive health services were also disrupted by the massive shift in resources that addressing the pandemic demanded of our healthcare systems (World Bank Group, 2020). At the Safer Drug Use Space, reproductive health supplies, including Plan B, Canesten, and prenatal vitamins, are always available for guests on the spot. Relatedly, we continuously stock safer sex supplies since we have intentionally designed our program to offer these supports for people who engage in sex work and use drugs. Staff also provide referrals to other supportive organizations in Hamilton, including the Sex Workers' Action Program (SWAP).

4. Isolation support

Beyond being a program for women and non-binary people to use their drugs, guests come to the Safer Drug Use Space to feel connected to their community. The pandemic created a context wherein people who were already excluded from many areas of society were further distanced from their tenuous connections with community and health services (Lew et al., 2022). A purposeful part of our work is to ensure guests know that we are ready to have a kind conversation or make a warm referral so people do not feel alone in their struggles. Since our first day, we have kept art supplies on hand for anyone who wants to express themselves artistically or just wants some calm time with company.

Figure 3. Our ongoing, collaborative mural project.



Daily Operations of the Safer Drug Use Space

The Safer Drug Use Space is located inside Carole Anne's Place, the low-barrier overnight drop-in program operated by YWCA Hamilton. We open our doors every night at 10:00 p.m. On a typical night, we have one or two YWCA Harm Reduction worker(s) and one Keeping Six peer support staff on shift. Program statistics and “need to knows” are communicated daily in an emailed shift report, sent to management and all staff. When someone is new to the space, staff go through our consent form with them. A “code” is assigned to each guest using the first two letters of their first name, the first two letters of their last name, and the last two numbers of their year of birth (e.g., the code for Jane Smith, born in 1979, would be JASM79).

We see an average of 16 visitors per night and have served approximately 230 unique guests. To date, staff have responded to 63 drug poisonings and made three calls to EMS, with zero transfers to hospital. Reasons for visiting the Safer Drug Use Space

vary; many people come in to use the stations to inject or snort drugs and then stay for monitoring, while others are monitored after smoking their drugs outside. People visit to talk to staff, grab snacks, or receive first aid, hygiene, and reproductive health supplies. When someone stays to use their drugs in the Safer Drug Use Space, staff document their guest code, what supplies they request, the substance(s) they are using, and the amount. We keep track of the supplies people use so we know what we need to order and to update public health. Staff do a “last call” for use approximately one hour before the program closes to give people enough time to use their substances and be monitored without rushing. Our current hours are 10:00 p.m.-5:00 a.m. and then 10:00 a.m.-1:00 p.m. as of May 2023.

Reflections and Lessons Learned

1. A trauma-informed response to drug poisonings in a community-based setting

The most important lesson we have learned is that a community-based approach to the toxic drug epidemic is possible. At a time when our hospitals were overburdened and our healthcare system was experiencing increasing strain due to the COVID-19 pandemic, care for people who use drugs was transferred to community-based supports. People who experience overdoses and drug poisonings do not always need to be cared for in healthcare settings; in fact, being cared for in the community by the community can be a trauma-informed approach to supporting people who use drugs.

Our approach to responding to drug poisonings in a community-based setting is unique in that we do not have healthcare professionals on staff. Rather, we work under a medical directive

provided by a doctor from HAMSMaRT. We require the medical directive because a key element of our program is the use of supplemental oxygen as our first response, rather than naloxone. Offering supplemental oxygen in a comfortable, community-based space is a critical part of a trauma-informed drug-poisoning response. It is a relatively gentle intervention that allows tissues to get sufficient oxygen and stimulates a patient to become more alert without abruptly putting someone into withdrawal the way naloxone does (Facher, 2023) or relying on Emergency Medical Services (EMS) and transfer to the hospital. In Ontario, the Regulated Health Professions Act, 1991 (RHPA) designates oxygen administration as a controlled act, or an act that may only be performed by authorized, regulated health professionals. A physician can delegate this act to be performed under their license by a person who is not a health professional using a medical directive that outlines the specific circumstances and steps to be taken to administer supplemental oxygen. The College of Physicians and Surgeons of Ontario's Delegation of Controlled Acts policy lays out the requirements for doing this (College of Physicians and Surgeons of Ontario, 2021).

The Safer Drug Use Space directive was modeled on a similar medical directive from Parkdale Queen West Community Health Centre. They graciously shared their policies, procedures, and directives with us, along with other resources and training materials. Physicians from HAMSMaRT adapted the directive to our context and then trained SUS staff on drug poisoning response and oxygen administration. All Safer Drug Use Space staff must be trained annually, and the medical director must sign off on staff administering oxygen under her medical license. Together, we are repatriating healthcare back to the community.

2. Cooperation across sectors can bring about innovative responses to public health crises

The planning and continued operation of the Safer Drug Use Space have brought together three unique partners. This partnership has been possible due to the unprecedented level of collaboration and coordination between health and social services during the COVID-19 pandemic (Salazar, 2023; Zafar, 2021). Our approach to this work is informed by YWCA Hamilton's commitment to intersectional feminist leadership in the areas of anti-violence work, the commitments of HAMSMART to the idea that health is political, and the meaningful involvement of people with lived and living experience of substance use, championed by Keeping Six. Together, we have worked to adapt our service model to the changing contexts and needs of Safer Drug Use Space guests.

For example, in our first year of operation, the changing drug supply led to more drug poisonings complicated by non-opioid sedatives and prolonged periods of decreased consciousness. Guests accessing the Safer Drug Use Space were clear they wanted to avoid a call to EMS and a transfer to the hospital as much as possible; however, we aren't equipped to perform a full medical evaluation for decreased consciousness to rule out other life-threatening causes like low blood sugar, septic infection, or head injury. The medical directive has been adjusted to allow for a period of enhanced monitoring in the case of drug poisonings where someone is breathing effectively but not yet alert, while ensuring that people who are totally unresponsive or are not improving within a specified timeframe are transferred to a higher level of care.

3. A model for supervised consumption programs integrated into places where women live

Finally, we have learned how valuable it is for women and non-binary people to have supervised consumption programs integrated into the settings where they live and/or sleep. In this chapter, we talked about intersecting factors that can increase women's and non-binary people's vulnerability to violence and coercion. Since the downtown YWCA is one of the only spaces open at night to support women experiencing homelessness in Hamilton, the building itself and the area surrounding it have become a hub of sorts for the community to access crucial supports overnight. Moreover, since most drug poisonings occur where people live (MacKinnon, 2020), the ability of Safer Drug Use Space guests to not hide their substance use and have the time to use around people they trust to care about them has contributed to a marked decrease in the number of drug poisonings staff respond to inside and outside of the building (Beattie, 2023).

Final Thoughts

Over the past year of operating the Safer Drug Use Space, we have learned many lessons together. These lessons have helped us refine our service approach and build a compassionate and caring model as we navigate new terrain. This model, which we continue to adapt, is unique and tailored to meet the needs of the people we serve at the Safer Drug Use Space. Our staff engages in continuous team and capacity-building activities to ensure we are facilitating a space where people can let their guard down and feel connected to the community, particularly because opportunities for connection were so few for people without access to many resources at the height of the COVID-19 pandemic.

We have created a space where people who use drugs are supported with dignity and care. We would love for our Safer Drug Use Space model to inspire other organizations or coalitions to open safe consumption programs for women and non-binary people that respond to their unique needs. Moreover, we hope our story demonstrates how essential it is for us to collaborate across sectors to address complex issues in our communities during large-scale public health emergencies like pandemics.

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Section One: Populations

CHAPTER FOUR

Endaayaang Indigenous Housing First for Youth: Exploring Service Provision and Planning During the Global Pandemic

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Abstract: Endaayaang is an Indigenous-led Housing First for Youth program. The program is guided by Elders and Traditional Knowledge Keepers along with a strength-based strategy, collectively working to help Indigenous youth remain housed. A major component of the program supports youth's (re)connection with their Indigenous identity, facilitated through traditional teachings and ceremony, and the building of relationships with Elders and Traditional Knowledge Keepers. Drawing from the narratives of eleven Indigenous youth as well as two service-provider interviews, this chapter explores the ways the COVID pandemic impacted them as they navigated the Endaayaang program. In addition to the thirteen interviews, this chapter uses archival data collected from the Endaayaang research team's virtual meeting minutes from 2021 to 2023 to recount the challenges and benefits Indigenous programs such as Endaayaang experienced during the COVID pandemic. The chapter uses Endaayaang as a case study, highlighting how Elders and service providers learned to adapt ceremonies and other Indigenous-specific programming in virtual spaces to support Indigenous youth while offering important lessons learned as they relate to young Indigenous people experiencing homelessness.

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Ethics Statement: This book chapter used interviews and narratives related to the "*Journey to Reconciliation: Indigenous Perspectives on Homelessness Prevention*" study. Certificate number is #2023-177 and was approved by York Office of Research Ethics. Youth who participated in the study received an honorarium of \$50 for their time and were recruited through their participation with Endaayaang, a program that sits in the Hamilton Regional Indian

Centre (HRIC) organization in Hamilton, Ontario. Endaayaang's program staff and Elders did not receive an honorarium for the time dedicated during the research process. Informed consent was obtained for each interview conducted by the Canadian Observatory on Homelessness (COH) research team. Each interview was recorded and transcribed and stored by COH.

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Endaayaang, an Ojibwe word meaning a safe place where your heart/spirit feels at home, is supporting youth with feeling at home by facilitating the connection to community, relationships, traditions, culture, identity, family, and belonging. Together, we are paving the way with a unique perspective to end youth homelessness; by addressing the needs of Indigenous youth with a cultural and community-driven focus, we aim to assist young people to learn the tools and skills necessary for becoming successful adults. (Green et al., 2018)

Introduction

Endaayaang is an Indigenous Housing First for Youth (HF4Y) program offered through the Hamilton Regional Indian Centre (HRIC) in Hamilton, Ontario. Endaayaang is located on the traditional territory of Anishnaabe, Erie, Neutral, Huron-Wendat, Haudenosaunee, and Mississauga Nations, protected by the Dish with One Spoon Wampum Agreement. Endaayaang is an Indigenous-led

program that foregrounds Indigenous Knowledges and principles to address youth homelessness, and as such, Endaayaang integrates ceremony, teachings, land gatherings, and other culturally-specific activities into its short and long-term objectives. Acknowledging that multiple factors can influence Indigenous youth homelessness, Endaayaang's primary mission and values are interconnected with the promotion of self-empowerment amongst Indigenous youth to find their way home. As such, programming includes support for Indigenous youth to begin to heal from known and unknown traumas, with hopes of helping them (re)connect to their Indigenous cultures and identities if they so choose (Green et al., 2018).

We begin this work by acknowledging the significant impacts that COVID has had globally. In Canada as well as other countries, many face-to-face interactions were restricted in March 2020, and this practice continued well into 2022 (Canadian Institute for Health Information, 2022; Naidoo et al., 2023). During this time, the ongoing impacts of colonialism became even harder to ignore for many Indigenous communities across the country (Patel et al., 2020; Wong, 2021; Richardson & Crawford, 2020). For example, Heck et al. (2021) draw attention to the fact that even pre-pandemic, some Indigenous families and communities were already experiencing “housing and water infrastructural issues [making it] difficult to adhere to public health guidelines regarding physical distancing and handwashing” (p. 382). Such disparities deepened in many of these communities due to the widespread health and economic crises created by the pandemic and restrictions (Heck et al., 2021). Specific to Indigenous spaces like Endaayaang, the COVID safety protocols resulted in a loss of fundamental in-person and on-the-land cultural gatherings.

This work contributes to a conversation that shifts our understanding beyond respecting differences. It draws attention to the importance of Indigenous Knowledges and cultural practices. When addressing Indigenous youth's housing needs now as well as during times when crises became compounded, for example, as youth navigate homelessness during a pandemic. This chapter concludes by offering lessons learned through Endaayaang's necessary adaptations to provide culturally-based programming during the pandemic. These lessons support the need to shift institutional responses to youth homelessness from relying on emergency services to a human rights-based approach that places the specific needs of Indigenous youths at the forefront of homelessness programming and support (Baba, 2013).

Background on COVID in the Indigenous Context: Colonialism as a Determinant of Ongoing Health Inequities for Indigenous Peoples in Canada

In this chapter, we use the term 'Indigenous' to refer to cultural groups (First Nations, Metis, and Inuit Peoples) across the country. The term Indigenous acknowledges the commonalities and the diversity of cultures, histories, teachings, languages, and experiences that comprise the Indigenous population worldwide (Stewart, 2018). In the context of this study, Indigenous youth within the Endaayaang program are between the ages of 16 and 24 (COH, 2016).

Indigenous Peoples have carried a heavy burden of infectious disease since European contact (Hillier et al., 2020). Colonialism, as an Indigenous social determinant of health (Greenwood & de Leeuw, 2012), with its many brutal historical and ongoing strategies, has had a lasting impact on Indigenous People's health in

general (Czyzewski, 2011; Greenwood & de Leeuw, 2012; Smylie & Firestone, 2016) through the unequal distribution of wealth and poverty, compounded by intergenerational trauma, systemic racism, and structural violence (Raphael et al., 2020; Metzl & Hansen, 2014; Metzl et al., 2020). This leads to an increased susceptibility to chronic and infectious diseases, which can increase the overall burden of illness.

COVID & Indigenous Communities

When viewing health through the lens of social and structural factors (Fournier, 2021), it can be observed that they contribute to deep and ongoing health inequities for Indigenous Peoples (Butler-Jones & Wong, 2016; Leach, 2023; Singu et al., 2020). A report authored by Courtney Skye (2020) at the Yellowhead Institute at the Toronto Metropolitan University in Toronto, Canada, asserts that the reported number of COVID cases amongst Indigenous communities has been misrepresented and, therefore, the impact of COVID on Indigenous communities might be greater than provincial and federal public health data suggests. One of the issues Skye (2020) highlights is that much of the public health data collection does not disaggregate data based on Indigenous identity, so the actual number of COVID cases and the impact on Indigenous communities may not be accurately represented.

However, in a recent study, Hillier and colleagues (2020) argue that Indigenous Peoples fared better than other racialized populations throughout the COVID pandemic because Indigenous communities asserted their authority when dealing with the COVID virus, including when creating their own public health orders such as restricting travel through their territory, adapting their ceremonies, and intensifying public health campaigns. These actions must be recognized as an expression of Indigenous nationhood and a

continued assertion of sovereignty. These community-led actions have, in part, led to a less severe impact of COVID on Indigenous communities when compared to the general public. The assertion of Indigenous sovereignty is essential for efficient healthcare development for Indigenous communities in Canada (Hillier et al., 2020). Other scholars clarify that regardless of the number of COVID cases, Indigenous communities are best positioned to make policies and laws in response to COVID as they are intimately aware of their community needs (Flood et al., 2020). While focusing only on First Nations communities, Flood et al., (2020) suggest that the provincial and federal governments must work with Indigenous communities on COVID-related interventions, including emergency preparedness, as this is a critical aspect of furthering Indigenous self-determination and improving the health of Indigenous Peoples at a broader level (Auger, 2016; Petrov et al., 2023; Richmond et al., 2021).

Concurrent with pandemic restrictions and the lack of access to basic public health measures, such as clean water, faced by some Indigenous communities in Canada (Bui, 2020; Beaudoin, 2021), COVID restrictions also had major implications for Indigenous ceremonies (Fournier, 2021). They resulted in a lack of access, or unpermitted access, to in-person gatherings such as healing ceremonies (e.g., the sweat lodge) and Elders' teachings, which are usually done in person. Indigenous healing ceremonies are essential to health care for many Indigenous Peoples (Eneas, 2020). Fournier (2021) argues that these restrictions are evocative of colonial-era restrictions such as the banning of Indigenous healing ceremonies and therefore can engender deeper harms as they are reminiscent of a brutal past (see also Eneas, 2020).

Historical and Social Context of Indigenous Peoples and Homelessness

Given the historical and social context of Indigenous homelessness, Indigenous leadership and governance are fundamental to Endaayaang. Endaayaang's focus on Indigenous-led programming is crucial for varying reasons. First, Indigenous youth's mental health has been profoundly impacted due to historical factors related to colonization, such as child welfare apprehension, the Sixties Scoop, residential schools, and intergenerational trauma (Sinclair, 2016; Stewart, 2018). This may explain the overrepresentation of Indigenous youth among the homelessness youth populations across the country (Barker et al., 2014; Kidd et al., 2019). Further, Indigenous youth who remain unhoused are more vulnerable to violence and incarceration and are at an increased risk of becoming involved in human trafficking (Kidd et al., 2019).

Although certain events, such as Elders' teachings and support, were eventually adapted to online spaces, the transition to doing virtual ceremonies was difficult and fraught with concerns over putting sacred ceremonies in online spaces (Wilson, 2021). For example, one Traditional Knowledge Keeper at Endaayaang said that when he did his first sharing circle online, he found it difficult because the meeting was held on his computer and he was only able to see people's faces. Furthermore, smudging, a typical way of opening a sharing circle, could not be experienced by all. Although participants could see the smoke, they could not smell it or smudge themselves, as typically the smudge bowl is passed around to each person in the circle so that they may cleanse themselves with the smoke. The pandemic posed a potential health threat on a physical level, however, as the COVID crisis subsides, we now recognize the mental, emotional, and spiritual impacts that social distancing has had on many people across the globe.

For many Indigenous communities, traditional healing practices are a part of wellness on a wholistic level, which was compromised as a result of mandatory social distancing regulations.

The Endaayaang Program

As mentioned, Endaayaang is an intervention designed to support Indigenous youth who have experiences of homelessness/houselessness, drawing on Indigenous cultures and Ways of Knowing to guide their program model. Endaayaang builds on an existing Housing First For Youth (HF4Y) model, an evidence-informed intervention designed to support and meet the needs of youth who lack stable housing (COH, 2022). The Endaayaang program was initially developed in collaboration with Indigenous Elders, Traditional Knowledge Keepers, and Indigenous youth with lived experiences of homelessness ensuring that supports offered are central to the needs of Indigenous youth (Fournier et al., I press). Endaayaang combines Indigenous Knowledges with the HF4Y core principles, specific to Indigenous youths' needs:

- 1.** The right to housing with no preconditions (such as abstinence or mandatory participation in school)
- 2.** Youth choice, youth voice, and self-determination
- 3.** Orientation toward positive youth development and wellness
- 4.** Reinforcing individualized client-driven supports, social inclusion, and community engagement, with no time limits
- 5.** Social inclusion and community integration (Gaetz et al., 2021).

Combining Indigenous cultural knowledges with the HF4Y model ensures that Indigenous youth are meeting their housing needs

and are connected to necessary programs to enhance their overall well-being. Endaayaang is unique in its support for Indigenous youth as its programming rests on the awareness that Indigenous Knowledge and Ways of Knowing are culturally diverse, as are their definitions of homelessness and houselessness (Thistle, 2017). Although First Nations, Métis, and Inuit cultures differ in many ways, their meanings and understandings of the home remain similar (Thistle, 2017). Endaayaang builds on the commonalities between the cultures, acknowledging that home for many Indigenous Peoples is more than a physical structure with “four walls and a roof” (Christensen, 2016, p. 87; see also Thistle, 2017). In the Indigenous context, “home” can conjure images of strong cultural connections to community, ceremony, and land that result in physical, mental, spiritual, and emotional well-being (Christensen, 2016).

Indigenous Peoples and their communities have been displaced in numerous ways, as identified through the Doctrine of Discovery and the Indian Act, systematically forcing the displacement from ancestral homelands and the erasure of their identities, languages, and other sources of their cultural formations (Kidd et al., 2019). Many Indigenous Peoples feel isolated or homeless if these connections and relationships are broken or missing (see Thistle, 2017). As a result of forced assimilation policies, Macdougall (2015) explains that many Indigenous children missed out on intergenerational practices, including the practise of grandparents raising grandchildren as a way to provide children with additional teachers and help them learn their place in the world. The state described this practise as a “*fatal character flaw of families who are too lazy or disinterested to take responsibility for their own families*” (p. 196).

Macdougall argues that such practices “...of family life that made [Indigenous Peoples] healthy and whole” (p. 196) were disrupted in

brutal and violent ways (see also Naidoo, 2020). Endaayaang deliberately incorporates such holistic practices that go beyond mainstream definitions of families and communities (Heck et al., 2021) to recreate the experience of home that is meaningful to Indigenous Peoples (ASCHH, 2012; Thistle, 2017), relying on cultural practices to ground services and provide comprehensive Indigenous youth-specific care.

Research Design & Indigenous Ways of Knowing

Indigenous Knowledges encompass all forms of knowledge, including technologies (broadly defined), know-how and skills, healthcare practices, and beliefs “*that enable Aboriginal communities to achieve stable livelihoods in their environment*” (Estey et al., 2009, p. 1). In relation, this research operationalized Indigenous Knowledges by using a community-based design that centres the Endaayaang program while collaborative decision-makers maintain meaningful and ongoing engagement from Traditional Knowledge Keepers, Elders, and Healers employed by the Endaayaang program.

To best understand the lives of Indigenous youth experiencing homelessness, this research used a mixed methodological approach, with the main focus on qualitative interviews. Data was collected in 2021 and consisted of eleven in-depth interviews where Indigenous youth shared their experiences of being part of the Endaayaang program and two interviews with Endaayaang’s service providers. The narrative interviews revealed how the COVID pandemic impacted young people’s lives and resulted in various limitations in how they navigated support for securing safe and stable housing. In addition, archival data was collected from the Endaayaang research team’s virtual meeting minutes from 2021 to 2023. These meeting minutes chronicled some of the challenges experienced by Endaayaang’s service providers, the program

manager, and one Elder as they altered culturally relevant services and programs to suit the limitations of virtual spaces during the pandemic. Due to pandemic restrictions, our Endaayaang program planning and research meetings were moved to virtual spaces.

During these meetings, our team sought the guidance of Elders to remain true to Indigenous practices despite the challenges of moving to the online world. As a result, each meeting opened in ceremony, allowing each attendee to provide a personal check-in prior to the meeting agenda, and each meeting closed in ceremony as well. The meeting ceremony was led by the appointed Endaayaang research Elder and Traditional Knowledge Holder. Reviewing Endaayaang's past virtual meeting minutes was effective for building a catalogue of stories that emerged from our team circle. The adaptation of these meetings brought a sense of togetherness that seemed different from other 'business as usual' virtual meetings that were happening as a result of the pandemic restrictions. It is important to note that our meetings, although providing a more intimate space than our work meetings, created disconnected spaces for many Indigenous youth who participated in Endaayaang's programming. We are using our meeting minutes to enhance some of the stories collected from Endaayaang's youth and to deepen our empirical knowledge (Bowen, 2009).

Individual interviews lasting 30 to 60 minutes were conducted via Zoom and transcribed and analyzed using a narrative coding and thematic analysis technique developed by Stewart (2008). Before beginning data collection, the Endaayaang research team ensured that research conducted with human participants had been approved by the Ethics Review Committee at York University, and throughout the project, the research team followed York University's Guidelines for Conducting Research with People Who Are Homeless (York University, 2024). Qualitative data was

analyzed thematically using Microsoft Word. An Indigenous researcher interviewed Endaayaang youth via Zoom to respect COVID public health protocols at the time of the data collection; youth names were replaced with pseudonyms to protect the confidentiality of the participants, as anonymity is of utmost importance when completing qualitative research. Youth were recruited by Endaayaang program staff and through a flyer, created by the research team, posted at the organization.

According to Lillejord and Soreide (2003), Indigenous communities typically present cultural knowledge as stories. They explain that Indigenous Knowledges, both local and situational, are “*closely connected to culture, everyday life, and the way people perceive the world*” (p. 94). Using narrative-based interviews creates a space to capture complex situations that shape the lives of Indigenous youth and have been proven to be an inclusive method of engaging with Indigenous Knowledges. The next section will present the findings from this research. The narrative interviews revealed themes related to the impact on service provision during the COVID pandemic, as well as the impact on culture and ceremony, relationship building, and collective well-being.

Findings

1. COVID: Impacts on Service Provisions and Programming

Our findings are presented according to three key themes that emerged in our data: the importance of creating connectedness for Indigenous youth; the understanding that Indigenous youth experiencing housing insecurities are also experiencing emotional and spiritual disconnection from their meaning of home; and finally, that placing emphasis on Indigenous-led programs that centre Indigenous ceremony can have multiple benefits

for Indigenous youth experiencing housing insecurities. We argue that establishing Indigenous-led programs that address the specific needs of Indigenous youth experiencing housing insecurities from the onset (Mirza, 2021; Rumboldt, 2022) is even more valuable during times of uncertainty.

The transition from in-person to virtual programming decreased Indigenous youth participation in many of the Endaayaang's programs. One of the Endaayaang leadership team members discussed that they saw an increase in participation during the summer months since outdoor activities relieved mandated lockdown protocols, but this changed as restrictions tightened. One year after Canada's initial stay-at-home orders, program staff expressed a sense of despair, saying in a March 3, 2021 meeting, *"We are not sure what to do at this point, as [young people] prefer in-person programming. I'm not sure how to address these changes when we have specific limitations because of the pandemic"* yet they continued to do their best.

Despite enforced lockdown measures, what became apparent during this time was how most youth felt connected to Endaayaang's services and programs. When asked how Endaayaang's programming could further improve, one youth explained that the pandemic was *"a very tricky time,"* recognizing that everyone at Endaayaang did *"the best they could around COVID"* (Youth #12, 2021). The same young person emphasized that mandated restrictions benefited the collective *"because there was not a lot of contact during this time as the main focus was to keep everyone safe."* Despite enforced federal and provincial stay-at-home orders, young people were hopeful about the changes made by Endaayaang to compensate for rigid COVID restrictions. One youth said:

| *I don't think there's anything else because we also have to follow the guidelines, right? Of what the government says. It's hard to say*

what else can we do when we have a pandemic going on and lots of people getting COVID. I feel right now there's nothing else other than try to stay safe, do things virtually, like craft and stuff that [Endaayaang has] been doing... (Youth #12, 2021).

Endaayaang actively found ways to create avenues to build youth connectedness that moved beyond virtual spaces. For instance, another youth felt supported during the pandemic:

...when the pandemic hit, I guess one thing that stuck out to me, is that we started getting hampers, like food drop offs. [Endaayaang's staff] would drop off a hot meal to us ... I think every month they'd drop off a food hamper with groceries. It was really fun. It was really good actually, because I think it was around the time where it was really difficult to go outside and go shopping. [Endaayaang's staff] would drive out and drop off the food hampers (Youth #18, 2021).

These narratives by Endaayaang's program staff and Indigenous youth speak to the significance of maintaining connectedness in programming and services for young people experiencing homelessness, even in more difficult times when it may seem impossible.

Creating connectedness was a recurring theme in the data. Part of that connectedness was described as staying rooted in the program's practices while adjusting to new COVID protocols. One of Endaayaang's Traditional Knowledge Keepers said that "Since COVID, everyone is in a rush to return to normal, but as an Indigenous person, things should not go back to normal. Change doesn't always feel right, but it is for the greater good and the collective well-being" (Traditional Knowledge Holder meeting minutes, HRIC, February 9, 2022). Burnett et al. (2022) argue that disparities in mental health at large "were compounded by the ongoing COVID pandemic, leaving many to struggle with changes to routines and feelings of

uncertainty,” however, “cultural identity, connectedness, and spirituality are associated with positive mental health outcomes of Indigenous Peoples” (p. 2) and help them feel a sense of belonging. In this case, Endaayaang continued to demonstrate the principles of connectedness as a part of their programming, proving to address more than young people’s immediate housing needs. Another staff member of Endaayaang said that “holistic care for Indigenous youth persistently guides Endaayaang’s work,” even during the unpredictable moments of the pandemic. For the program directors, Endaayaang is more than a program providing wrap-around services to meet young people’s physical housing needs. Rather, Indigenous youth require services that are also culturally specific; as one program director said, “many of our Indigenous Peoples have experienced trauma. And if we’ve experienced trauma at a young age, we get stuck in a place of trauma, and it impacts our spirit, distorting or breaking the spirit altogether.” Looking at Indigenous youth holistically is imperative as it aligns with Indigenous Ways of Knowing and maintaining a sense of community as Indigenous youth move through extreme difficulties, such as the pandemic compounded with challenges of homelessness.

2. COVID: Impacts on Culture & Ceremony

Data collected from the Endaayaang program also shows that (re) connection to culture and ceremony must be included while moving Indigenous youth into safe and secure housing, connecting them to life skills and other supports to help prevent them from repeating patterns of homelessness. During COVID, the impact on culture and ceremony became increasingly apparent due to restrictions on in-person contact. For instance, one youth shared that:

Before COVID, I know that Endaayaang used to have a Knowledge Holder and once a week they would do programs at nighttime where

the youth could come in and have dinner and speak with the Knowledge Holder. I used to go to those programs because I love the teachings. Since COVID, Endaayaang and the Hamilton Regional Indian Center had only one youth and Elders gathering and I participated in that. I got to listen to different Elders every day for a week, which was really nice (Youth #3, 2021).

Many of the Indigenous cultural components offered by Endaayaang's Traditional Knowledge Keepers and Indigenous support workers were either suspended or altered to fit with the mandated lockdown protocols. However, as a Knowledge Holder at Endaayaang explains, moving ceremonial practices online was not as simple since:

Virtual circles [can be] challenging. You have to be able to feel the room.... the process of ceremony is organic and is touched with spirit and trust. It's a powerful thing, where the facilitator holds the focus, you can contain that energy. If someone is upset, you better be aware of that and help them. You must know yourself and deeply do your internal work before you can facilitate a talking circle (Traditional Knowledge Holder meeting minutes, HRIC, March 9, 2022).

Endaayaang intentionally situates its programs in culture and ceremony, which requires a "relationship of trust building" (Traditional Knowledge Holder, meeting minutes, October 26, 2022). Building trust is manifested over time and space, and online meetings may seem more operational than organic. On the other hand, Indigenous youth saw validity in offering online ceremonial programs. One young person explained the merits of online programming:

Personally, I'd like to see more ceremonies. If they had an Elder come over Zoom and they did a full moon ceremony that we can do. I know a lot of us used to go to the ceremonies before COVID and now that

it's closed, we can't really get out there, right? Coming up that we are looking forward to Pow Wow in July (Youth #3, 2021).

Another youth respondent expressed a lack of belonging due to virtual programming: *"It's kind of hard with COVID, right? Prior to COVID, I had everything because I was at the center every day"* (Youth #7, 2021). For many of the Indigenous youth, being able to participate in the cultural and ceremonial aspects of the program was essential, as it allowed them to feel anchored, even if such access was limited to online spaces:

[Endaayaang] was efficient when they were handing out crafts and stuff. Like last year, they would drop off crafts and then you'd watch them do it online and you could do it with them. There was somebody on Facebook doing some storytelling for Indigenous stories. I didn't really participate, but every once in a while I would watch the videos and stuff (Youth #17, 2021).

While in-person programming was favoured by staff, Elders, Traditional Knowledge Keepers, and youth, providing alternative modes of gathering during the pandemic helped maintain connections between Endaayaang's services and some of the Indigenous youth.

In Burnett et al.'s (2022) cross-sectional observational study measuring the cost of COVID, they found that Indigenous youth who were attached to culturally Indigenous-led programs reported feeling positive about their mental health and well-being compared to others who were detached from Indigenous services. Our data shows similarities to the Burnett et al. (2022) study, where having a sense of community corresponded with positive feelings of connectedness. A Traditional Knowledge Holder shared that for many Indigenous youth, engaging in ceremonies at Endaayaang was momentous in *"learning who they are and where they come*

from.” Thus, Endaayaang’s deliberate insertion and maintenance of various ceremonial practices on multiple online platforms helped the program remain authentic to Indigenous ways of being. A Traditional Knowledge Holder explained that it helped youth “*discover their purpose*” even during global uncertainties.

3. COVID: Impacts on Relationship Building and Collective Well-being

Endaayaang recognizes that healing for young people includes attempting to heal intergenerational trauma directly linked to historical brutalities, injustices, racism, and prejudice, as well as the multiple experiences of homelessness due to the forced displacement from their ancestral homelands (Green, 2021). As a result of homelessness, Indigenous youth are subject to constant hardship, including exploitation, violence, high rates of addiction, illness, and mortality, a higher risk of being HIV positive, participating in sex work to help them survive, and encountering the criminal justice system (Patrick & Budach, 2014).

One of Endaayaang’s Traditional Knowledge Keepers (2022) explains that working with Indigenous youth must include a heightened awareness of how past traumas continue to impact the present, and that knowing this will help build trusting relations. He advocates that for young Indigenous Peoples their realities include varying reasons that brought them to the point of homelessness, where they:

Have experienced a whole lot and maybe they did some things in the past that they are not too proud of... [it is important that mainstream] researchers engage in cultural sensitivity training. To be aware of the different needs that the Indigenous communities have and how these needs are different for Indigenous Peoples across Canada (Traditional Knowledge Holder meeting minutes, HRIC, Feb 9, 2022).

Public health guidelines that lawfully enforced either contactless or virtual services also interfered with the trust-building process that would have emerged more naturally through in-person settings than online. One youth described the active efforts of Endaayaang staff to stay connected:

Before we were able to go and have more actual contact. We'd be able to make dream catchers and stuff like that. Now because of the pandemic, I would say nothing really changed. I've been getting a lot more calls, [Endaayaang's staff] call Wellness Calls. (Youth #5, 2021).

While Youth #5 may have seemed unaffected by the shift from in-person contact to virtual, Youth #16 felt differently. When Youth #16 was asked how the pandemic affected their relationships with Endaayaang their response was:

I do feel it is harder sometimes to really connect with [Endaayaang] because they still do call me a lot and check-in. It is easier to talk face-to-face rather than on the phone all the time, because I'm with my kid a lot. I do feel like this in real life, it was easier to just go by the center and talk to them there. Obviously, it can't be like that right now because of the pandemic" (Youth #16, 2021).

Similarly, another youth responded:

It's really hard right now, just because we can't really see each other in person. I definitely feel more comfortable being at the [HIR]Center and seeing people face-to-face. I just think really having more time set out to get to know people or have some type of counselors. Or even just referrals, like if there's places that I could be referred to or informed about that" (Youth #1, 2021).

Many Indigenous youth require culturally informed care to counteract old, prescribed narratives that resulted from the "intergenerational effects of residential schools, child welfare, and

homelessness” (Ruttan et al., 2008; p. 47). Further, they found that recognizing points for establishing trust among Indigenous youth can “*activate strengths, assets, and resilience [and] can enhance positive identity and relationships*” (p. 47). For instance, Youth #16 may not have wanted to express insecurity or reveal sensitive information that may invoke fear in their child. Carving out a space at Endaayaang was important in allowing youth to express themselves in various ways, which was deemed difficult when the COVID pandemic disrupted those spaces.

Endaayaang as a program acknowledges the unspoken fears that Indigenous youth may carry, creating spaces to unpack trauma and mistrust in mainstream systems, for example, which proved to be difficult during the pandemic. As one program staff member says, we understand that Indigenous Peoples’ spirits are impacted by past and ongoing trauma that is intertwined with the process of reconciliation. This staff member explained that “*if the spirit is broken, it [also] breaks from the focus of who we are, where we come from, it breaks high levels of trust and feelings of inclusion, all of those things that our young people may struggle with.*” For this staff member, broken spirits can hinder everyday tasks, preventing Indigenous youth from “*attending their unit viewing, to keeping their units clean. To go returning to school, or finding a job, [or] whatever their goals are they want to achieve.*” In doing so, this staff member says that Endaayaang relies on Indigenous teachings and lessons to relay practical and relatable life skills, no matter the circumstances. These include following up with youth to ensure they build positive homes for themselves. One of Endaayaang’s support staff explained that as soon as COVID health restrictions started to modify, so too did their daily practices:

We have started to do the unit checks again and we usually do that in pairs with other staff. With restrictions lifted, we have been able to do that and recently we have been going through [young people's] paperwork, partnering with others to do co-programming (Coordinator meeting minutes, HRIC, June 1, 2022).

These are necessary aspects of Endaayaang's program that help young people achieve success. Many of Endaayaang's staff felt that the pandemic created distance between Indigenous youth and the services offered by Endaayaang. The evidence was apparent during the sweat lodge ceremonies after COVID restrictions were lifted, when there was a lower than usual youth participation rate. One Traditional Knowledge Keeper accounted for the decrease in numbers, explaining that "*part of the reason youth may not be participating is due to a need for more relationship building*" (Meeting minutes, HRIC, October 26, 2022,). As a result, the team decided that the youth may have needed an additional option of a talking circle or an alternative space where these relationships could be rebuilt and strengthened, after the distance COVID created.

Recommendations & Concluding Thoughts

Culture and ceremony are foundational aspects of the Endaayaang program. Access to Indigenous teachings and ceremonial practices has significantly helped young people (re)connect with their Indigenous identities, creating a consistent sense of support, connection, and a place of belonging. This is especially important when the grip of homelessness has made young Indigenous people suffer great losses related to family, friends, and community, all while facing trauma, intergenerational trauma, and having to focus on acquiring necessities (Kidd et al., 2019). During the pandemic, cultural and ceremonial aspects of the program had to

be shifted to an online platform. Despite the impacts this can have on relationship building and traditional Ways of Knowing, it is still important for young people to access these supports virtually.

Building relationships and having a sense of collective well-being is another significant part of the Endaayaang program. However, the COVID pandemic restrictions made this difficult, as in-person and face-to-face contact violated public health mandated rules. For young people who are facing homelessness and already feel vulnerable, alienated, and isolated, the COVID pandemic created another layer of exclusion. The following are some recommendations that resulted from this research:

- 1.** Cultural and non-cultural virtual programming aspects led by Elders, Traditional Knowledge Keepers, and other Endaayaang staff should be made available and accessible after the lifting of COVID restrictions.
- 2.** Offering hybrid options can be beneficial, especially when COVID numbers are higher. COVID has taught us that young people who are feeling isolated and alone can gain a sense of belonging if supported at a distance or virtually. This can be done through home deliveries, phone calls, and the incorporation of cultural practices either online or through other social media platforms.
- 3.** Young people's collective voices need to be brought forth through research so that policy and practice changes can actively include the opinions of those who are most vulnerable to the impacts of Indigenous homelessness.

These recommendations continue to develop and must be considered when addressing the unique experiences of homelessness among Indigenous youth. This research demonstrates the challenges Endaayaang faced during the COVID pandemic while

aiming to serve Indigenous youth experiencing homelessness. Having virtual spaces that foster tailored approaches and include culture, ceremony, and access to Elders and Traditional Knowledge Keepers is central to finding pathways out of homelessness for our Indigenous youth. As pandemic-related research increases regarding the housing crisis and scarcity of resources, there is a growing awareness of the impact on the mental, emotional, physical, and spiritual health of many populations.

While our recommendations emerge from our research in relation to the COVID pandemic, they are a small part of a larger story that expresses the need for more Indigenous-centred programming like Endaayaang that directly addresses the unique needs of Indigenous youth navigating homelessness. The holistic care that Endaayaang provides Indigenous youth strengthens their chances of living healthfully and reduces their chances of being entrenched in chronic states of homelessness and winding up on the streets.

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CHAPTER FIVE

A qualitative exploration of community supports, well-being, and goals during the COVID-19 pandemic among youth experiencing homelessness

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Abstract: Social-contextual factors (such as sense of community and social support) have been widely studied in relation to well-being among various populations and in diverse contexts, including among youth experiencing homelessness. However, most of this work has been quantitative, correlational research utilizing measures that may or may not be fully applicable to (and valid for) the population and context under study. Thus far, little qualitative research on the topics of well-being, community experiences, and social support has been conducted with youth experiencing homelessness. The current study addresses this gap in the literature by interviewing 17 youth experiencing

homelessness about their community supports and well-being, with a focus on how the COVID-19 pandemic has impacted these factors. Findings can inform future research and potential intervention work aimed at supporting the well-being of youth experiencing homelessness, particularly during times of multifaceted upheaval, such as a global pandemic.

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Introduction

Youth experiencing homelessness are individuals aged 24 and under who are houseless, in precarious living situations, and typically unaccompanied (Kidd & Davidson, 2009). Research on youth homelessness has outlined the familial breakdown (e.g., Samuels et al., 2019), trauma, and abuse (e.g., Coates & McKenzie-Mohr, 2010; Haber & Toro, 2009) that often precedes homelessness for this population. This literature has emphasized the negative consequences and implications for homeless youth as compared to their housed peers, including adult homelessness (Johnson & Chamberlain, 2008) and worse mental-emotional and physical health outcomes (Parks et al., 2007; Smollar, 1999.)

Practitioners and researchers have come to understand that solving youth homelessness requires a whole-person approach and interventions that go beyond addressing youth's basic needs (Kidd, 2012). Many service organizations and researchers recognize the importance of supporting the holistic well-being of

youth — including their mental, emotional, and spiritual needs (e.g., Grabbe et al., 2012) — in tandem with meeting more basic physical needs such as food and healthcare (e.g., Kidd & Davidson, 2007; Stewart & Townley, 2019). The current study contributes to this more holistic approach to conceptualizing and supporting the well-being of youth experiencing homelessness.

Of special relevance to the current study is the COVID-19 pandemic that began in the United States in February of 2020 and continued throughout this research. Current research suggests that the pandemic had drastic economic, social, and health impacts on the majority of the population (e.g., Haleem et al., 2020). New research has also documented the effects of the pandemic on the housing and food security of populations closer in age to youth experiencing homelessness, such as college students (e.g., Townley et al., 2020).

Well-Being among Youth and the Need for Ongoing Research

As many community psychologists and researchers have long espoused (e.g., Kelly, 1986; Trickett et al., 1985), interventions — and thus the research that informs the development of interventions — need to be tailored to specific contexts to be useful, applicable, and effective. Methodologies that invite participant perspectives can help researchers and practitioners understand how these variables play out in the day-to-day lives of the population under consideration.

There is a greater need for research that incorporates the unique context and perspectives of youth experiencing homelessness, which can allow for more nuanced data that tell us the *how* and *why* of youth's experiences, as opposed to only the numerical *what* and *how much*. While quantitative research has pointed to factors

that correlate with the well-being of youth experiencing homelessness (e.g., Stewart & Townley, 2019; Osborne et al., 2009), the mechanisms behind these associations are not clear and may not be easily captured with quantitative methodologies.

Qualitative methodologies, on the other hand, can help researchers arrive at more ecologically sensitive understandings of behavior (Trickett, 1996), and can promote culturally anchored research (Hughes & DuMont, 1993) that more accurately reflects the contextual influences impacting a given population, such as the COVID-19 pandemic. While much research on well-being and sense of community has occurred over the last several decades, researchers have continually pointed to the need for more qualitative studies (Chavis & Pretty, 1999; Stewart & Townley, 2019) to provide the field and focal communities with more nuanced, culturally anchored, in-depth understandings of how these phenomena operate within the specific ecologies of different populations.

To promote grounding of the research in ecologically valid ways (which is particularly relevant during times of upheaval, such as a global pandemic), the current study employed qualitative interviews with youth experiencing homelessness to understand how – in real time – the COVID-19 pandemic was impacting their community experiences, well-being, and goal pursuits. This unique natural experiment of the pandemic allowed the research to explore what youth's experiences are when their social supports are removed so suddenly and extremely, which was a critical way to expand on prior research demonstrating the importance of these social supports in youth's lives (e.g., Stewart & Townley, 2019; Stewart & Townley, 2020; Townley et al., 2016).

Methodology

1. Description of the Partnering Organization Before and During the Pandemic

We partnered with a local homeless youth service and advocacy center whose mission is to “mentor homeless youth to affirm personal worth and create healthier lives and communities.” Prior to the pandemic, this organization was a space of community, support, and joy for youth, many of whom would visit every day that it was open. Due to the COVID-19 pandemic, there were drastic changes to the organization’s physical space and operations and to youth’s engagement with the organization.

2. Participants

A total of 17 youth participated in this study. All participants were accessing services at the time of the interview. Their ages ranged from 18 to 25 (*mean* = 23). Ten youth (59%) identified as heterosexual; six (35%) as gay, bisexual, or demisexual; and one (6%) chose to not disclose their sexual orientation. Eleven participants (65%) were Black, Indigenous, and other people of color (BIPOC); six youth (35%) reported being White.

Seven youth (41%) indicated living in transitional, low-income, or temporary housing or a shelter (thus still meeting criteria for homelessness according to the US Department of Housing and Urban Development); and ten youth (59%) reported living on the streets, out of a car, or couch surfing.

3. Measures

Youth were first asked a series of open-ended questions about their racial or ethnic background, age, gender identity, sexual orientation, and current living situation. Youth were asked

questions about how they define their well-being, their community experiences and social supports, and their goals. Of particular relevance to the current study, the following questions were used to understand the impacts of the COVID-19 pandemic on youth' experiences:

1. *How has the COVID-19 pandemic impacted your community experiences and social supports?*
2. *How has the COVID-19 pandemic impacted your well-being?*
3. *How has the COVID-19 pandemic impacted your progress towards your goals?*

4. Procedures

Due to constraints posed by the pandemic, recruitment consisted primarily of convenience sampling. Interviews took place in a large but private room. Interviews were audio recorded and averaged 30 minutes in length. Youth received \$20 for their participation.

5. Data Analysis

Following interviews, recordings were listened to and transcribed, which included a note-taking and reflexive journaling process. Data were analyzed with an inductive thematic approach (Hesse-Biber, 2017; Strauss & Corbin, 1990) that included multiple read-throughs of the transcripts, coding, and development of themes. Codes were based directly upon participants' responses to a question.

Codes were then grouped into similar categories (e.g., *“getting enough food to eat”* and *“water, food, shelter”* were grouped into a *“basic needs”* category). Themes were created that grouped together similar categories, and thus those categories became

subthemes (e.g., “*physical health*” and “*basic needs*” became subthemes of “*physical well-being*”).

Quotes were selected based on their ability to capture the essence of each theme, while also striving to include both common and unique examples for each theme and/or subtheme. To ensure a high level of quality in qualitative research, we drew upon principles of trustworthiness and reflexivity (Merrick, 1999), including ongoing peer debriefing (Lincoln & Guba, 1985) to elucidate other perspectives and areas of consensus. In order to promote transferability of findings, the results contain “*thick descriptions*” of the research context, the youth’ experiences, and quotes that provide readers with enough information to determine whether conclusions and understandings drawn from the current research can be transferred to other populations. To practice reflexivity, the Primary Investigator kept an ongoing journal of her experiences, thoughts, ideas, and reflections.

Results

The following sections review the topics and themes that emerged from youth’ descriptions of how the pandemic has impacted their lives. Quotes included throughout are cited as a participant number (e.g., PO1) to help the reader recognize when quotes are being provided by different participants and demonstrate the variety of participant quotes included.

1. Well-Being

Most participants ($n = 16$) described some kind of impact the pandemic had on their well-being: eleven youth described a negative impact; three youth described a neutral impact (e.g., some good, some bad); and two youth described a slightly increased

well-being because of the impacts of the pandemic.

The negative impacts of the pandemic that youth described focused on the ways in which it affected their mental health. Youth discussed how the pandemic contributed to increased stress, depression, and fear, and how the pandemic created a loss of community supports, employment, or other resources that then negatively impacted their well-being.

Many participants reported experiencing declines in their mental health, which included urgent mental health crises among participants. One participant explained, “I [was] suicidal... [I was] really depressed and my well-being was not okay” (P01). Other youth reflected this experience, explaining, “It’s been depressing” and described a sense of confusion created by misinformation during the pandemic:

“It’s kind of one of those things where I don’t know a lot about it cause a lot of it’s become propaganda at this point, unfortunately, to the point where I’ll wear a mask, but there’s just so much drama behind it and so much information that it’s all just very confusing” (P10).

More specifically, youth also described an increase in stress and fear about themselves or their loved ones getting sick, explaining, “It’s definitely stressing me out. Socially and mentally, it’s been pretty weighing” (P08) and, “It definitely frightened me a little bit and I was kind of afraid of it... I have obligations I got to take care of, I got things that love me in this world” (P02). Another participant explained the impact that the pandemic had on her mental state and ability to cope in the face of all the stressors brought about by the situation:

I’m kind of scared of how everything gets, but I’m just taking it day by day, cause honestly, I don’t know how long this is going to go on

and I don't really want to think about it. I just feel like I'm surviving... me not making any money, I don't feel like I'm going to thrive during COVID – and that really worries me, and that kind of affects my mental state, but I try not to think about it. (P17)

Similar to this narrative, another participant—who had been housed for a year and continued to use services because he could not afford all of his needs on his own—described the stress of losing his job and his fear of becoming unhoused again:

I wake up stressed every day. It's hard for me to get a good night's sleep anymore. When you have that much back-rent weighing on your mind... When you're homeless for six years and then you pull yourself out of it, you do not want to be homeless again. Unless you've been homeless, you don't know how hard that is... I just don't want to [be homeless] again. (P05).

The above quotes demonstrate how the pandemic negatively impacted youth's well-being through their increased levels of stress and fear about physical illness, and increases in general feelings of depression. Youth' narratives also revealed negative impacts on their well-being because of the financial strain that pandemic-induced societal changes had on their lives.

Some participants also described how the pandemic negatively impacted their well-being through the loss of community supports. One participant explained that he felt “disempowered” by the loss of outdoor activities provided in the community, and that having to stay indoors “has done a huge drain on my mental health” (P12). Another participant explained that she hadn't been able to see her therapist, which made it “difficult to reach out for help” with her mental health and to receive the medications she needed to manage her mental health effectively (P07). Finally, one participant described that because the pandemic had shut

down so many services, it had been *“difficult to find what I need,”* including easy access to a restroom and hygiene services (P06).

Alternatively, three participants described a more neutral impact of the pandemic on their well-being, explaining that in some ways it impacted their well-being, while in other ways their well-being is the same as it would be otherwise.

These participants explained that the impact of the pandemic on their well-being has been *“kind of bad, kind of good”* and that, aside from some limitations to where they can go, their well-being is *“just the same as always”* (P11). Along these lines, participants described that sometimes the pandemic is *“just kind of annoying,”* but that they are *“neutral on it”* (P04).

For the two participants who described a positive impact of the pandemic on their well-being, one participant explained that *“it’s actually kind of made [my well-being] better, enhanced it. Cause I’ve been able to work on myself”* (P14). Another described how it was beneficial to his well-being because a living and employment opportunity arose due to the pandemic:

“In a way it gave me a slightly safer place to stay because of the [homeless] camps opening up. And that also temporarily gave me a job cause they were employing some of the villagers... I guess that’s one positive thing that came out of it” (P16).

While these neutral and positive descriptions of how the pandemic impacted participants’ well-being demonstrate a capacity for optimism and ability to find something positive in difficult situations, they represent isolated counterexamples to the predominant narrative of how the pandemic negatively impacted youth’s well-being. And while a handful of participants explained either neutral or positive impacts of the pandemic on their well-being, their descriptions of how the pandemic impacted

their community experiences, social supports, and goals were all negative.

2. Community Experiences and Social Supports

All 17 participants discussed the impacts of the pandemic on their community experiences and social supports. These descriptions focused primarily on changes to resource access and social relationships.

A total of 14 participants described changes in their ability to access needed resources because of how the pandemic forced societal changes, such as service centers shutting down or severely limiting their indoor capacity and services. Youth explained how *“in the beginning, it was really rough cause everything was shut down”* (P02) and, *“a lot of the resources that were there are closed now. Or there’s a very long waiting list”* (P16). Youth also explained that the changes created by the pandemic *“made it so that services are harder to get to because of how many people can be in the building”* (P17) and that *“it’s really hard to get to most of the resources that were there before”* (P15).

Youth described how this loss of access to services impacted their ability to acquire food, clothing, and other resources; their access to clean restrooms and places to take care of their hygiene needs; and left them without some of the services that had previously provided them with programming that supported their well-being, such as art and recreational activities.

Youth also explained changes in their social relationships ($n = 9$) that had a negative impact on them. This included increases in social isolation created by the need to social distance and the loss of supportive networks or relationships. One participant explained that because she is immunocompromised, *“I have to be very careful how close I am to people”*. She went on to describe how

this made face-to-face interactions difficult and said, *“That kind of isolation has really changed me as a person”* (P07). Other youth described similar experiences of isolation, explaining, *“I don’t see anyone ever, really, so it’s like I’m kind of alone”* (P17), and how this eventually led them to become disheartened by the thought of trying to engage socially: *“The whole social distancing thing kind of makes it a little bit difficult to be social... you just get to the point where you don’t want to hang out with anybody. It’s been isolating”* (P08).

Youth also described how the social isolation negatively impacted the social supports that they used to rely on. For example, one participant described, *“I just don’t see [my best friend] anymore. She was a huge support for me”* and that he had lost friends due to the COVID-19 virus (P05). He went on to describe larger-scale negative impacts because his social network and community could no longer gather, explaining that the social distancing *“makes it so much harder to work together, to help each other, to find out who needs support. All these things we all did for each other have just gotten so much more difficult”* (P05).

Similarly, another participant described how the pandemic has *“severely restricted how I can reach out to others and build community”* (P12). Another participant reflected this sentiment, explaining that she can no longer *“be close to anybody... we can’t touch each other, we can’t be next to each other, have to wear face masks,”* and that these changes to her social interaction have *“definitely taken a huge impact on my community itself”* (P13).

Overall, these changes to participants’ social environments – both the service centers they used to rely on and the relationships that were once a major support for them – impacted their well-being negatively because it compromised their ability to meet their needs and have the emotional support of others during such a difficult time.

3. Goal Striving

To conclude the interviews, participants were asked how the pandemic impacted their ability to work toward goals. Fourteen youth described the ways in which the pandemic created barriers to working on their goals. One youth shared that *“it has inhibited all of [my goals]”* (P16). For most youth, the pandemic contributed to delays in their goals through its impact on service access ($n = 14$). This limited access to services had a negative impact on their ability to meet their own basic needs, as well as on professional training programs they were in and on other ways that service centers supported them, such as by helping get on waitlists for housing. With all of these supports severely limited, youth had to focus more of their time and energy on these needs, some of which were foundational to their stated goals.

For example, some youth describe how one goal was to acquire a job to financially support themselves, or explained that they needed to be employed to work on other goals they had. However, due to the pandemic and its impact on employment, their goals were delayed because they either lost or couldn't find a job. One participant explained, *“It feels like it's slowed [my goals] down just 'cause of how long it took [to get a job]. 'Cause you need money for everything”* (P17). Other participants described a similar experience, explaining how the pandemic had slowed down their goals because they could not get a job (e.g., P15, P08). Another respondent described, *“[I had] my dream job lined up right before this,”* but the program they were planning to work for got canceled due to the pandemic. They went on to explain, *“That would've been the ideal job for me,”* and that having that job *“probably would've gotten me off the streets”* (P11).

In sum, the pandemic created barriers and delays to participants' abilities to work toward their goals, primarily by limiting their

access to services that previously supported their goals – either indirectly through helping them meet their basic needs, or directly through specific services and opportunities that were offered. However, other general social changes also inhibited youth’ goal striving, such as the social isolation imposed on them and how it impacted their ability to engage with in-person activities. One participant’s response captured the essence of these negative effects of the pandemic:

It’s been really hard for me to be able to get adequate food, really hard for me to be able to get to the support or medical needs that I have. So those have been really hard. It’s been hard for me to go out and have conversations with people and talk about things with people. No one that you weren’t super close to before is willing to hang out with anyone cause it’s just not safe, and that’s the smart thing to do... It’s very much poked gaping holes in the foundation of my life... (P05).

Discussion

The current investigation sought to incorporate the perspectives of youth experiencing homelessness into research focused on the impacts of the COVID-19 pandemic on their well-being, community experiences, social supports, and goals. Findings can inform researchers about what is relevant and important to the well-being of this population, what will help them better achieve their goals, and how to better serve youth during rapidly changing social circumstances such as a pandemic or political unrest.

Participants reported that the COVID-19 pandemic impacted them both directly and indirectly, and in primarily negative ways. Many youth reported stress, fear, and anxiety related to the pandemic, which took a direct toll on their well-being. Indirectly, youth reported that the pandemic negatively impacted their access to services and resources, and their ability to rely on community and social supports. The impacts of the pandemic also hindered and delayed youth' progress in reaching their goals, primarily by taking away opportunities and access to resources, but also through its negative impact on their well-being.

Despite these difficult impacts of the pandemic, many youth also expressed a level of optimism and resilience. Numerous participants described how the beginning of the pandemic was very difficult: they experienced major emotional and lifestyle upheavals (including the loss of employment), and they had to learn how to navigate a drastically altered and minimized resource system. However, by the time of the interviews (eight months after the pandemic began), most of the youth described being in at least a slightly better mental state. Further, other negative impacts of the pandemic were beginning to improve: some youth had regained employment, found housing, or were more recently able to access service centers again. Nevertheless, most of the interviews had an energy or attitude of *"I'm doing my best, given the circumstances,"* reflecting the resilience noted in other research with this population (e.g., Kidd & Davidson, 2007).

Interestingly, several youth explained that their well-being is better because of the pandemic: that it brought opportunities for housing or employment, or they were able to focus more on their internal worlds or themselves, which improved their well-being. This could be the case for many reasons. For example, the global pandemic forced governments and communities to create safe

spaces for people experiencing homelessness to sleep and be, including designated areas for tents or alternative shelters and camps, some of which were staffed and structured with oversight from local government (Levinson, 2020). Similarly, several youth were able to get into a shelter or transitional housing because of governmental changes made due to the pandemic, and simply having a small space – like a bed – to rest and be alone gave them the opportunity to focus inward, process, and heal, and thus improved their well-being.

It took the pressures of a global pandemic for the government to invest in the urgent needs of those experiencing homelessness – needs that were present long before the pandemic started, but that of course were heightened during the time of the pandemic. While some resources for youth experiencing homelessness were taken away during the pandemic, other resources and opportunities were added. Ideally, going forward, no resources are removed and the government and communities can understand the ever-present urgency of the variety of needs that we all have, including those experiencing homelessness, and work to address those needs in a more holistic way.

Limitations

There are several notable limitations of this study. First, due to constraints on the service center and the youth who were visiting the service center and concerns about the research being delayed or stopped due to COVID, the interviews were slightly shorter than anticipated. While all of the planned topics were covered in the interviews, some youth expressed hesitation before the interviews about how long they would take, and several stated that they would have spoken in more detail if they had more time than they did.

Second, while the range of experiences related to homelessness was quite varied among the small sample, only youth aged 18 and older were able to be interviewed. Thus, the perspectives of youth who were under 18 are missing, which limits our understanding of their experiences during the COVID-19 pandemic.

Third, there are youth experiencing homelessness who cannot or choose not to utilize service centers. Their experiences with the topics in this study may differ drastically from the youth who did participate, which should be considered carefully when interpreting the results.

Conclusions and Future Directions

Findings of the current investigation provide rich and nuanced information to service providers about how to best support the well-being and positive outcomes of the young people who walk through their doors. Results suggest that many youth are missing important supports that they received from service centers prior to the pandemic, which overall negatively impacts their well-being. Service centers could use the findings from this study to advocate for increased philanthropic and government funding that allows them to better serve youth during times of upheaval.

This research also demonstrates the richness and nuance of understanding that can be gained from an in-depth conversation with a young person experiencing homelessness about their lives, and how this can inform our understanding of their needs, their well-being, their community experiences, and their goals. Research and organizational feedback loops with youth experiencing homelessness should focus on ways to expand our understanding of both the youth more broadly as well as our theories about their well-being, sense of community, and social support.

This study also expanded prior research by focusing on the context of the COVID-19 pandemic. Participants described how the COVID-19 pandemic has negatively impacted their well-being and access to community supports. This research can help contribute to our understanding of how to better prepare for future large-scale societal challenges, including major threats to health, and also how to better support the well-being of our most vulnerable populations during those times. For example, systems and organizations that serve this population could work with local health officials, governmental authorities, and youth to determine what social supports and community activities young people would want or need to continue through future societal challenges, and what structures would need to be in place to make that happen (e.g., outdoor activities, wearing masks, phone-based supports).

While the natural experiment qualities of the pandemic provided an opportunity to highlight how the sudden loss of support and changes in service structures can impact youth, these uncertainties also occur for youth on a regular basis outside of a pandemic – but they are less visible and potentially seen as a “normal” experience with homelessness. The current research focused on an extreme way that social supports were removed from youth’s lives during a perilous time and the resulting impact, but critically points to the need for a greater understanding of how these losses can impact youth on a daily basis and what can be done to sustain consistent supports for youth during a critical time of their lives.

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SECTION TWO

Service Provision and Models

Sarah Cullingham

The World Health Organization's declaration of a pandemic in March of 2020 significantly altered daily life for many people across the globe. However, these changes were not felt evenly across nor within nations. In this section of the book we explore some of these changes as they were experienced by people delivering frontline homelessness services. Together the chapters highlight how existing services were adapted to align with new public health measures, how new services (e.g. vaccination programs) were rolled out, as well as some of the wider impacts the pandemic had on the people responsible for providing care to unhoused individuals. Peer support models take centre stage here, affirming both the importance and challenge of grounding service delivery in lived expertise.

The section begins with the chapter, *Traumatic Stress but Not Burnout in Frontline Staff During COVID* in which Jeanette Waegemakers Schiff, Eric Weissman, Rebecca Schiff, and Alana Jones

assess the emotional impacts the pandemic had on frontline staff. Reporting quantitative findings from a pan-Canadian sample of service providers, their work brings to light the personal toll experienced by workers who were tasked with providing essential services.

The personal impacts of frontline service delivery amid the pandemic are further explored by Alana Jones, Jeanette Waegemakers Schiff and Eric Weissman in their chapter *Frontline Staff with Lived Experiences in Homelessness and Housing Precarity*. The chapter focuses on the psychological impacts of the pandemic, specifically as experienced by frontline workers who themselves have lived experience of homelessness. Reporting quantitative survey results, their work highlights the importance of amplifying the voices of, and providing necessary supports to, people with lived experience who work in homelessness service delivery.

Shifting focus from impacts to responses the next chapter, *Partnering with Peers in Homelessness to Face Systemic Crises: Experiences and Lessons Learned*, reports on a participatory research project undertaken to embed a peer support worker at a community health clinic in downtown Montreal during the pandemic. Authors Andreea-Cătălina Panaite, Odile-Anne Desroches, Daniel Turgeon, Mathieu Isabel, and Antoine Boivin explore the positive impacts of partnering with peers to deliver services to people experiencing homelessness, especially in times of crisis.

Sticking with the theme of response the chapter *Pandemic Planning and Homelessness: Delivering Vaccinations to People Experiencing Homelessness in Pandemics* focuses on the work of delivering vaccinations to people experiencing homelessness. Based on a review of the literature and lessons learned by the author, Laura K. McCosker, in running COVID-19 vaccination clinics in Queensland Australia, the chapter describes the

challenges associated with delivering COVID-19 vaccinations to people experiencing homelessness and offers potential solutions to these challenges.

The final chapter in this section, written by a team from HELP-USA, provides another example of a service provider's agile response to this global health emergency. The chapter describes HELP-USA's pandemic response measures, including de-densification strategies, vaccination programs, and a peer vaccine support program. Their experience builds on existing literature demonstrating the potential for peer support models to enhance access to health services by vulnerable groups.

Together the chapters in this section demonstrate the adaptability and resilience of the homelessness servicing sector in the face of sudden and unexpected changes. Such adaptability does not come without a toll, however, and we are also reminded of the health and emotional impacts that this crisis has had on the people on the frontlines of service provision. While peer support programs are evident as important cornerstones to successfully deliver services to vulnerable populations, the chapters in this section further underscore the need to be conscientious of the specific kinds of emotional labour that people with lived experience take on as they perform service delivery roles. As frontline workers and service provider organizations do the work of providing care to vulnerable populations in times of crisis, they too must be provided with supports and appropriate resources to do so.

CHAPTER SIX

Traumatic Stress but Not Burnout in Frontline Staff During COVID

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Abstract: Since the initial outbreak of COVID-19 and the ensuing global impact of infections, a number of scholars have cautioned about the psychological repercussions, including sweeping economic shutdowns, forced confinements, and pervasive social isolation. Some researchers have also used this global experience to document the emotional toll that these restrictions have extracted on specific groups of people. Many have discussed pervasive burnout. Underlying the concern about social isolation is the concern that, for many, the overtones of pandemic life echo dynamics that were created or resulted from traumatic stress. Indeed, some argue convincingly that the pandemic is a new form of traumatic stress hallmarked by its sudden appearance, lack of personal control

over infection, spread, and impact; an invisible life-threatening enemy that could cause serious illness and deaths, and a danger that could travel undetected, making everyone a potential and suspected carrier. For most groups, assessing the impact of pandemic stress is hampered by lack of pre-COVID-19 data on psychological health and specifically primary and secondary traumatic stress, burnout, and compassion fatigue.

Before the pandemic, frontline workers in services for people experiencing homelessness were not thought of as working in a high-risk environment, encountering traumatic events as part of their jobs. The study clearly documents otherwise. At the onset of the COVID-19 outbreak, public health officials cautioned that frontline workers in health and social services were at significant risk of adverse mental health effects. The pandemic highlighted the extent to which they were placed in both physically and psychologically vulnerable situations as a work requirement. We present the results of several related studies that found that traumatic stress, but not burnout, was the greatest psychological impact of the pandemic on frontline workers in homelessness services in many locations in Canada, prior to and after the onset of COVID restrictions.

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Introduction

In contemporary Canadian society, work-related stress is a ubiquitous feature of many organizations and occupations. Within human services organizations, it has often been linked with issues of burnout and secondary traumatic stress rather than Post-Traumatic Stress Disorder (PTSD). These issues have received considerable attention from researchers internationally and across a range of workplaces (Cieslak et al., 2014; Roberts et al., 2021; Vîrgă et al., 2020; Zakeri et al., 2021). These studies all report burnout and secondary traumatic stress as significant factors in employee mental and physical health, morale, productivity, and job retention.

Homeless shelters and soup kitchens are chaotic places where traumatic events frequently occur (McDonald & Hale, 2022). Until recently there had been little research into the emotional well-being of staff who work in these environments and with persons experiencing homelessness, and none within the context of a pandemic. Secondary data from the United States points to important concerns over minimal staff preparation for this demanding work, as well as potential detrimental effects of exposure to clients whose lives are permeated by trauma (Hopper et al., 2009). Homeless people are considered vulnerable with many comorbid health conditions, shortened life-expectancy, and higher risk for adverse outcomes in the wake of a pandemic (Hwang et al., 2010; (Waegemakers Schiff et al., 2016). In a previous study of pandemic preparedness in the homeless sector in Canadian cities, we found that municipal governments, homeless organizations, and staff in shelters were unprepared for the unique demands of those who could not “*shelter in place*”, practice preventative hygiene, or social distance. Furthermore, staff were perceived as ill-informed on how best to respond to clients (Waegemakers Schiff et al., 2016).

In another work-related study on traumatic stress in over 31 agencies that provide an array of supports for homeless persons, reported rates of traumatic symptoms indicative of a PTSD diagnosis ranged from 33% to 41% (Schiff & Lane, 2019). These symptoms in turn lead to sick leave and disability claims for stress-related mental health problems (Wright & Kloos, 2007). As the COVID-19 pandemic unfolded, frontline workers in shelters and soup kitchens were deemed “essential” and required to work on-site. However, unlike health care staff who had access to personal protective equipment, important apparel such as N-95 masks was not widely available in shelters, exposing vulnerable staff and clients to increased probability of transmission (Campbell et al., 2022). Lack of PPE was not what would have the most significant consequences for staff well-being, though, The risk of transmission, the inability to shelter in place, and other work-related stressors would have the greatest impact on staff.

Historically, organizations providing homelessness services have been ill-prepared to implement pandemic protocols for clients and staff, and the resulting stress is detrimental to their mental health and the effectiveness of the services they deliver (Waegemakers Schiff, 2019). These mental health impacts include trauma, burnout, and secondary traumatic stress, and are exacerbated by increased demand for specific services, modifications to outreach activities, organizational inattentiveness to worker psychological safety, and limitations on social distancing (Waegemakers Schiff et al., 2023). During the COVID-19 pandemic workers faced additional work-related stressors and potentially traumatizing situations, including an escalation of opioid overdose deaths (Volkow & Blanco, 2021). Stress is socially contagious and readily transmitted among staff and clients but is reduced by the presence of physical and psychological safety in the workplace (Waegemakers Schiff et al., 2023).

Complicating staff stressors is the reality that those who fall ill or require stress-leave cannot readily be replaced, leading to a worsening care crisis for the remaining staff and their clients. The psychosocial stressors of frontline workers in homeless services have recently been highlighted, as reports indicate high rates of traumatic stress twice that of other emergency services workers (Waegemakers Schiff, 2019). Some qualitative reports document staff needs and the stressful effects of working with high acuity and very vulnerable individuals (Peters et al., 2022). However, lacking historical data or baselines, they are unable to provide evidence of the durability and pervasiveness of these stressors, and do not adequately explore which staff have training and supports to deal with such conditions.

While quantitative studies can provide an understanding of the ubiquity of work-related upsetting experiences, researchers relying on adequate samples for reliability are challenged by recruitment approaches with low response rates. The accuracy of surveys depends to some extent on the recruitment methods used, as well as the minimizing of drop-out rates (Halbesleben & Whitman, 2013). Those who choose to participate are usually self-selected and may be the most healthy and resilient versus those who are experiencing adverse psychosocial impacts and have limited emotional resources for participation. Standard recruitment approaches typically result in low response rates and/or high rates of attrition (Kerman et al., 2021; Lemieux-Cumberlege & Taylor, 2019). Halbesleben and Whitman (2013) documented how studies that use convenience samples become problematic due to self-selection bias and low response rates (Weisæth, 1989), and underscores how under-reported rates of traumatic stress minimize the true impact. As avoidance is a common response to traumatic stress, response rates reflect that those impacted by symptoms of trauma are less likely to complete a survey that

may evoke traumatic memories and feelings (Greenspan et al., 2006). Cumulatively, these studies can document some of the work-related stressors, but are unable to establish true prevalence or its implications in the workplace.

Another factor that impacts survey recruitment is that many frontline staff do not have a professional affiliation, such as social work or nursing (Schiff & Lane, 2019), and thus do not belong to associations that are used in widespread recruitment. Further, frontline staff who lack reliable and private internet access at work must participate at home after hours, away from their work setting. These additional dynamics may influence responder bias (Halbesleben & Whitman, 2013). Therefore, a survey methodology that proactively minimizes these response biases is more likely to capture the voices of those most adversely impacted by work-related stress (Halbesleben & Whitman, 2013).

Methodology

Prior to the COVID outbreak, between 2015 and 2020, a total of 850 frontline staff from shelters, outreach and support programs, and domestic violence housing programs in several Canadian sites participated in a survey about their psychosocial well-being and the extent to which organizational factors contributed to their self-reported stress. The multi-faceted survey was used with frontline homelessness service workers in Calgary and Edmonton in 2015-2016. This data provided a unique baseline for determining levels of stress and burnout amongst this frontline workforce in the immediate pre-pandemic years. This same survey was subsequently used in 2017 with staff in all domestic violence shelters in Calgary and in 2019 with staff in supportive housing and outreach programs in Calgary and Saint John, New Brunswick. During the second wave of COVID (December, 2020

to May, 2021) we used the same survey with additional measures to capture COVID-related organizational adaptations that incorporated public health mandates.

The aim in 2020-2021 was to address the questions:

1. *Have traumatic stress levels changed as a result of the pandemic?*
2. *Has the introduction of trauma-informed practices occurred and, if so, mitigated levels of staff PTSD?*

In order to address COVID-specific dynamics measuring stress and coping, the survey was adapted to include measures that focused on resilience and adverse childhood events (ACEs), and also included a series of questions related to COVID-specific practices. Contextually, it is important to note that during this time frame effective vaccinations or alternative preventative measures were yet to be established and COVID distancing measures were imposed, forcing us to adapt survey administration protocols. The survey was distributed in seven cities across Canada including Calgary, Edmonton, Thunder Bay, Toronto, Fredericton, Saint John, and Moncton.

Survey responses are influenced by the environment in which they are administered, and this has been an important consideration in shaping our research with frontline workers over the last 8 years. We tried to arrange data gathering so that surveys were completed within the actual work environment, but with sufficient privacy to ensure confidentiality for completion and anonymity of response. To maximize inclusion of highly impacted staff, we adopted an ethics board approved intensive recruitment strategy that involved targeted recruitment in specific organizations with which we had developed prior relationships. In addition, we used a snowball technique that relied on the networking

of key administrators with others in the sector to expand the agencies included in the project. The protocol ensured that staff were able to complete the survey during regular work hours and this both increased participation and mitigated the possibility of other factors, such as personal distractions at home, influencing survey responses.

The protocols for the 2015 data collection used only in-person survey administration, as researchers were able to meet with staff face-to-face to explain and distribute the surveys. The protocols needed to be modified in 2020-2021 to address COVID-19 social distancing requirements and work-from-home mandates. We did this by establishing two participation modalities: paper based for those mandated by job responsibilities to work onsite, and internet-based for those primarily working remotely. Most participating organizations had a combination of staff deployed to 24/7 shelters, street outreach, and community support for those in transitional and Housing First programs. The paper-based surveys were delivered to participating sites and distributed by staff peers. The participants had access to an online presentation that explained the study and how to complete the survey anonymously. The paper-based surveys were filled out privately, sealed in unmarked envelopes, and collected by a research assistant or returned by courier to the survey team. Research staff were able to communicate with those working from home during online staff meetings in order to present the goals of the study and provide a link to complete the survey. All staff were provided paid time during work hours to participate. This provided opportunities for those whose personal commitments would otherwise make participation impossible.

1. Survey Instruments

The survey captured organizational and individual responses to worker wellness in homelessness services. Of specific interest was the extent to which staff reported emotional exhaustion, traumatic stress, and burnout. These are not identical constructs yet are often conflated with one another. In order to increase precision and discrimination among them we used instruments specifically designed to differentially assess these experiences. Several tools were incorporated into the survey: the Professional Quality of Life (PROQOL) (Stamm, 2010), the PTSD CheckList (PCL-C) (Wilkins et al., 2011), and the LEC-5 (Weathers et al., 2013). The PROQOL, found in hundreds of studies internationally, is commonly used to assess the professional life quality of people who work with those experiencing extremely stressful events (De La Rosa et al., 2018). Its strong psychometric properties, as reported by Stamm (2010), consist of three 10-item scales with Cronbach's alphas reported as: burnout (BO = .74), secondary traumatic stress (STS = .84), and compassion satisfaction (CS = .88). Although there has been some recent debate about the measurement precision of the PROQOL (Wang et al., 2023), it remains basically a valid instrument and is especially useful for consistency in reporting outcomes over several related studies. Since we adopted it for the initial studies, it has been valuable for reporting results in different populations and locations in Canada.

The PCL assesses primary PTSD symptoms in both military and civilian populations (Blevins et al., 2015). In order to minimize respondent fatigue, we opted for a 6-item civilian version (PCL-C) with strong sensitivity (.92), and specificity (.72) (Lang, 2012), as a screening tool for acute traumatic stress and potential PTSD (Blevins et al., 2015). The PCL-C and the PROQOL both use a previous 30-day framework which corresponds to DSM-5 diagnostic

criteria for acute traumatic stress and PTSD. As the PCL-C measures post-traumatic symptoms (PTSS), which are indicative of a potential PTSD diagnosis (score ≥ 14), but does not measure severity of symptoms or functional impairment, which are required for a diagnosis, we refer to post-traumatic stress symptoms (PTSS) rather than a PTSD diagnosis.

We used the Life Events Checklist (LEC-5) and the Adverse Childhood Experiences (ACE) checklist screen for lifetime and childhood-specific experiences (Chapman et al., 2007). The connection between prior traumatic experiences, ACEs, and adverse outcomes has been well established (Malvaso et al., 2022). The LEC captures events that may contribute to PTSD (Weathers et al., 2013) and importantly captures traumatic events as “*part of my job*” among frontline staff in the homeless sector, a work stressor not reported elsewhere in the literature. As work events can act as emotional triggers, there is reason to examine how that response is, or might have been, preconditioned by earlier experiences. The ACE questionnaire (Center for Disease Control [CDC], 2016) captures significant childhood experiences that have been linked to the development of PTSD in adults (Frewen et al., 2019). Together with the ACE questions, the LEC could help determine specific staff vulnerabilities.

A set of questions on personal and organizational supports, including COVID-19 transmission reduction protocols, identified environmental stress and protective factors in the workplace. By design, these questions were developed to measure peer support, managerial, and organizational responses. A prior study indicated that a sample of 296 would provide sufficient power (.80) to detect significant change (i.e. large effect size) in PTSS, burnout, and STS scores (Schiff & Lane, 2019). In the 2020-2021 COVID study, we achieved almost twice that number (547), ensuring confidence in the reliability of the results.

2. Data analysis

We evaluated each instrument (PCL, PRoQOL, ACE) embedded in the survey for scale strength and reliability. The organizational variables were compiled into one scale of 19-items that addressed COVID-19 related precautions, and two scales that focussed respectively on organizational and peer supports. All three scales were evaluated for their strength and reliability using Cronbach's alpha. Beyond simple demographics, correlational analyses and stepwise hierarchical linear regression were used to evaluate relationships between predictor variables (including demographic, work role and setting, life events, adverse childhood experiences, and resilience). Regression models were sectioned into two sets: personal characteristics and work-related variables. These were used to examine the extent to which variables individually and jointly contributed to traumatic stress and resiliency. We used SPSS (v..24 in 2015 and v..27 in 2021) for all analyses.

The PCL and PRoQOL scores cannot be directly compared because they use different anchor points to indicate the implications of their scores. The PCL measures traumatic symptoms that would suggest a diagnosis of PTSD with a score of 14 or greater as 95% accurate for a PTSD diagnosis (Wilkins et al., 2011). In contrast, the PRoQOL scores are reported as percentiles relative to those reported by other human services workers (Stamm, 2010). These benchmarks are listed in Table 1¹.

1. Stamm (2010) defined compassion fatigue as a combination of burnout and secondary traumatic stress. Although Del la Rosa (2018) reported slightly different benchmarks, that report conflates burnout and compassion fatigue by listing them as separate constructs, rather than burnout as one dimension of compassion fatigue in the PRoQOL, as described by Stamm. Thus, we use the original benchmarks presented by Stamm.

Table 1. PProQOL Benchmarks*

	High	Average	Low
Secondary Traumatic Stress	> 42	23 – 41	< 22
Burnout	> 42	23 – 41	< 22
Compassion Satisfaction	> 42	23 – 41	< 22

*Percentile of human services workers.

Key Findings

The multiple waves of data collection over 7 years produced several data sets. In 2015, 472 usable surveys were received from 23 organizations in Calgary and Edmonton (96% response rate). In the 2019 study, direct outreach and support service workers from 19 organizations in one city completed the same survey under similar conditions (85% response rate). In the national study completed during the pandemic, we received 574 responses (543 usable) from 29 organizations in seven Canadian cities. The response rate varied from 55% to over 75% depending on the organization², with lower response rates reflecting challenges of remote recruitment and data collection.

With minor variation, demographically the national profile (as shown in Table 2) aligns with that provided by Statistics Canada (Toor,2019). Women represented 69.7% of participants nationally and 61.7% in Calgary, compared with the Statistics Canada rate of 76.6% who identify as female. The inclusion of shelters that serve a large proportion of men in Calgary and Toronto, with a greater number of male staff, accounts for some of this difference. Nonetheless, the frontline workforce is predominantly female.

2. Several large organizations had difficulty providing accurate data on number of employees (full-time, part-time, and casual) as they collected this information across several data bases and funding sources. Thus, the level of participation is based on the most conservative numbers provided.

Non-binary identification was minimal at 1.1% nationally and 0.6% in Calgary, 2020-2021. In Calgary, the proportion of people employed for less than two years in their positions grew from 56.4% in 2015 to 65.3% in 2020-2021, some of which reflects additional medical staff hired during the pandemic.

Table 2. Key Work Demographics

Education and Employment		2021 National		2015-16 Calgary		2021 Calgary	
		Frequency	Percent	Frequency	Percent	Frequency	Percent
Highest Education Level	High School	21	3.7	17	7.8	7	4.3
	Some College	66	11.5	37	17	33	20.4
	College Diploma	182	31.7	47	21.6	34	21.0
	BA/BSN/BSc/BSW	205	35.7	80	36.6	67	41.3
	MA/MSc/MSW	58	10.2	37	17.0	12	7.4
	Other	35	6.1	0	0	8	4.9
	Missing Data	7	1.2	0	0	2	1.2
Total		574	100	218	100	218	100
Area of Concentration	Social Work	186	32.4	58	26.6	35	21.7
	Psychology	63	11.0	35	16.1	19	11.8
	Health Sciences	44	7.7	n/a	n/a	23	14.3
	Social Sciences	92	16.0	17	7.8	25	15.5
	Business	28	4.9	n/a	n/a	6	3.7
	Other	147	25.6	73	33.5	53	32.9
	Missing	13	2.3	12	5.5	3	1.8
Total		574	100	218	100	164	100
Length of Employment in Homelessness Services	<1 year	91	15.9	42	19.3	58	34.4
	1-2 years	132	23.0	33	15.1	52	31.9
	3-5 years	138	24.0	71	32.6	31	19.0
	6-10 years	70	12.2	35	16.1	15	9.1
	>10 years	124	21.6	29	13.3	9	3.5
	Missing	19	3.3	5	2.3	1	0.6
Total		574	100	218	100	164	100

Education and Employment		2021 National		2015-16 Calgary		2021 Calgary	
		Frequency	Percent	Frequency	Percent	Frequency	Percent
Time in Current Position	<1 year	177	30.8	70	32.1	56	34.4
	1-2 years	158	27.5	53	24.3	52	31.9
	3-5 years	96	16.7	66	30.3	31	19.0
	6-10 years	50	8.7	19	8.7	15	9.2
	>10 years	72	12.5	9	4.1	9	5.5
	Missing	21	3.7	1	0.5	1	0.6
Total		574	100	218	100	164	100
Primary Role	Intake Worker	23	4.0	7	3.2	2	1.2
	Outreach Worker	32	5.66	9	4.1	9	5.5
	Counselor	15	2.6	9	4.1	9	5.5
	Shelter Staff	198	34.5	53	24.3	82	50.0
	Case Manager/ Care Coordinator	103	17.9	44	20.2	22	13.4
	Other	185	32.2	93	41.7	40	24.4
	Missing	18	3.1	5	2.3	0	0
Total		574	100	218	100	164	100

In the 2019 survey, 46.8% (N= 248) of participants reported that they had witnessed or been involved with a major traumatic event as “*part of my job.*” By 2020-2021 that incidence was reported at 52.8% nationally. A combination of COVID-related events and the rise in onsite opioid overdoses during that timeframe (one major shelter reported an increase from 70 incidents in 2018 to 735 in 2021) best accounts for this increase.

The most important aspect of this result is the high rate of work-related traumatic events that staff report. In the 2020-2021 survey, rates of reported traumatic stress had increased both in Calgary and across the national profile (Table 3). We note the significant increase in PTSS scores in the COVID 2020-2021 study from prior studies. In addition to a general increase in trauma scores, we looked specifically at the Calgary cohort for comparison with

previously reported levels of direct traumatic stress. The proportion of workers nationally who had PTSS that met the criteria for a PTSD diagnosis during the 2020-2021 study was 50%. In Calgary this rate was 47.3%, an increase in average scores from the baseline of 33% in 2015.

Examination of the mean scores in BO, STS, and CS (shown in Table 3) over the 6 years of data collection, including results from the 2021-2022 national study, did not indicate significant differences in these scores across different years. Essentially, there was no increase in reported rates of burnout during the COVID pandemic. Despite references in the literature to high rates of burnout (Chirico et al., 2021), these findings concur with those of Ratzon et al. (2022), who also found that under 25% of participants reported high rates of burnout. The significant increase in PTSS scores in the COVID 2020-2021 study compared to prior studies is of note. In addition to a general increase in trauma scores, we looked specifically at the Calgary cohort for comparison with previously reported levels of direct traumatic stress. The proportion of workers nationally who had PTSS that met the criteria for a PTSD diagnosis during the 2020-2021 study was 50%. In Calgary, this rate was 47.3%, an increase in average scores from the baseline of 33% in 2015. What these results clearly indicate is a rise in traumatic stress but not burnout during the pandemic.

Table 3. Mean Scores of PTSS, STSS, BO, and CS Across All Studies

	Study 1 Cal-gary 2015 N=245	Study 2 Edmonton 2015 N=234	Study 3 Calgary 2019 N=312	Study 4 National 2020-2021 N= 534	Calgary 2020-2021 N=167
PCL-C	12.54	12.41	12.41	14.24**	13.82*
STS	21.24 88-89 %ile	21.09 88-89 %ile	21.09 88-89 %ile	22.61 90-91 %ile	22.61 90-91%ile
Burnout	22.78 60-63 %ile	22.82 60-63 %ile	23.82 64-68 %ile	22.99 60-63 %ile	22.79 60-63 %ile
Compassion Satisfaction	39.43 56-61 %ile	39.94 56-61 %ile	38.78 51-55 %ile	38.45 51-55 %ile	38.45 51-55 %ile

** p < .000 * p < .00

1. Changes in Psychosocial Stressors during COVID

A main aim of the 2020-2021 study was to assess which psychosocial stressors were most impacted by the pandemic. Comparison groups needed for this analysis were provided by the Calgary respondents since those same organizations had participated in 2015. By design, the 2020-2021 study had a subset of 164 surveys from five organizations in Calgary that met this baseline criteria and provided data on psychosocial stressors prior to COVID. It is important to note that because the data was collected anonymously, and staff turnover is high, the comparison group is based on a similar demographic profile of respondents but does not represent the same individuals at both collection points (Table 3).

Before and during COVID results indicate that in the Calgary cohort, those who met PCL-C criteria for a probable PTSD diagnosis rose from 33% in 2015 to 47.3% during the COVID-19 pandemic, an increase of 14.3%. One probable reason for the smaller increase in Calgary compared to national statistics, was that PCL scores decreased for one large organization, thus lowering the overall

average for programs. In Calgary, there was minimal change in burnout, compassion satisfaction, and secondary traumatic stress scores, but a rise in average primary traumatic symptom scores. This suggests that the impact of trauma on the workforce is obvious, observable, and urgent. Importantly, this impact cannot be dismissed as attributable to direct and troubling contact with clients, as already high STS scores increased, but not significantly, and compassion satisfaction scores remained stable. However, and in strong contrast, there were significant increases in primary traumatic scores. Both the PCL and the PRoQOL measure traumatic stress and are significantly correlated (Schiff & Lane, 2019). However, in the PRoQOL, secondary traumatic stress is measured through questions that anchor emotional experiences to work and client specific issues (e.g. *“I feel depressed because of the traumatic experiences of the people I help.”*). In contrast, the PCL inquires about symptoms without specifying if they are related to working with clients. The results indicated that symptoms did increase but attribution to staff-client interaction did not. This suggests that they are related to the exigencies of COVID but not specifically to work.

2. National Results

High scores, indicating participants had a burnout score at or above the 75th percentile compared to other human services workers (Stamm, 2010), are presented in Table 3. This is in line with results from other pandemic-related studies of health care workers that used the PRoQOL to assess dimensions of professional quality of life (Azizkhani et al., 2022). A score of 14 or higher on the PCL is indicative of a PTSD diagnosis (Blevins et al., 2015). In the 2021 national cohort, the mean PCL-C score was 14.24 (SD=5.84), which meant that over 50% of participants had symptoms in the last 30 days that would suggest a positive screen for PTSD (Wilkins et al., 2011).

Given that Calgary had no substantive changes in rates of homelessness, shelter capacity, housing programs, and supported housing availability, nor significant expansion of the frontline workforce in the last five years, and that worker access to mental health supports has been relatively stable, there appears to be no additional extraneous dynamics that would account for the changes in reported stress during the pandemic. One Calgary organization that had seen a spike in opioid overdoses actually had a lower rate of traumatic stress than other local organizations (Waegemakers Schiff & Falvo, 2022). The Calgary results would therefore suggest that this increase was largely driven by pervasive traumatic anxiety based on COVID creating anxiety related stressors. It is worth noting that during all years of data collection, frontline workers reported extremely high rates of STS, at or above the 88th percentile, reinforcing common reports of high stress in this workforce. That there was no rise in STS ($M=22.61$; $SD=7.27$) may be the result of pre-existing high rates and may also reflect a small proportion of staff who are stress-resistant individuals.

3. Distinguishing Burnout from Traumatic Stress

Burnout, as a combination of personal coping strategies and organizational dynamics, is usually described as developing gradually and being more likely to impact those who have been in their job for an extended period (De la Rosa et al., 2018). However, by definition, trauma arises from sudden and unexpected events that impact workers regardless of their years of service. Additionally, burnout characterized by disengagement, disillusionment, and depersonalization (De La Rosa et al., 2018) should be consistent with decreased compassion satisfaction as there is a significant inverse relationship between compassion satisfaction and burnout ($-.294$, $p < .001$). In the 2020-2021 study, there was no significant change in burnout or compassion satisfaction.

In our studies, 63% of staff had been in their current position for less than five years and 39% for less than 2 years, and such short tenure would not normally be associated with burnout. In the 2020-2021 data, the mean score for burnout ($M=22.79$; $SD=6.91$) was in the low/moderate range (25th to 49th percentile), while compassion satisfaction was in the high-moderate range ($M=38.45$; $SD=7.04$). Consistent among all our studies was a moderately high degree of compassion satisfaction which did not decrease markedly during the COVID pandemic. These findings are consistent with rates of compassion satisfaction and burnout reported by others (Azizkhani, 2022; Monroe, 2020). The strong rates of compassion satisfaction indicate a workforce that continues to care while under increased stress and related anxiety. This could be perceived as an increased moral dilemma as staff continue to care but feel emotionally drained.

Younger staff (aged 20-29) were most affected by traumatic stress during COVID, with significantly different mean scores for this age group during COVID (PTSS =15.9, BO = 25.1 and STS = 24.6, $p < .000$). Scores were successively lower in older (40 and over) age groups, perhaps due to learned coping strategies or wellness practices over time. Some job roles had significantly higher traumatic symptoms. Receptionists reported a PCL-C score of 18.5, but being a small cohort, these results should be taken with caution and indicate the highly stressful nature of gateway positions. Case managers/client care coordinators ($N = 98$) who provide outreach and case coordination reported the second highest mean scores in PTSS (15.0) and BO (25.25), followed by counsellors ($N=15$) at a PTSS score of 14.87 and BO at 23.8. The lowest mean PCL-C score (13.29) was reported by shelter staff (those working onsite, $N=198$), whose important but relatively unexplored issue has been the extent they are exposed to traumatizing life events while supervising overnight guests.

Major adverse events, both inside and outside of work, may impact overall traumatic stress. In 2021, the Calgary cohort reported that 94.5% had experienced at least one major adverse life event and 62.2% reported this as “*part of my job.*” Nationally, 92% of participants reported at least one major lifetime traumatic event, 53.8% reported at least one workplace-related event, and 40.6% reported multiple events. However, life events had only small correlations with PTSS (.244 locally and .240 nationally, $p < .001$) and BO (.214 locally and .147 nationally, $p < .001$), indicating that while they are precipitants, their impact on further symptoms is modest.

4. Additional Predictors of Traumatic Stress among Homelessness Sector Frontline Workers

We also examined the extent to which demographic and work-related variables may be predictive of PTSS and BO. In the national 2020-2021 sample, linear correlation analysis of the predictor variables indicated no relationship with PTSS, BO, or STS. While the negative relationships between age and PTSS (-.220), BO (-.264), and STS (-.209) are significant ($p < .000$), indicating that lower age results in higher PTSS scores, they are modest but insufficient for a regression analysis. To examine the possibility that social support may be a predictor of lowered PTSD, we included the organizational questions in a factor analysis (principal components, Varimax rotation) that yielded two scales: organizational supports ($N=11$; range 5-55; mean 35.59, SD 8.76, alpha .87) and personal (social) supports ($N=6$; range 4-20, mean 9.42; SD 4.58, alpha .83). Correlations of the PCL-C and BO scales with organizational supports, social supports, and COVID-relevant organizational and personal supports (shown in Table 4) indicated the strongest negative correlations between BO and both organizational and personal supports variables. This concurs with other studies that report the importance of both organizational and personal factors in mitigating BO (Rees et al., 2019).

Table 4. Relationships Among Psychosocial Stressors and Organizational Supports

		Compassion Satisfaction	Burnout	Secondary Traumatic Stress	PCL Total Score	COVID Scale 2 - Support From Work
Burnout	Pearson Correlation	-.294**				
	Sig. (2-tailed)	<.001				
	N	541				
Secondary Traumatic Stress	Pearson Correlation	-.112**				
	Sig. (2-tailed)	<.009	.694**			
	N	540	<.001			
PCL Total Score	Pearson Correlation	-.252**	.613**	.688**		
	Sig. (2-tailed)	<.001	<.001	<.001		
	N	533	533	533		
COVID Scale 2 - Support From Work	Pearson Correlation	.363**	-.407**	-.232**	-.303**	
	Sig. (2-tailed)	<.001	<.001	<.001	<.001	
	N	539	539	538	534	
COVID Scale 2 - Time Off	Pearson Correlation	.327**	-.572**	-.435**	-.468**	.514**
	Sig. (2-tailed)	<.001	<.001	<.001	<.001	<.001
	N	539	539	538	534	543

A regression analysis of the PCL-C with all three scales indicated that only social support was a significant predictor ($\beta = -.30$; $t = -5.32$, sig. .000), providing further evidence of the importance of peer supports in mitigating PTSS. Time off from work also emerged as an important and large predictor of reduction in BO, STS, and PTSS. It also resulted in an increase in compassion satisfaction.

Strengths and Limitations

An important consideration in this research was the adoption of a methodology that would avoid the pitfalls of convenience sampling. Because of the purposeful recruitment we had a 95.3% return rate of usable surveys. This provided us with considerable confidence in the accuracy of our results and in their reflection of staff stressors. Those who declined to participate, and those who did not complete a survey, may simply have been too emotionally spent to participate in a study that highlights these vulnerabilities. Their absence means that the survey was completed by those not severely impacted. This may also account for the higher rates of traumatic symptoms reported in our participants.

We rapidly deployed research teams in diverse areas of Canada, however because of time limitations and COVID restrictions, we were unable to include locations in all provinces and territories. Although reported rates of traumatic stress and burnout have been relatively consistent across regions, it is premature to assume this represents system-wide levels of stress without further input from under-represented areas, such as francophone, rural, and northern regions. Additionally, while there was considerable ethnic diversity reported by participants, there was an under-representation of those with Indigenous backgrounds. This is of concern as, in Canada, persons of Indigenous background comprise a disproportionate number of those who are without housing (Bingham et al., 2019), and yet they are not helped by those with a similar cultural background.

The use of the PRoQOL as a lead instrument in measuring quality of life for frontline workers has both strengths and limitations. Because we started with this instrument based on its strong psychometric properties and wide international adoption, we

have continued to use it so that our results can be compared over time and different geographies. More recent critiques of this instrument relate to its inherent structure rather than its acknowledged reliability and validity (De La Rosa et al., 2018). Thus, we chose to continue to use the P_{Ro}QOL as it has now provided a database of over 1254 respondents across seven years.

Conclusion

During the COVID pandemic, researchers examined the ways frontline care providers were affected by pandemic work demands, with several studies focusing on the homelessness sector. However, these studies lacked baseline data that would explain the extent to which the pandemic demands heightened stress in an already overburdened system of care. The availability of prior surveys allowed us to demonstrate that the stress due to COVID quite likely stemmed from traumatic responses such as intrusive memories of disturbing events, emotional disconnectedness, and avoidance of upsetting reminders of events. The data also clearly showed that the operative factors did not reflect burnout, which remained fairly consistent with previous results, but rather reflected traumatic stress, which was exacerbated by work-related traumatic events. The responses on coping mechanisms indicated that a combination of time off and support from managers and colleagues was most impactful in potentially reducing this stress response.

Studies that have looked at staff stressors frequently fail to include measures of the work-related incidents that may account for heightened traumatic stress in homelessness support workers. In the 2019 and 2020-2021 studies, we included measures of personal experiences with major traumatic events and if they were “*part of my job.*” Results from these studies indicated that over half of all

reported traumatic events are job-related. This paves the way for strong advocacy to organizational leaders and policymakers of the mental health hazards of working on the frontlines. In turn, this has implications for the need for substantial mental health leave time, disability leave, and recognition of the psychosocial hazards of the workplace by funders of sick leave and disability benefits.

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CHAPTER SEVEN

Frontline Staff with Lived Experiences in Homelessness and Housing Precarity

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Abstract: Staff with lived experience of housing precarity and homelessness are often hidden in the workplace as they are employed in various roles unrelated to peer support activities. Although it is often thought of as a more recent practice, peer support has been a key piece of service provision for over 90 years in mental health and substance use (addictions) services. Designated peer support roles are varied with most in a volunteer or paraprofessional capacity, which offers minimal remuneration. In contrast, people with lived experience do not occupy positions because of their housing experiences. Rather, they are employed as full-time staff in various roles and their additional expertise is largely unknown and unrecognized. In part, lack of visibility may be attributable to stigmatization of homelessness. Thus, their expertise is hidden as they fear being victimized by the cruel

social diminution that accompanies housing precarity. Anecdotal reports of this discrimination exist but systematic analysis of prevalence of lived experience (LE) and concomitant stressors in this workforce has not. Based on a recent national study of psychosocial stressors on frontline workers in homelessness services, this report addresses the gap. It examines how frontline workers with lived experience (FLWEs) cope with the psychosocial pressures of an extremely emotionally and psychologically taxing profession and compares those experiences to counterparts without lived experience. Results indicate that FLWE are employed at all levels of the sector, tend to be older, have been employed longer in homelessness services, and report lower levels of burnout than their counterparts who have not experienced housing precarity. The findings reinforce the fact that they possess experiences and coping skills that make them substantial resources. Managers and program directors should expand and emphasize ways to utilize FLWE as mentors for other staff.

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Introduction

A frequent claim is that people who have endured significant psychosocial challenges, such as housing loss, are in a better position to understand the myriad of needs of those without housing. Lived experience creates an authentic empathy for understanding the vulnerabilities and needs of those they serve (Waegemakers Schiff, 2019; Weissman, 2017). Additionally, lived experience makes a person familiar with the idiomatic expressions and non-verbal language used by the cohort who have lost housing. They are familiar with the unspoken feelings of those who walk with discouragement, in despair, seeking some stability in their lives. This culture of the unhoused/unsheltered is aptly illustrated in the book *Ragged Company* (Wagamese, 2009) where the author's lived experience is wisely used to illustrate the marked divide between those who are privileged and housed and those who sleep rough. Staff who have experienced housing loss play a vital role in the homelessness sector because their lived experiences provide them with insightful and instrumental approaches for the work of addressing housing need, dealing with crises, and communicating in a common lexicon with others in similar situations.

Frontline workers (FLWs) are dug into the trenches of a precarity battlefield that seemingly grows year by year in Canada. They connect vulnerable individuals living in poverty and experiencing homelessness to much needed support and services in the continuum of homelessness services including emergency shelters and soup kitchens, day programs, temporary accommodation, and supportive housing. The essential functions of FLWs are key nodes, or points of contact, in connecting clients, organizations, even co-workers, to the broader social service sector. These direct ties with their clients and the unique place of FLWs may also provide unexpected benefits for clients.

High acuity, the interplay of mental health diagnoses, substance use disorders, multiple health problems and housing precarity (Hwang et al., 2012), combine to exacerbate the needs and difficulty of finding solutions. Hence FLWs, tasked with supporting a client group whose long histories of trauma, concurrent disorders or disabilities, addictions, poor health, and other comorbidities have a particularly difficult job dealing with multiple daunting challenges. Ethnographic studies and anecdotal evidence attest that a concentration of persons experiencing homelessness in a limited physical service space creates often urgent dynamics and can make for a chaotic and unpredictable environment (Hopper et al., 2009). In turn, this can have marked impact on the well-being of staff (Carver et al., 2022), some of whom have their own history of housing insecurities. It is this staffing cohort with prior housing loss that is the focus of this presentation.

Historically, critical academic and professional discussions on improving homelessness services and supports have mainly focused on the profiles, needs, and acquisition practices of service users (clients) (Schiff & Lane, 2019). These discourses have emphasized service delivery using lenses of race, gender, ethnicity, and mental and physical disabilities, and how the intersection of such factors impacted client's abilities to access safe and affordable housing or shelter (Hwang et al., 2012). Recently, there has been some effort to recognize the vital contributions that staff make in the system of care (James et al., 2023). Concomitantly, some discussion has emerged about the employment of peers with lived experience (LE) of housing loss to enhance homelessness services, but this discussion has restricted itself mostly to peer mentors, supports, and positions designated for peers (Miler, 2020). The presence of frontline workers with lived experience (FLWEs) is often unknown as hiring regulations preclude asking personal questions about LE, and thus most prospective employees

would not volunteer this information. Thus, missing from the discussion is the extent to which, unbeknownst to managers and supervisors, the sector employs persons with lived experience of homelessness (PWLE) and if this adds value to their work or presents personal hazards of retraumatization.

In the last 20 years, the inclusion of persons with lived experience in service delivery has been seen as improving program effectiveness (Weissman, 2014; 2017; Woodhall-Melnik & Grogan, 2019), but this focus has been on employment in positions self-identified as peer support workers and these positions tend to be at lower pay scales and with less organizational status. This group of peer workers does not include those who seek employment through regular recruitment channels, do not self-disclose their prior lived experiences with housing precarity/loss and thus remain largely hidden. As a result, the workplace has no effective way to identify and recognize the contributions that PWLE bring to the workplace.

There appears to be a trend towards use of the term PWLE, rather than peer, in mental health, addictions, and other health care settings. However, there has been little distinction made between those who are specifically employed or are volunteers in roles designated for peer support, and staff who have LE but are not hired in this capacity. Rather, FLWEs are workers who do not disclose their lived experiences but who are employed at all levels of the organization and are compensated according to those formal roles. Throughout the ensuing discussion, we use the acronym 'FWLE' to refer to staff as frontline workers with lived experience of homelessness. Because of their diverse range of lived experiences, FLWEs add tremendous value to service provision organizations (Magwood et al., 2019). However, it is sometimes difficult to ascertain just which attributes associated with lived

experience are most salient because PWLE, when interviewed or surveyed, may omit this important attribute. Hence, an intersectional analysis that includes diverse issues can be limited due to lack of staff self-identification of housing loss.

The inclusion of peer support workers in the homelessness sector has become increasingly visible in Canadian communities. At the 2014 Canadian Alliance to End Homelessness Conference, PWLEs called for more intentional platforms that contribute to policies and decisions that address their human condition and impact them more than other Canadians (Paradis, 2016). The activism mentioned above was undertaken by peers who, because of their academic or professional status, had already gained a seat at the table in the homelessness discourse. Some were scholars, researchers, leaders of non-profits, counselors, and political advocates. Others were peers from projects like *Chez Soi*, *First Step to Home*, and others. Although alluded to earlier, this is a good place to distinguish between peers and PWLE.

Peers as PWLEs may provide paid or volunteer assistance to others and are usually employed at paraprofessional levels. Their role designation is framed by their life experiences and does not rely on specific training in delivery of psychosocial services (Barker & Maguire, 2017). Their tasks include peer-to-peer support, education by co-delivering workshops, advocacy by providing feedback on services and raising awareness about service gaps, and participating as co-researchers in research and evaluation activities. In contrast, FLWEs are people who have endured housing loss, come from diverse backgrounds, may have specialized training, and are hired to perform specific functions in organizations in the homelessness sector without disclosure of their own lived experiences. They are usually selected on the merit of their education, training, and work experience, for all levels of the

organization. FLWEs are hired without disclosure of their lived experience of homelessness as this information cannot be asked on hiring forms or used as the basis for a position unless that job is specifically targeted for a peer role. FWLEs bring heightened levels of relatability and empathy that may not always be present in workers without lived experience (Cochrane et al., 2020). To date, the proportion of staff who fall under this description is unknown as previous studies of staff have not included identification of lived experience of housing loss. In the absence of data, the presence, and contributions of FLWE as a group who bring additional expertise to their work in the homeless serving sector has not been recognized.

Workers who have endured housing loss may have a range of reactions to the difficulties that their clients experience. Many persons who experience literal homelessness contend with multiple traumatic events, both before and after housing loss (Coates & McKenzie-Mohr, 2010; Hamilton et al., 2011). In turn, their trauma stories and responses can trigger traumatic responses in staff, especially when staff haven't the tools or resources to address these complex needs (Carver et al., 2022; Rogers et al., 2020; Weissman, 2005). Staff without LE were stressed, contemplated job changes, and expressed a stoic acceptance of a degree of futility in their work. However, FLWEs may be more understanding of, and resilient to, the adverse effects of client traumas as they have developed coping strategies for these stressors. A third possibility is that depending on the specific characteristics of the situation, triggers and resiliency may both be operant.

Services for people facing homelessness are embedded in a system characterized by stressful and chaotic interactions that have not been widely explored (Carver et al., 2022; Davidovitz & Cohen, 2022). Thus, the extent to which FLWs are exposed to traumatic

events is undocumented. While the stress experienced by staff in chaotic environments such as shelters and soup kitchens has recently begun to receive some attention (Carver et al., 2022; Kerman et al., 2021; Voronov et al., 2023), most reports have relied on qualitative analysis (Davidovitz & Cohen, 2022), or convenience samples with high attrition rates (Kerman et al., 2021). None have used an intersectional lens, documented the extent to which staff with LE are employed in the homelessness sector, or examined the impact of lived experience on staff. As a result, it is impossible to understand if prior housing precarity puts staff at risk of trauma, protects them from adverse emotional experience, or provides valuable insight into client struggles and improves their functioning at work. The opportunity to understand these dimensions was provided in a national study that examined traumatic stress and mental health impacts of the Covid-19 pandemic on front-line workers in the homelessness sector (Waegemakers Schiff et al, 2023).

The initial research question was: *“How has COVID-19 affected the emotional and mental health of FLWEs?”* Because not all FLWs have LE, one of the additional goals was to identify the prevalence of FLWEs in that sector. Once identified, the research could examine how they were impacted by the stressful environment in which they worked and explore the extent to which their responses to stress were similar to their colleagues without LE. One hypothesis was that FWLEs would be at a greater risk for traumatic stress than their non-lived experience peers. This was based on the premise that the work environment was replete with traumatic events (Waegemakers Schiff et al., 2023) that could act as emotional triggers. As mirrors of each other’s experience, this kind of agonizing empathy is not an uncommon result when FLWs, social workers, researchers, ethnographers, and others with LE work closely with people actively affected by precarities (Weissman, 2017). In this

study, across many locations, FWLEs were providing support during the COVID pandemic in communities and environments they had previously accessed as homeless individuals. This potentially could render them more vulnerable to traumatic stress and psychological trauma as spatial, psychological, social, sensory, and other triggers cannot be underestimated.

Methodology

From 2019 to 2021, research teams surveyed FLWs in shelters, outreach and transitional housing programs in seven Canadian cities. The goal was to determine if and to what extent the COVID-19 pandemic had exacerbated previously reported high levels of traumatic stress in the homelessness sector workforce (Schiff & Lane, 2019). The survey included tools to assess work-related quality of life (PRoQOL) (Stamm, 2010), a measure of Traumatic stress (PCL-C) (Wilkins et al., 2011), the Life Experiences Checklist with assessment of major traumatic experiences (LEC) (Weathers et al., 2013), adverse childhood experiences (ACEs) (Chapman et al., 2007), and resilience. Additionally, questions about organizational supports provided data about organizational contexts. This survey had been used in studies about FLWs prior to COVID-19 (Waegemakers Schiff & Lane, 2019) and thus provided a unique set of baseline data on the extent to which staff was impacted by work-related traumatic events and provided a profile of mental health and psychosocial stressors prior to COVID (Waegemakers Schiff et al., 2023). The current pandemic-context survey also asked if participants had personal experiences of homelessness and, to supplement the traumatic events checklist, if they had adverse experiences in their childhood, as this is a predictor of PTSD.

The PRoQOL, evaluates the quality of the professional life of staff

in human services (Stamm, 2010), has solid validity and reliability and has been used internationally in hundreds of studies (De La Rosa et al., 2018). It consists of three scales: burnout (BO), traumatic stress (STS) and compassion satisfaction (CS). The most commonly used instrument to assess PTSD symptoms in various populations is the PTSD Checklist (PCL). A short, six-item civilian version (PCL-C) has demonstrated strong sensitivity (.92) and specificity (.72) and can be used to reliably screen for traumatic stress/PTSD (Bressler, 2018). Time frames for the PROQOL and the PCL is 30 days, which aligns with DSM-5 criteria for acute traumatic stress and PTSD (Wilkins et al., 2011). The Life Events Checklist for DSM-5 (LEC-5) includes 17 different types of traumatic events that are criteria for PTSD (Weathers et al., 2013), while the ACEs tool (Chapman et al., 2007) captures events not reflected in the LEC. Its companion questionnaire on resiliency looks at protective factors that may shield an individual from the adverse impacts of significant life events (Sciolla et al., 2019). Questions about organizational dynamics examined COVID-19 pandemic experiences, supports, and stressors within the workplace, which may impact staff mental health. Using factor analysis, organizational data was subsequently sectioned into two scales. It is important to note that the prior research did not ask about the respondents' experiences of homelessness, whereas the current project did and thus allowed us to examine demographics and psychosocial stressors through the lens of lived experience.

Using the local contacts that the co-investigators had developed in each location, survey respondents were recruited from organizations that provide an array of emergency and transitional housing for persons experiencing homelessness. We used purposive sampling in order to recruit participants with preselected criterion of frontline staff and all data was collected anonymously. Because of COVID restrictions on face-to face contact, the

data collection protocol was modified. Staff who were directed to work from home were contacted through video-based staff meetings and completed the survey in the privacy of their homes, using an on-line videoconferencing application. Staff who were required to work face-to face such as in shelters, were contacted through managers and peer employees. The peers distributed and then collected the completed surveys (which were placed in sealed envelopes) and forwarded them via courier to research assistants. The study was conducted across 29 organizations in Calgary, Edmonton, Saint. John, Moncton, Fredericton, Toronto, and Thunder Bay and received Research Ethics Board approvals from the participating universities.

Data Analysis

Results were entered into two separate databases: one collected all online responses, the other was used to enter the paper-based surveys. This established two separate groups, those working on-site and those working remotely. The groups were then merged and an additional variable was introduced to indicate method of data collection so that differences could be explored between these groups.

The demographics were analyzed through descriptive statistics that separated those with and without LE. The main PROQOL dependent variables: post-traumatic stress symptoms (PTSS), burnout, STS, and CS, were transformed to T scores (Stamm, 2010) and checked for outliers (none found). A previous meta-analysis of predictors of PTSD (Ozer et al., 2003) discussed the possibility that social support may be a significant predictor of lowered PTSD. Especially in research on homelessness, social supports are central to ameliorating social anxiety, disaffiliation, the sense of vulnerability, and addressing survival anxieties (Weissman, 2017).

The same can be said of informal supports in organizations, and fostering these informal ties for peers and PWLE in service groups is not uncommon. In this research the relationship was explored by including the organizational questions in a factor analysis (principal components, Varimax rotation). Stepwise hierarchical linear regression was used to evaluate relationships between predictor variables (demographic, lived experience with homelessness, work role, sets and setting, life events, adverse childhood experiences, and resilience and organizational variables). SPSS (v. 24 in 2015 and v. 27 in 2021) was used for all analyses.

Results

The study data collection began in December 2020 and was completed in May 2021, which corresponded to the second wave of the pandemic. Across seven sites, 574 unique respondents participated and, after eliminating those with excess missing data (10%), yielded 547 usable surveys. Of these, 25.3% indicated that they had lived experiences with homelessness. Fourteen people did not answer this question. Based on common expressions of concern by staff and clients about being stigmatized for housing precarity, we assumed that these 14 respondents either were PWLE, or were not clear if their prior housing precarity was homelessness or not. For this research, we presumed these 14 respondents probably also experienced homelessness as there is no other way to account for their lack of response to this specific question. If this group is included, the total proportion of staff with lived experience rises to 27.7%. However, we did not include these 14 respondents as part of the FLWE cohort. Of those identified as PWLE, 68.2% were female, which was slightly, but not significantly, lower than the proportion of females who did not have lived experience (72.8%). Respondents self-identified as non-binary accounted

for less than 2% and were insufficient for further analysis. Table one compares the demographics of those with lived experiences and provides a profile that compares them with their co-workers who do not have lived experience. Significant differences were found in age, education, earnings, and length of employment in homelessness services. Those with LE are more likely to be between 30 and 49 years of age while those without LE are more likely to be in their 20s. They are significantly more often Black ($p < .000$) and/or belonging to a visible minority group. Consistent with post-secondary education achievement in Canada, these employees are more likely to have a community college diploma, while those without lived experience more often have an undergraduate degree (BA or equivalent). Interestingly, 18% of those with LE report professional training (nursing, social work and psychology), and 10% had a graduate degree. The reported annual income was commensurate with education and ranged between \$40 and \$49 thousand dollars annually and thus no lived experience (NoLE) staff who generally had more education also had greater annual earnings.

Table 1. Demographics of Staff With Lived Experiences

		No LE %	Yes LE %
Gender	Female	72.8	68.2
	Male	25.2	30.4
	Non-binary	1.5	0
	prefer not to say	0.01	1.5
Age	18-19	0.01	0
	20-29	36.5	21.7
	30-39	27.5	25.2
	40-49	19.2	25.2
	50-59	9.5	21.8
	60+	7.1	6.3
Ethnicity	Caucasian	60	46.2
	Black	14.8	25.2
	Indigenous	1.5	6.3
	Asian	12.1	5.6
	Arab	1.2	1.5
	Latin	1.2	1.6
	Multi-racial	3.6	7
	Other	4.4	6.3
Education***	High school	3.2	5.5
	Some College	9.2	18.8
	College Diploma	28.6	43.1
	BA	25.9	11.8
	BSc/BSN	6.8	5.5
	BSW	9	4
	MA/MSc	8.7	7
	MSW	2.4	3
	Other	6.3	8

Section Two: Service Provision and Models

		No LE %	Yes LE %
Annual Earnings *	<20k	5.1	3.6
	20-29k	7.6	14.5
	30-39k	14.2	19.6
	40-49k	31.5	24.6
	50-59K	19.6	23.9
	60-69k	13.2	8.7
	>70k	8.1	5.1
Role	Intake Worker	3.2	6.9
	Outreach	6.2	4.9
	Counsellor	2.7	2.7
	Shelter staff	34.2	38.9
	Case manager	20.1	15.2
	Receptionist	1.7	.01
	Other	29.5	29.9
How long have you been employed in your current position *	<1 yr	32	32
	1-2 yrs	29	28
	3-5 yrs	17	19
	6-10 yrs	9	9
	>10 yrs	14	11
How long have you been employed in homelessness services *	<1 yr	18	13
	1-2 yrs	25	20
	3-5 yrs	24	29
	6-10 yrs	15	7
	>10 yrs	19	32

*** p < .001; ** p < .00; *p < .05

Staff with LE are more likely to remain employed in the homelessness sector for a longer duration than staff without LE. They account for over 29% of the respondents who worked for 3-5 years, compared with 24% of those with NoLE. Nearly one third of FLWEs (32%) reported being on the job for over ten years compared with 19% among those without LE. In contrast, 43% of

the staff with NoLE had less than 2 years of homelessness job experience compared with 33% of those with LE. When we look at all staff who are employed 5 or more years, those with LE form a significantly greater cohort (68% for LE vs 58% for those with NoLE). Essentially, those with LE tended to be older and had worked in the sector for significantly longer periods of time. FLWEs were employed at all levels of the organization: intake, outreach, shelter staff, and case managers. Management and administrative staff were not included in the survey.

FLWEs reported significantly more adverse life experiences with an average LEC score of 17.21935, compared to their counterparts without lived experience who had an average score of 12.70945 ($p < .000$). This was also reflected in the adverse childhood experiences, where a score of 4 or greater (out of ten) is a signal of a troubled childhood. 56.9% of FLWEs met this threshold, compared with 30.3% of those with no LE. The average reported resilience score for respondents with LE was 52.5362, while those with NoLE indicated a higher resilience of 57.5185 ($p < .000$). This disparity is not surprising, as we found due to scale construction that focused on childhood resiliency, a high inverse correlation between the ACE and resiliency.

Amongst our most urgent concerns was the extent to which staff with LE might be more susceptible to burnout and traumatic stress, as this would signal greater vulnerability to job-related psychological injury. On the main outcome measures of traumatic stress¹ symptoms (PTSS), STS, BU and CS, we found significant differences (Table 2) in burnout and compassion satisfaction, but not in either primary or secondary traumatic stress. Surprisingly,

1. The original work on traumatic stress differentiated primary and secondary stress. Since the changes in criteria in the DSM5 (APA, 2013), events heard about qualify for a primary traumatic stress diagnosis. We continue to acknowledge both as this continues to be a distinction in the literature.

staff with LE reported lower burnout (21.53) than those with NoLE (23.34) ($p < .001$) and respondents with LE reported having a higher compassion score of 40.32, compared to NoLE (37.81), indicating that those with lived experience had greater satisfaction in their caring roles and were less likely to report being burned out. There were nonsignificant differences in primary (PTSS) traumatic stress scores as those with LE reported an average PCL-C score of 14.26, while those with NoLE had a score of 14.12. Similarly, secondary traumatic stress scores attributable to work-related experiences were also similar as those with LE had a mean score of 22.24 and the NoLE a score of 22.73.

Table 2. ANOVA of PTSS, STSS, BU and CS for those with and without LE

		Sum of Squares	df	Mean Square	F	Sig.
PCL total score	Between Groups	.813	1	.813	.024	.877
	Within Groups	17636.645	520	33.917		
	Total	17637.458	521			
Burnout	Between Groups	339.951	1	339.951	7.364	.007
	Within Groups	24283.819	526	46.167		
	Total	24623.771	527			
Secondary Traumatic Stress	Between Groups	24.265	1	24.265	.466	.495
	Within Groups	27330.254	525	52.058		
	Total	27354.520	526			
Compassion Satisfaction	Between Groups	651.282	1	651.282	14.206	<.001
	Within Groups	24114.488	526	45.845		
	Total	24765.771	527			

We had hypothesized that FLWs would encounter significant numbers of work-related traumatic incidents that could be attributable to increased traumatic stress symptoms, and that this would be more problematic for FLWEs. An ANOVA of LEC, PCL and ACE scores indicated no differences between NoLE and LE groups (Table 3). However, a regression analysis indicated that work related traumatic incidents and ACE scores were predictive of traumatic stress for the NoLE group (Table 4).

Table 3. ANOVA: PCL, LEC and ACE Scores

Model		Unstandardized Coefficients	Standardized Coefficients			
			B	Std. Error	Beta	t
1	(Constant)	12.670	.379	33.437		<.001
	ACE total score	.514	.096	.232	5.372	<.001
2	(Constant)	12.032	.401		30.041	<.001
	ACE total score	.467	.095	.211	4.935	<.001
	LEC - Part of my job	.289	.069	.185	4.332	<.001

a Dependent Variable: PCL total score

Table 4. Linear Regression Models: PCL, ACE and LEC- job-related

ANOVA ^a						
	Model	Sum of Squares	df	Mean Square	F	Sig
1	Regression	968.727	1	968.727	30.196	<.001 ^b
	Residual	16618.349	518	32.082		
	Total	17587.077	519			
2	Regression	1579.630	2	789.815	25.509	<.001 ^c
	Residual	16007.447	517	30.962		
	Total	17587.077	519			

a Dependent Variable: PCL total score

b Predictors: (Constant), ACE total score

c Predictors: (Constant), ACE total score, LEC - Part of my job total score

Two strong scales, organizational supports (11 items, range 5 – 55; mean 35.59, SD 8.76, Cronbach’s alpha .87) and personal (social) supports (6 items, range 4 – 20, mean 9.42; SD 4.58, alpha .83), emerged from a factor analysis (Varimax rotation) of the social support questions. The FLWE group reported more organizational support (44.53, $p < .05$) than those with NoLE (42.45), but personal supports for issues such as time off, flex time, etc. were not significantly different. Linear regression (stepwise entry) of traumatic symptoms (Tables 5 and 6) with key predictor variables (gender, age, ethnicity, length of time working in homeless sector, LE, on the job and total life experiences with traumatic events, social support and time off) produced a model that showed social and time-off supports as significant predictors of PCL scores ($p < .000$).

Table 5. ANOVA of Age, Work-related traumatic events (LEC), ACE, and Work Supports

ANOVA ^a									
	Model	Sum of Squares	df	Mean Square	F	Sig	R	R Square	Adj. R. Square
5	Regression	3759.877	5	751.975	29.675	<.001	.488 ^e	.238	.230
	Residual	12011.248	474	25.340					
	Total	15771.125	479						

Predictors: (Constant), COVID Scale 2 - Time off, ACE total score, COVID Scale 2 - Support from Work, LEC - Part of my job total score, How old are you?

Table 6. PCL Regression Model with Age, ACE, Work LEC and Work Supports as predictors

Model		Unstandardized Coefficients	Standardized Coefficients			
			B	Std. Error	Beta	t
5	(Constant)	14.328	1.636		8.756	<.001
	COVID Scale 2 - Time off	.226	.037	.277	6.059	<.001
	ACE total score	.351	.090	.159	3.919	<.001
	COVID Scale 2 - Support from Work	-.090	.024	-.165	-3.774	<.001
	LEC - Part of my job	.173	.064	.112	2.688	.007
	How old are you?	-.496	.190	-.107	-2.608	.009

Conclusions from these results show, firstly, that work-related traumatic stress is pervasive in frontline staff and prior traumatic experiences are not a major contributor for either those with or without LE. Secondly, younger workers are more vulnerable to traumatic stress than their senior counterparts. Next, despite literature that most often presents women as more prone to traumatic symptoms (Olf et al., 2007), in this study gender was not a significant factor. Finally, of all organizational factors that mitigate this stress, time off from work is twice as effective in reducing stress as is peer and supervisor support.

Discussion

One quarter of all frontline staff across multiple regions, employed at varying levels of paraprofessional and professional roles, had lived experience with homelessness. FLWEs tended to be older, had worked longer in the homelessness sector, but still had lower rates of burnout and greater compassion satisfaction for the work

that they do. These attributes allow them to provide the empathy and shared narrative experience essential to creating the communication channels that facilitate helping clients. Like their NoLE counterparts, FLWEs report similar rates of work-related trauma and are equally likely, but not more so, to suffer work-related traumatic stress. Although FLWEs report more lifetime traumatic experiences, they do not usually get more triggered by adverse workplace events as likely they have developed coping skills to recognize major events and help them to maintain emotional balance. These skills could be valuable in teaching and supporting young, inexperienced staff.

While it is helpful to recognize the strengths that FLWEs bring to the workplace, frequently managers and supervisors are unaware of these assets as privacy laws forbid soliciting this information as part of employment recruitment. Additionally, those with LE may fear that because of stigma related to homelessness, disclosure of personal experiences will diminish the respect of their peers and management. Until senior management shifts its views to incorporate the wisdom of LE as invaluable assets to the organization, this secrecy, and the lost opportunities for informed work by those with LE, will continue.

Workers with and without lived experience differed in the extent to which they reported lifetime experiences with traumatic events (LE, 97% and NoLE, 90%) but had similar reports of experiencing one or more traumatic events as part of the job (LE, 52.5%; NoLE 53.4%). This suggests that prior experiences do not necessarily result in people with LE reporting more traumatic experiences at work than those without prior trauma. FLWEs have likely learned to cope with a stressful work environment because they have an in-depth understanding of the turbulence of living in homelessness, coupled with a services recipient awareness of the

available systems of services and programs. Because they have previously encountered seriously upsetting events, they have either (or both) developed coping strategies and may have an innate capacity to endure difficult situations. This by no means suggests that FLWEs are unaffected. It does lead one to consider that these adversities have led to coping skills not developed by their NoLE counterparts or conventionally housed populations.

The reports of burnout in this study are notable as FLWEs report a lower burnout rate than NoLEs. Ascertaining the reason for this difference presents a challenge as there is insufficient evidence in the current study to establish causality between work, individual stressors and coping strategies. However, FLWEs have anecdotally shared in informal discussions with co-investigators that based on past experiences of navigating these environments as clients their awareness of workplace dynamics is not burdensome or chaotic but familiar. Thus, it seems that FWLEs arrive at the workplace having a better fundamental understanding of the work and of the clients. They may have greater compassion based on their shared experiences, and a developed resilience to navigating these chaotic environments. There may be a wide range of other variables to account for these differences that are best explored in a qualitative analysis. However, the inclusion of FLWEs in most current housing services is a testimony to the now common proposition that lived experience provides individuals with exactly the insight and ability for engagement and empathetic support that improves their efficacy.

In this study, 42.8% of NoLE workers had been employed in homelessness services for two or less years, compared to 32.5% of FLWEs while more FLWEs report working in the sector for more than 5 years. Those with lived experiences appear to stay employed longer and constitute a more stable work force, which

is an important consideration in a sector where turnover rates are high (Schiff & Lane, 2019). Furthermore, age matters: younger workers, who make up the greatest proportion with two or less years' experience are more adversely affected by work stress. As mental health stressors in the workplace are pervasive among staff they are also a notable precipitant for leaving employment across sectors. High rates of staff turnover tend to exacerbate the chaos common to the sector and those with LE thus provide more stability. It is imperative that agency leadership addresses the current rates of trauma among staff in homelessness services and formulates ways to foster preventative measures and processes that support the team. One avenue is to recognize and utilize the stabilizing influence that FLWEs can bring to the job.

In most places traumatic stress and burnout remain problematic, and thus the sector needs to be more proactive in addressing this early on in employee recruitment and retention. One such proactive step is to ensure that employee recruitment includes explicit discussions about the emotional and stressful nature of the work. Thereafter, those hired should be provided with training on stressful client situations frequently found in the workplace. Finally, personal stress identification should be taught, and self-care measures included in workplace activities, in order to provide trauma-informed care training to the staff by emphasizing reducing harm and increasing resiliency (Leitch, 2017). Ideally, these measures would allow staff to address their wellness and self-care proactively.

When experiencing burnout, staff concomitantly lose the inherent positive reinforcement that caring for others can provide. This concurs with other findings that burnout is not the primary stress factor in frontline work (Carver et al., 2022; Waegemakers Schiff et al., 2023). FWLEs reported having a greater rate of satisfaction

($p < .000$) than those with NoLE. With substantial compassion satisfaction there is also lower burnout and thus a greater positive environment for both staff and clients. These findings were of particular interest to the research team.

The original hypothesis was that FWLEs had higher rates of burnout and lower rates of compassion satisfaction based on their previous histories of homelessness. In fact, they had lower rates of burnout and higher levels of compassion satisfaction than their colleagues without lived experience and bring this as an added richness to the workplace. Based on this research, it is evident that it is the particularities of the workplace that have a serious impact on the mental health of all FLWs. The increased incidence of the trauma that all staff experience in the homelessness sector (Waegemakers Schiff et al., 2023) should be cause for alarm to supervisors, administrators, and policymakers as the ongoing exposure to trauma can be cumulative and lead to anxiety disorders and PTSD. However, the present results also strongly suggest that increased time-off benefits will provide a substantial impact on reducing the staff stress burden and reduce stress leave.

Limitations

The idea that “*time is of the essence*” in rolling out this study during the COVID crisis precluded a more complete recruitment of participants in other major Canadian cities. Thus, the input from francophone and northern/remote communities is minimal and we hesitate to speculate if their experiences would be comparable. Recruitment of organizations was based on those that previously participated as well as some that were able to make a rapid commitment to the study. Staff working on-site were recruited at a distance and researchers had less control over distribution and collection. However, a post-collection analysis showed substantial

participation by both on-site and distance workers. We could not validate the extent of staff participation in some of the (larger) programs because the human resources data systems in these agencies had partitioned staff into multiple data bases according to funding source. Because this was a first effort to understand the prevalence of staff with LE, and due to limitations of response burden, we did not include additional questions specific to this cohort, thus, richness of experience is missing. However, based on the fact that FLWEs form a significant proportion of staff, it is important that qualitative studies explore their dynamics.

Conclusion

The emergence of COVID-19 provided the opportunity for FLWs to be widely recognized for the essential services they provide and the chance for greater introspection into how ongoing management of complex and traumatic situations was impacting them (Campbell et al., 2023). Frontline staff across various sectors were included: pharmacy workers, grocery store attendants, bus drivers, nurses, community workers, shelter staff, etc. An outpouring of compassion toward all FLWs from various levels of government, organizational leadership and community goodwill allowed FLWEs to distinguish themselves from within a diverse workforce. They came to the sector with multiple backgrounds of housing precarity, many educated, full of potential, and with a strong desire to serve others despite the (heretofore unknown) threat of serious psychological injury.

While reports from the field had indicated that there were staff with lived experience, we were surprised to document that they comprised between 24% and 27% of the total cohort in this study and they occupy roles at various levels of organizational hierarchy. They are both older and more likely to have long-term

employment in homelessness services, which adds a stabilizing element to a workforce replete with high turnover. Their prior involvement as services recipients probably acts as an asset rather than liability as they have lower rates of burnout and higher compassion satisfaction. They are no more likely to experience symptoms of traumatic stress than their always housed counterparts. However, they are not immune to workplace stress and their lived experiences also entail sensitivities that require respect. The social stigma that accompanies housing precarity and homelessness plagues FLWEs who are reticent to share their personal experiences for fear of censure and ostracism. Employers should seek ways to acknowledge the presence and recognize the importance of lived experience in their staff as well as the extent they can be used as mentors in supporting the development of empathetic work skills in younger and less experienced staff.

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CHAPTER EIGHT

Partnering with Peers in Homelessness to Face Systemic Crises: Experiences and Lessons Learned

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Abstract: Economic, housing, health, and social crises disproportionately affect people experiencing homelessness. The COVID-19 pandemic highlighted and compounded such disruptions: the economic shutdown pushed new segments of the population into homelessness, while shelters and resources limited their services,

and access to care became more complex. The importance of fostering the health ecosystem's resilience to crises became paramount in order to tackle these consequences, especially through key leverages of resilience such as trust building, collaborative, flexible, and adaptive approaches. Amid the pandemic, our team supported the integration of a peer support worker in a community health clinic in Montréal. Drawing on a qualitative study of a three-year participatory research project, we explore how partnering with peers in homelessness can foster resilience to crisis. Partnering with the peer helped to foster trusting relationships with people experiencing homelessness and to build collaborative bridges between community and health services. The flexible approach of the peer helped providers translate interventions and adapt public health measures to the realities of people experiencing homelessness. Moreover, for the care team, working with a peer brought a sense of shared meaning, reconnecting them with the purpose of their work in a period filled with a sense of fatigue and powerlessness due to the pressure of the pandemic on the healthcare system. Looking at the pandemic as a “*cluster of crises*” at the intersection of economic, social, policy, and sanitary disruptions, we explore how partnering with peers may strengthen resilience to ongoing systemic crises affecting people experiencing homelessness.

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Introduction

Homelessness pathways in Canada are complex, implying various factors mutually reinforcing each other over the life course, namely poverty, precarious housing, substance use, trauma, or discrimination (Piat et al., 2015; Dej, 2020). These pathways are intricately linked to systemic crises affecting Canadian society. Lack of affordable housing and the reliance on emergency shelters limit access to sustainable and safe housing for people experiencing homelessness, while socio-economic policies are insufficient to alleviate economic insecurities driving people in and out of homelessness (Gaetz et al., 2016). Moreover, the healthcare system struggles to provide coordinated care (Magwood et al.,

2019) despite homelessness being disproportionately linked to multimorbidity, including higher prevalence of physical, psychological, and social issues (Bowen et al., 2019).

The COVID-19 pandemic highlighted and compounded many intersecting crises. While some found themselves in the streets for the first time, the support systems that people experiencing homelessness relied upon were disrupted, impacting their already precarious living conditions (Leblanc, 2020). Places where they went for food, toilets, or to spend time abruptly closed while shelters and drop-in centres limited or ceased their activities to implement physical distancing, as they were particularly at-risk for COVID-19 outbreaks (Perri et al., 2020). Without access to a home to isolate, quarantine and testing procedures posed further challenges (Tsai & Wilson, 2020). People experiencing homelessness were also among the most vulnerable to COVID-19 complications, considering the high multimorbidity rates in this population (Tsai & Wilson, 2020).

The importance of fostering the health ecosystem's resilience to crises became paramount to tackling these consequences, especially through key leverages of resilience, namely trust building, collaborative, flexible, and adaptive approaches. Engaging collaboratively to (re)organize health services and policies is key to maintaining core functions and enabling individuals and systems to bounce back and adapt to changing needs during crises (Haldane et al., 2021). When caring for and with people experiencing homelessness, trust and intersectoral collaborations are particularly important (Pottie et al., 2020). Their health and social care needs usually require navigating various programs and policies that often operate in silos (e.g., medical, employment, mental health, corrections, housing) (Doberstein & Nichols, 2016).

Drawing on a three-year participatory research project conducted

during the COVID-19 pandemic, we explore how partnering with peers in homelessness can foster resilience to systemic crises. The paper is structured in four sections. We first provide background information about peer support in homelessness and on our research project of integrating a peer support worker in a homelessness community health clinic in Montréal. Second, we detail our participatory research approach to support and study the peer's integration. The results section highlights how the peer's integration leveraged key factors identified in the literature to support system resilience to crisis: trust building, collaborative partnerships, flexibility and adaptation, and support to health-care teams. Finally, we discuss some lessons learned that foster resilience to systemic crises with peers in homelessness.

Background of the Project

Peers in homelessness are people with significant lived experience who mobilize the knowledge and abilities acquired through challenges to support and accompany others to achieve their own life goals (Erangey et al., 2021). Peer support workers usually have received a form of training or experienced reaffiliation (S. L. Barker et al., 2020). In North America and Europe, peer support has a long tradition in mental health and harm reduction, and some programs have been launched to tackle crises (e.g., HIV or opioid crises) (Needle et al., 2004).

Amid the COVID-19 pandemic (summer 2020), the Canada Research Chair in Partnership with Patients and Communities partnered with a community health centre in Montréal to integrate a peer support worker in its homelessness community health team. This clinic is located in a neighbourhood where rates of homelessness, mental health illnesses, substance use, and economic insecurity are particularly high (Landry et al., 2021). Additionally, this

borough is a historic hub of citizen and community engagement; close to a hundred community organizations are active. During the last three decades, this clinic has specialized in integrated health and social care for people experiencing homelessness through an interdisciplinary team (i.e., social workers, nurses, physicians, and psychosocial educators) and a community-based outreach program in collaboration with shelters, community organizations, and street workers in the borough. For some time, the clinic had been interested in expanding their services by integrating a peer support worker. The research team had previously led the Caring Community participatory research program on peer integration in community health, first implemented in a primary care clinic in Montréal (Boivin & Rouly, 2020).

The project thus started out as a collaboration between the homelessness community health clinic and the research team building on its Caring Community program. The former led the clinical and community outreach activities (e.g., defining the peer's role and mandate), while the latter focused on research and support components (e.g., recruitment, organizing meetings, weekly follow-up on the peer's integration). However, both contributed to the intervention and research aspects of the project. The research team supported the recruitment and mentorship of the peer and the clinical team, while the community health clinic contributed to the research in monthly project meetings and through the part-time integration of the peer (Turgeon) and medical director (Isabel) in the research team.

The project first emerged to tackle the disproportionate impact that the pandemic had on people experiencing homelessness. In spring 2020, Montréal was among the epicentres of COVID-19 in Quebec (Meloche-Holubowski, 2020). Local and provincial authorities put in place numerous public health measures to mitigate the

spread of COVID-19, such as physical distancing, closure of public institutions, or gathering restrictions. Through subsequent waves, public health measures were sometimes softened (e.g., limited access to restaurants was permitted) and eventually reinforced (e.g., obligatory masks, provincial curfew). Specifically, during the second COVID-19 wave (January-May 2021), Quebec was the only province in Canada to implement a population-wide curfew, which shortly prohibited people experiencing homelessness from walking or sleeping outside at night. In this context, the peer's interventions aimed to reach people experiencing homelessness where they were (physically and emotionally), to build relationships, and to bridge them to the clinic's services.

Study Method

During the last three years, the project team tracked the peer's integration using a participatory research approach and specific tools. These include a log of the project's implementation, a log of the peer's interventions, a focus group with community health clinic staff, and semi-structured interviews with key informants (the peer, people experiencing homelessness, community health clinic staff, and community partners). From the project's inception, the implementation log was filed in a timely manner, and fed by monthly meetings between the research and clinic teams. The peer's intervention log was filed by the peer support worker (Turgeon), and later on (October 2022) supplemented by monthly discussions with a research professional (Panaite). From March 2021 to June 2022, the research team conducted the focus group and the semi-structured interviews. While informed by the implementation and intervention logs, this chapter focuses on a thematic analysis of the interviews and the focus group to answer the following question: *How was peer support leveraged to respond to (pandemic) crisis?*

Purposive sampling was used to recruit key informants. In March 2021, the project team conducted a focus group with five community health clinic staff members to explore the peer's integration and the perceived effects of his work with clients and providers. They were afterwards interviewed individually to deepen understanding of the project's implementation, the barriers and facilitators of the peer's integration, the perceived effects of his work, and the impact of the COVID-19 pandemic. The peer had a follow-up interview in the summer of 2022 to explore the evolution of his role. Three community partners working closely with the peer were also invited to an interview exploring collaborations with the peer and the homelessness clinic, the impact of COVID-19, and perceived effects of the peer's interventions. A member of the research team conducted a brief observation session (half of a day) in November 2021 at the organization. Finally, three people experiencing homelessness (n=3) who received support from the peer for at least a month were interviewed to explore their background, their relationship with the peer, and the perceived effects of his support. All the interviews were conducted in French, and ethical approval was received (#2020-564, DIS-1819-77). We also followed ethical principles of participatory research with community members (e.g., negotiating dual identities, divergent objectives) using meetings to solve disagreements on objectives, interpretations, or dissemination, with a focus on building trusting and accountable relationships (Groot & Abma, 2022).

Two members of the research team (Panaite and Desroches) conducted a hybrid (inductive and deductive) thematic analysis with the purpose of identifying, analyzing, and reporting patterns in the collected data (Braun & Clarke, 2006). Panaite and Desroches agreed on an initial coding grid after familiarizing themselves with the content of a few interviews before proceeding to code one interview together to refine the grid and solve disagreements.

After reaching strong agreement in the second coded interview, Panaite and Desroches pursued coding individually. The last interview was coded together to ensure agreement was maintained. QSR Nvivo 12 was used to analyze all documents and evaluate levels of agreement.

Through the coding process and discussions between authors of the chapter, Panaite and Desroches delineated four potential themes, capturing the way peer support was leveraged to respond to (pandemic) crises. After completing coding, codes were sorted and regrouped into themes to analyze associated extracts. Themes were further refined and reviewed to ensure each formed a coherent pattern (Braun & Clarke, 2006). To strengthen our understanding of the data and support reflexivity in analysis (Mays & Pope, 2000), we triangulated statements between interviews and the peer's intervention log and between interviews. To contextualize statements, we paid close attention to "who" was talking and the COVID-19 period associated. The preliminary analysis was reviewed in meetings between Panaite and Desroches, the peer support worker (Turgeon), the medical director of the clinic (Isabel), and the clinician-researcher co-leading the project (Boivin) to see if it reflected their experiences.

The discussion below explores the potential of partnering with the peer to foster resilience in times of crisis. The four subsections are articulated around different actors with whom the peer collaborated and the potential associated with those partnerships:

- 1. *People experiencing homelessness, to navigate daily challenges of the pandemic***
- 2. *Community partners, to support intersectoral collaborations***

3. Healthcare providers, to adapt public health urgent responses (e.g., quarantine measures)
4. The care team, to offer hope and support them through challenging times.

Experiences : Partnering with Peers to Face Systemic Crisis

1. Building Trust with People Experiencing Homelessness

Community organizers and clinic staff members interviewed insisted on the pandemic's toll on people experiencing homelessness. Living conditions were disrupted; places frequented during the day abruptly closed (e.g., restaurants, malls), while shelters and resources had to limit their capacity. According to participants, the pandemic also complexified access to community and healthcare services, further fueling distrust and apprehension toward providers and institutions. People experiencing homelessness had to (re)adapt daily to changing services and new public health measures. By building relationships based on trust (e.g., taking the time to listen, focusing on the client's goals), the peer support worker was able to help people experiencing homelessness face these daily challenges and access the clinic's services.

Community workers, clinic staff, and the peer described the peer's approach as "*global*" and "*human*." In contrast with health or community providers who may have less time to build trust, the peer used his own experience to slowly establish relationships. He first acknowledged the person as a whole, searching for strengths and needs that were not pinpointed to a specific dimension of

their life. Bruno¹, a staff member of the community health clinic, recalls that this approach was particularly useful to support the navigation of changing services during the pandemic:

It turned everything upside down. The resources were not the same. There were new players. Having someone who was focused and had answers to their needs, and able to navigate, and support them at a time when everything had changed, that helped them a lot.

According to participants, the peer empowered people experiencing homelessness to access health and community services, accompanying them throughout the process. Andre, a person experiencing homelessness, recalls the way the peer encouraged him:

Right away, you start negative. Because you haven't slept for nights. Then, the other one wants to send you to the nurse for your leg. You almost don't care at that moment. You know, at some point. Yeah, but there's hope. You have to... he [the peer] encourages. He's there. He's really there, you know.

The peer uniquely partnered with people experiencing homelessness, as he was regularly present for them and acknowledged who they were and their hardships as well as the impact on their sense of hope towards their goals and lives. This work, coupled with the peer's accompaniment, empowered people experiencing homelessness to access needed services because they were not alone in navigating changes to services and public health measures due to COVID-19 infections. According to Justine, a community health clinic staff member, people experiencing homelessness also had to face additional stigma from other clients who mistakenly thought they were more likely to spread COVID-19. For

1. To ensure participant's anonymity, pseudonyms are used throughout the text. Their professional titles are voluntarily omitted to limit possible identification.

some, this fueled existing apprehensions about accessing the clinic's services (e.g., fear of discrimination or mistreatment).

Participants also stated that the pandemic created additional frustrations for people experiencing homelessness. For instance, during the first waves, people could be denied access to shelters or resources to sleep or eat, even in winter conditions, as physical distancing measures reduced capacity. This could lead to aggressive behaviours towards others and fuel disorganization, jeopardizing a person's ability to access the resource services in the future. According to participants, the peer could prevent outbursts or disruptions by validating the injustice experienced and opening a person to other perspectives based on his lived experiences (e.g., the idea that discomfort can be temporary as well as encouraging possible actions to alleviate it).

Our analysis suggests that the peer partnered with people experiencing homelessness in a unique way. He took time to build relationships based on trust and empowered them to access the care they needed by being present and by their side. This was particularly helpful at a time when access to services was complicated by changing services and public health measures.

2. Partnering with Peers to Support Intersectoral Collaborations

The COVID-19 pandemic, notably the first waves, also impacted the community health clinic's collaborations with community resources. Outbreaks and frequent (re)organization of resource services blurred the framework of intersectoral collaborations while these required ongoing discussions and (re)negotiations to limit misunderstandings and tensions about the clinic's mandates. In this particular context, the peer acted as a bridge. Partnering with community workers, he supported the community

health team to (re)create ties and relationships with certain organizations and strengthen their collaborations.

Participants described collaborations between the healthcare system and community organizations as marked by misunderstandings around expected versus actual roles of the community health clinic, which could fuel tension in some cases. While community workers interviewed discussed the difficulty in accessing clinical services, they also stressed a change in perception after being introduced to the peer. During an observation session, Simon, a community worker, expressed how the peers' integration as a part of the clinic's outreach staff was pivotal in improving access and collaborations:

Before [the peer], we, in the community network, hated the [community health clinic]. There was no way to get in there unless you were in conjunction with Jupiter on a Tuesday morning between 10:11 and 10:12. Now, we are able to have quick access thanks to [the peer], and the guys tell us that they are having a good experience.

The community workers spoke highly of the peer support worker, recalling the way he followed up with them on their clients' cases, even if the clinic could not provide services. As he did with people experiencing homelessness, the peer took the time to establish these relationships and understand how the team worked. Acting as a bridge between these organizations seemed to have facilitated access to clinical services, as stated by a community health clinic staff:

It happened a few times, you know, that people came afterwards, you know, that [the peer] reminded them of the walk-in appointment for the nurse, or that he was able to walk with them to the [clinic], at least to show them the place. So, you know, I think that in a context where

he himself is in a resource, he is... You know, it's it can be really cool that he's the one who makes the first connection with the person too.

Participants reflected that, in order to bridge people to the clinic, the peer had to be regularly present in the partnering community organizations to sustain collaborations with the staff, who faced frequent turnover. This was also important to allow the peer and the clinic to (re)negotiate the limits and boundaries of his role, especially when the organization's expectations exceeded the clinic's mandate. Outbreaks of COVID-19 and changing services, however, limited opportunities to discuss and clearly delineate such boundaries, which further blurred the framework of intersectoral collaborations. In some cases, this led to partnership withdrawal from organizations, limiting the peers' ability to act as a bridge.

Intersectoral collaborations have been deemed crucial for coordinated responses to emerging needs during sanitary crises (Gaetz & Buccieri, 2016). While the peers' ability to act as a bridge was temporary in some cases, our analysis suggests that partnering with peers may hold the potential to strengthen collaborations between the community health clinic and community organizations, even when these were challenged by the pandemic.

3. Partnering with Peers to Adapt Public Health Measures

During the fifth wave of the COVID-19 pandemic (winter 2022), quarantine facilities for people experiencing homelessness were unable to respond to the growing and sudden number of infections caused by the rapid spread of the Omicron variant. As a response, the city of Montréal, in collaboration with community organizations, launched a larger quarantine facility. For three weeks, the peer and healthcare providers from the community health clinic were mobilized in that facility. Our analysis suggests

that partnering with a peer in this particular situation supported some providers in adapting a public health crisis response to suit the needs and realities of people experiencing homelessness.

The peer and two healthcare providers interviewed recalled the anxiousness experienced by clients having to stay in the quarantine facility. After adapting to changing services and measures in past waves, they were brought to an unfamiliar space, cut off from their community, and then were strongly encouraged to stay for the duration of the isolation period. Participants stated that the possibility to talk to the peer may have alleviated the pressure and frustrations of being confined to the facility. Drawing on his experiential knowledge and ability to empathically acknowledge and validate their concerns, he could, for instance, remind them that the situation and discomfort associated were temporary. As a clinic staff member stated:

[The peer's] role was well suited to this context where people were destabilized. There, you had to have someone to listen to, someone to talk to, someone to take your mind off things. I think there was something very specific to the... to the contact in the [quarantine facility] than, to what [the peer] does usually, you know.

The peer's flexible and human approach supported the adoption of a public health measure, isolation in an inhospitable quarantine facility, for people experiencing homelessness. The two providers who worked with the peer in the quarantine facility highlighted the complimentary nature of his role with the service providers. While he talked to people and reassured them, providers could focus on coordinating access to services or update information for public health authorities. Outside the quarantine facility, Caroline, a community health clinic staff member, reflected that the potential to adapt interventions operated at a

deeper level. Working with the peer, for her, was a way to bridge the “gap between our lenses, our ways of seeing people.” He built awareness, highlighting how a clinical decision may not be suited to the reality of homelessness (e.g., living in and out of shelters, mistrust of institutions) from the point of view of those experiencing homelessness.

As public health responses to crises are drawn from emergency needs they are not necessarily suited to the context of homelessness. Our analysis suggests that partnering with peers may create potential for healthcare providers, helping them to adapt public health responses and, more broadly their interventions, to the daily life and realities of people experiencing homelessness.

4. Partnering with Peers to Support Care Team’s Resilience

Partnering with the peer also had benefits for the staff of the community health clinic who reported having faced challenges during the COVID-19 crisis in their personal and professional lives. On a personal level, the pandemic’s uncertainty created a situation conducive to feelings of anxiety, which Michelle, a clinic’s staff member, named “collective exhaustion.” At the professional level, as multiple services came to a halt, it became harder to maintain services. The providers interviewed shared a sense of powerlessness to mitigate the extent to which COVID-19 impacted their clients, as the clinic and their partners had limited resources. In this context, some described feeling useless and having lost meaning in their jobs, as stated by a participant during the focus group:

I found myself with a lot of loss of meaning! And even still, what are we doing? [...] And that’s what we heard from some employees who left. They found themselves kind of like: what am I doing here? What’s the point?

Integrating the peer in the clinic during this period brought the team together to work on a joint project that would reach beyond the crisis. Staff members were mobilized at different stages of the peer's integration (e.g., bi-monthly meetings, recruitment procedures, research interviews), in collaboration with the research team (see background of the project). Some staff of the community health clinic highlighted that the project grounded them in the purpose of their work and brought them back to the core of their mission. The project's novelty and potential, which was in coherence with the team's values and priorities, made it a stimulating and mobilizing endeavour. It also brought hope for some, as illustrated by Isabelle:

I found it stimulating. You know, it's true we were in a period where everything came to a halt. We... the network was on hold for a while. So it was definitely stimulating to have a new project, uh, that... that gave hope [laughs].

Two staff members working closely with the peer also reflected on the occurrence of support from the peer. While this sometimes took the form of completing documents or tasks, partnering with the peer also allowed them to share expertise and insights regarding the psychosocial role. This was described as a way to limit compassion fatigue by one of the providers during the focus group:

There is something very healthy about sharing the intervention. [...] Sometimes when we face a little more compassion fatigue towards a person, [the peer] takes over. [...] We share the intervention, and for me, not as a worker, but as a person, it's really good for me to work together.

Partnering with the peer thus seems to have potential to support providers through crises as a team, by anchoring them in a

meaningful and impactful project, and as individuals, by sharing the intervention and associated workload. Noteworthy, these benefits were stated by providers who were invested in the project and who collaborated closely with the peer.

Lessons Learned: Leveraging Partnership with Peers to Build Resilience and Face Systemic Crisis

COVID-19 was a sudden shock, but it highlighted and exacerbated the long-term, pervasive crises impacting people experiencing homelessness, namely the lack of affordable housing, deficient socio-economic policies (re)producing economic insecurity, and health system failures to ensure continuity in care (Gaetz et al., 2016; Magwood et al., 2019; Maretzki et al., 2022). In Quebec's 2022 point-in-time count, 15% of people experiencing homelessness reported having lost their previous housing due to the pandemic (e.g., job loss), with the most frequent reason being eviction due to unpaid rent, highlighting deficient preventive measures (MSSS, 2023). While our analysis is embedded in the pandemic's context, we could apply lessons from it to respond to ongoing and future crises.

We thus conclude by discussing ways that peer partnerships may build resilience to bounce back and adapt timely to shocks, maintain services, and tackle changing needs of populations (Haldane et al., 2021). According to the literature on health system and community resilience, trust building, collaborative partnerships, and adaptive and flexible approaches are particularly useful to build resilience to crises (Forsgren et al., 2022; Thomas et al., 2020). Our analysis suggests peer partnerships could influence these key factors of resilience for different actors working in homelessness care.

Collaborative partnerships with people with lived experience and communities are important to build resilience, as they can foster trusting relationships with healthcare providers or representatives during crisis (K. M. Barker et al., 2020; Forsgren et al., 2022). Authors have suggested that trust building improves care responses and cooperation in sanitary crises (K. M. Barker et al., 2020; Kruk et al., 2015). In our analysis, the peer was able to bridge people experiencing homelessness to resources by building trust, validating concerns, and accompanying them while accessing care services they needed. The ability to build trust has the potential to facilitate accessible and continuous care, especially when people face additional barriers to care (Lennox et al., 2021).

Fostering collaborative partnerships and engagement between community and health sectors is also a key lever to support coordination of care and comprehensive responses (K. M. Barker et al., 2020). During the COVID-19 pandemic and the Ebola epidemic in West Africa, such partnerships allowed effective and timely responses to health and social care needs, and to implement innovative navigation solutions (e.g., citizens linking community members to mental-health services) (Haldane et al., 2021; Kruk et al., 2015). This echoes our analysis: peer partnerships helped to (re)create ties with certain community organizations, allowing clients to access the clinic's services in a timely and coordinated manner. Importantly, the peer's ability to act as a bridge was sometimes temporary due to misunderstandings between community organizations and the clinic, around the latter's expected and actual mandate.

Tailored and adapted services are cornerstones of the health ecosystem's resilience (Haldane et al., 2021; Thomas et al., 2020). Flexible approaches to service delivery of both health and social

care needs - beyond the healthcare sector - are particularly useful to support the health system's capacity to adapt to the changing needs during sanitary crises (Kruk et al., 2015; Haldane et al., 2021). Our analysis suggests that peer partnership induced more flexibility in providers' interventions and public health measures, adapting them to the realities of people experiencing homelessness during the pandemic and beyond. Interestingly, the peer was later invited to design workshops to reorganize the local health authority's services for people experiencing homelessness, highlighting the potential to bridge perspectives with managers and policymakers. Peers may thus act as knowledge brokers to leverage resilience (Haldane et al., 2021). However, the peer's ability to bridge perspective depended on providers', managers', and the organization's understanding and recognition of the value of his work, as well as their capacity to preserve flexibility in his role. According to participants, taking the time to establish partnerships between the peer and his colleagues and getting accustomed to one another, even during a period of rushed decision-making, was crucial to negotiate his role, and support his integration in the team.

Our experience occurred in a small-scale environment, which may have been favourable to a peer's integration and thus facilitated positive outcomes. Participants, for instance, reflected that the research team was a pivotal supporting structure in sharing the project load (e.g., organize meetings, ensure follow-ups, orient the peer's recruitment), providing a space to mitigate arising challenges, and offering the peer external support. In addition, the project benefited from the support of key stakeholders (e.g., directors and managers) in the organization, which may have facilitated the organization's commitment to the project and allocation of resources to support the peer's integration during a sanitary crisis. Nonetheless, our experience suggests that peer

partnerships could be a creative way to build resilience to ongoing systemic crises impacting people experiencing homelessness, as it is a trust-building, collaborative, and flexible approach to care. Through their ability to navigate health and social services, peer partnerships with organizations and providers may support access to housing or financial security. However, peers cannot act alone to address the crises impacting people experiencing homelessness. Tackling drivers of homelessness in a coordinated and timely manner requires mobilization from different social and health sectors, at different stages of a person's life trajectory (Doberstein & Nichols, 2016). Peer partnerships may be one of the many cornerstones to build resilience to crises in homelessness.

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CHAPTER NINE

Pandemic planning and homelessness: Delivering vaccinations to people experiencing homelessness in pandemics

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Abstract: This chapter discusses the delivery of vaccinations to people experiencing homelessness. People experiencing homelessness are at greater risk of COVID-19 infection, and of poor associated health outcomes, than people in the general population. Vaccination is vital in reducing these impacts of COVID-19, and of other pandemic diseases. However, delivering vaccinations – particularly, multi-dose vaccinations required at specific dosing intervals – to people experiencing homelessness is challenging. Subsequently, COVID-19 vaccination rates among people experiencing homelessness are often significantly lower. Throughout 2021 and 2022

– prior to and during the first major wave of COVID-19 infection in Queensland, Australia – I helped to run a mobile vaccination program for people experiencing homelessness. Using randomised trials, I tested financial incentives and reminder text messages as strategies to support vaccination uptake. I also completed systematic reviews identifying effective vaccination strategies, COVID-19 vaccination rates, and effective vaccine incentives among people experiencing homelessness globally. This chapter begins by considering the challenges associated with delivering COVID-19 vaccinations to people experiencing homelessness. It then presents a critical overview of the range of solutions to these challenges, in the context of COVID-19 vaccination specifically, via a systematic review of global literature. Finally, I reflect on the many lessons learned running a vaccination program in pandemic conditions.

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Introduction

People experiencing homelessness are at greater risk of COVID-19 infection (Corey et al., 2022; Levesque et al., 2022; Mohsenpour et al., 2021), and of poorer associated health outcomes (Richard et al., 2021), than people in the general population. Vaccination is vital in reducing the impacts of COVID-19, and of other pandemic diseases and infectious disease generally. However, as will be demonstrated in this chapter, delivering vaccinations – particularly, multi-dose COVID-19 vaccinations required at specific dosing intervals – to people experiencing homelessness is challenging. Subsequently, COVID-19 vaccination rates among people experiencing homelessness are often low. In pandemic conditions, this is a problem for people experiencing homelessness, and also puts the broader population at risk of disease outbreaks.

This chapter begins by considering the multiple, complex challenges associated with delivering COVID-19 vaccinations to people experiencing homelessness. It then presents a critical overview of a range of solutions to these challenges, in the context of COVID-19 vaccination and the pandemic specifically. Finally, it offers a reflection on additional lessons learned by the author through running a vaccination program for people experiencing homelessness in pandemic conditions. Together, the chapter forms an evidence-based guideline for future pandemic planning, in relation to delivering vaccinations to people experiencing homelessness.

Methods

The first two sections of this chapter are based on a scoping review of the literature about COVID-19 vaccination in people experiencing homelessness. The review used an existing database of literature, developed for a systematic review about interventions,

to improve vaccination uptake in people who are homeless. The database was created through searches undertaken on seven electronic databases using keywords related to ‘homelessness’ and ‘immunisation’. Full methods used to develop the database are detailed in McCosker et al. (2020) and McCosker et al. (2022). The database was limited to 2019 onwards, and updated on May 25, 2023. Over 900 pieces of literature were retrieved, and 59 were selected for inclusion.

All three sections are based on the author’s experience of running a COVID-19 vaccination clinic for people experiencing homelessness during the COVID-19 pandemic. This was, primarily, a mobile outreach clinic, which operated in Queensland, Australia, throughout 2021 and 2022. The clinic was part of the author’s PhD research about the impacts of COVID-19 on, and strategies to improve COVID-19 vaccination uptake in people experiencing homelessness.

Challenges associated with delivering COVID-19 vaccinations to people experiencing homelessness

There have been multiple, complex challenges associated with vaccinating people experiencing homelessness for COVID-19. Many of these challenges reflect those in the general population (Cox et al., 2023). While some are specific to COVID-19, many also relate to other vaccines and health issues. As people experiencing homelessness are a heterogeneous group (Bentivegna et al., 2022), the significance and impacts of these challenges are variable. Common challenges cited in the literature include: (1) mistrust, (2) confusing information, (3) vaccine concerns and hesitancy, (4) difficulties with access, and (5) ‘other’ challenges – as follows:

1. Mistrust

People experiencing homelessness often mistrust healthcare systems and services. Previous experiences of stigma, discrimination, and dehumanising treatment mean people experiencing homelessness sometimes choose to actively avoid healthcare services (Abramovich et al., 2022; Balut et al., 2022; Knight et al., 2021; McCann, 2021; Roederer et al., 2023; Rosen et al., 2022a). As a result, their access to vaccination is limited (Akingbola et al., 2022).

In people experiencing homelessness, mistrust of healthcare systems and services often relates to a broader mistrust of government. This was a particular problem during the COVID-19 pandemic, and with the COVID-19 vaccines. In people experiencing homelessness, mistrust of government was underpinned in part by government responses to the pandemic – for example, vaccine mandates (Balut et al., 2022); changing messages around vaccination (e.g. the need for multiple booster doses) (Berrou et al., 2022; Cox et al., 2023); and quarantine, masking, and social distancing enforced despite vaccination (Bentivegna et al., 2022; Cox et al., 2023). People experiencing homelessness frequently expressed concerns that governments were experimenting on them and others, with the COVID-19 vaccines (Abramovich et al., 2022; Balut et al., 2022; Berrou et al., 2022; Gin et al., 2022; Knight et al., 2021).

2. Confusing information

Many people experiencing homelessness reported finding public health information about COVID-19 vaccination to be unclear, contradictory, and excessive (Abramovich et al., 2022; Cox et al., 2023). Some considered this information to be too generalised and insensitive to their unique needs and lived realities (Abramovich

et al., 2022). Many did not trust the information they received about COVID-19 vaccination (Abramovich et al., 2022). These issues were complicated by low rates of health literacy (Knight et al., 2021) and formal education (Richard et al., 2022) commonly seen in people experiencing homelessness. An inability to seek and use health information was a significant predictor of hesitancy and refusal of COVID-19 vaccination in people experiencing homelessness (Longchamps et al., 2021).

Confusing public health information also meant people experiencing homelessness were often uncertain about if and when they were eligible to receive a COVID-19 vaccination (Balut et al., 2022; Berrou et al., 2022). They were also sometimes unsure about the risks associated with COVID-19 infection (Shariff et al., 2022). Low personal risk perception is another significant predictor of hesitancy and refusal of COVID-19 vaccination (Berrou et al., 2022; Grune et al., 2023; Kuhn et al., 2021; Rogers et al., 2022; Rosen et al., 2022a).

3. Vaccine concerns and hesitancy

Mistrust and confusing public health information meant that many people experiencing homelessness were concerned and thus, hesitant about receiving a COVID-19 vaccination. In one study, nearly half of the people experiencing homelessness surveyed reported that they did not trust the COVID-19 vaccines (Tucker et al., 2021). Key concerns are shown in Table 1.

Table 1. Key concerns reported by people experiencing homelessness about COVID-19 vaccination

- Concerns about vaccine side-effects, including unknown and long-term side-effects
- Concerns that vaccines are still experimental and their development was rushed

- Concerns about the need for more or better data on vaccine safety and efficacy
- Concerns that vaccines are not necessary and/or will not work
- Concerns that vaccines and/or their ingredients are harmful and will cause illness
- Concerns that vaccines have a malicious intent (e.g. tracking, control)

Note: Data from Abramovich et al. (2022); Cox et al. (2023); Della Polla et al. (2022); Gin et al. (2022); Jiménez-Lasserrotte et al. (2023); Knight et al. (2021); Kuhn et al. (2021); Meehan et al. (2022a); Meehan et al. (2022b); Roederer et al. (2022); Rosen et al. (2022a).

As shown in Table 2, many studies from different locations and dates identified that a large number of people experiencing homelessness were unwilling to receive a COVID-19 vaccine:

Table 2. The proportion of people experiencing homelessness unwilling to receive a COVID-19 vaccine, by location and date of data collection, reported in a sample of literature

- 15.4% (n=14, Canada, January 2021 to June 2021) (Abramovich et al., 2022)
- 17.2% (n=850, USA, May 2021 to November 2021) (Rosen et al., 2022a)
- 30.0% (n=6, USA, January 2021 to April 2021) (Gin et al., 2022)
- 31.5% (n=23, USA, December 2020 to February 2021) (Kuhn et al., 2021)
- 32.1% (n=36, Italy, 2021) (Iacoella et al., 2021)
- 35.3% (n=220, USA, March 2021 to June 2021) (Meehan et al., 2022a)
- 40.9% (n=98, France, May 2020 to June 2020) (Longchamps et al., 2021)
- 49.6% (n=62, USA, March 2021 to October 2021) (Tucker et al., 2021)
- 50.3% (n=492, France, November 2021 to December 2021) (Roederer et al., 2022)
- 55.0% (n=33, USA, February 2021) (Meehan et al., 2022b)

In addition, many people experiencing homelessness were unsure about receiving a COVID-19 vaccine and/or preferred to wait to receive a vaccine (Abramovich et al., 2022; Meehan et al., 2022a). Rates of vaccine hesitancy in the general population were far lower, ranging between 22.4% and 35.0% (Ahillan et al., 2023). However, it must be acknowledged that vaccine deliberation in people experiencing homelessness decreased (Rogers et al., 2022), and intent to receive a vaccine increased (Cox et al., 2022), over time throughout the pandemic.

4. Difficulties with access

People experiencing homelessness reported multiple difficulties with accessing COVID-19 vaccines and vaccination sites. For many people, vaccination was a low priority compared with accessing food and shelter (Abramovich et al., 2022; Cox et al., 2023; Gin et al., 2022; McCann, 2021; Roederer et al., 2023; Rosen et al., 2022a). Many people found registering and making appointments to be a complicated process (Goode et al., 2021; Knight et al., 2021; Paudyal et al., 2021; Roederer et al., 2022), due to literacy issues and/or a lack of access to internet technology (Mosites et al., 2022; Shariff et al., 2022). People reported long wait times due to COVID-19 vaccine shortages, and were discouraged by an absence of appointments (Grune et al., 2023; Lashley & Stoltzfus, 2021; Meehan et al., 2022a). Further, people often lacked the means to travel to vaccination sites (Abramovich et al., 2022; Akingbola et al., 2022; Balut et al., 2021; Bentivegna et al., 2022; Meehan et al., 2022a; Paudyal et al., 2021).

5. Other challenges

There were a variety of additional challenges associated with delivering COVID-19 vaccinations to people experiencing homelessness. Common challenges are shown in Table 3.

Table 3. Other challenges associated with delivering COVID-19 vaccinations to people experiencing homelessness

- Insufficient funding of non-governmental organisations delivering vaccinations
- Difficulties with providing vaccinations at recommended time intervals, tracking multiple doses across different record-keeping platforms, and verifying doses given
- Complexities around consent, particularly with mental illness and/or addiction

- Issues with reaching people with vaccination reminder messages
- Unwillingness to present for vaccination among people without legal residence status

Note: Data from Alsaïdi et al. (2021); Balut et al. (2022); Baral et al. (2021); Bentivegna et al. (2022); Gibson et al. (2022); Goode et al. (2021); Knight et al. (2021); Longchamps et al. (2021); McCann, (2021); Roederer et al. (2023); Roederer et al. (2022).

Because of these challenges, COVID-19 vaccination uptake among people experiencing homelessness was low. In 25 studies retrieved by the author for a systematic review, uptake for ≥ 1 dose of any COVID-19 vaccine ranged from 0.6% (USA, 2020-21) (Rogers et al., 2022) to 83.9% (Italy, 2022) (Della Polla et al., 2022). Generally, vaccination rates in people who are homeless were significantly lower than in the general population (Balut et al., 2021; Bentivegna et al., 2022; Berrou et al., 2022; Della Polla et al., 2022; Montgomery et al., 2021; Nilsson et al., 2022; Roederer et al., 2022; Shariff et al., 2022; Shearer et al., 2022).

There were particular challenges with reaching people experiencing homelessness from certain demographic groups. Generally, people from ethnic minority groups (e.g. Black, Asian, Latinx, Indigenous/First Nations) (Abramovich et al., 2022; Bentivegna et al., 2022; Gibson et al., 2022; Shariff et al., 2022; Shearer et al., 2022), those who experience clinically-significant mental illness (Abramovich et al., 2022; Kuhn et al., 2021), those who were unsheltered (Gebert, 2022; Gibson et al., 2022; Roederer et al., 2023; Roederer et al., 2022; Rosen et al., 2022b; Shariff et al., 2022), or who were transient (Bentivegna et al., 2022) had the lowest rates of vaccination.

Strategies to deliver COVID-19 vaccination to people who are homeless

To respond to the significant challenges associated with vaccinating people experiencing homelessness for COVID-19, evidence-based strategies were needed. In 2021 and 2022, the author completed a systematic review about strategies to deliver vaccinations to people experiencing homelessness. Although none of the studies included in this systematic review focused on COVID-19 vaccination specifically, as it was still early in the pandemic, the findings can be extrapolated to this context. The strategies identified are presented in Table 4.

Table 4. Findings from a systematic review about effective strategies to successfully deliver vaccinations to people experiencing homelessness

- Using nurses to deliver vaccinations
- Delivering vaccinations at locations convenient to people experiencing homelessness
- Using accelerated vaccination schedules (if available)
- Vaccinating at the first appointment, regardless of whether a person's vaccination history or serological status were known (if clinically safe)
- Operating clinics for a longer duration
- Offering training to staff about working with people who are homeless
- Widely promoting clinics, so people know where to go to be vaccinated
- Considering education, reminders, incentives, and co-interventions
- Ensuring no out-of-pocket costs to people presenting for vaccination

- Working collaboratively with stakeholders, including people who are homeless

Note: Data from McCosker et al. (2022).

The literature about COVID-19 vaccination in people experiencing homelessness identifies additional strategies: (1) prioritisation of people experiencing homelessness in vaccination rollouts; (2) mobile outreach clinics; (3) dedicated fixed clinics; (4) improving vaccination messaging; (5) harnessing vaccination motivators; (6) concurrent service provision; (7) interdisciplinary partnerships; (8) ensuring correct staffing; (9) utilising peer ambassadors; (10) vaccination incentives; (11) vaccination reminders; and (12) ‘other’ strategies, as follows:

1. Prioritisation in vaccination rollouts

Because they are at a greater risk of COVID-19 infection, and of poorer associated health outcomes, there is a strong case for prioritising people who are homeless during COVID-19 vaccination rollouts (Eriksen et al., 2022; Leifheit et al., 2021). In many regions, including parts of Canada (Shariff et al., 2022) and some states in the USA (e.g. California, New York, Washington), people experiencing homelessness were identified as a priority group early in the rollout. Elsewhere, including in the UK, people experiencing homelessness were only identified as a priority group after lobbying by homelessness advocates (Paudyal et al., 2021).

2. Mobile outreach clinics

In most regions, the COVID-19 vaccination rollout to the general population involved delivering vaccinations at medical clinics, pharmacies, and mass vaccination hubs. People experiencing homelessness were often “*left behind*” by this approach (Leifheit et al., 2021). Subsequently, mobile outreach clinics were

implemented for this population. These frequently targeted shelters; not only are people experiencing homelessness easier to reach in shelter settings, outbreaks of infectious disease are common in these settings (Baral et al., 2021; Chen et al., 2022; Paudyal et al., 2021). For example, in Toronto, Canada, all shelters hosted at least one vaccination clinic within the first 6 months of the vaccination rollout (Akingbola et al., 2022; Shariff et al., 2022). Other locations for mobile outreach clinics are shown in Table 5.

Table 5. Locations for mobile outreach clinics delivering COVID-19 vaccinations to people experiencing homelessness

- Hostels, boarding houses
- Encampments in public places (e.g. parks, train stations, factories)
- Homelessness services centres
- Physical distancing hotels
- Churches, religious organisations
- Warming and cooling centres
- Meal programs
- Opioid replacement programs
- Recycling centres
- Syringe/safe injecting locations
- Correctional institutes, prisons, jails

Note: Data from Bentivegna et al. (2022); Berrou et al. (2022); Leifheit et al. (2021); McCann, (2021); Montgomery et al. (2022); Mosites et al. (2022); Rosen et al. (2022a); Shariff et al. (2022); Shearer et al. (2022).

Often, these sites were targeted with vaccination ‘blitzes’, which aimed to vaccinate as many people as possible in a short period of time (Babando et al., 2022; Balut et al., 2022; Lashley & Stoltzfus, 2021). Sometimes, regular clinics were scheduled – for example

weekly (Bentivegna et al., 2022) or fortnightly (Rosen et al., 2022b) – until saturation was reached.

3. Dedicated fixed clinics

In addition to mobile outreach clinics, many regions implemented fixed clinics focused on delivering COVID-19 vaccinations to vulnerable populations, including people experiencing homelessness (Currie et al., 2022; Roederer et al., 2023). These were typically situated in existing health services locations, including hospital emergency departments (Ford et al., 2023; Rodriguez et al., 2021), veterans' health centres (Balut et al., 2022), and general homeless health services locations (Currie et al., 2022). To promote engagement, it was necessary that people were helped to feel safe, valued, and confident in the clinic space (Currie et al., 2022). Provision of transport to fixed clinics was an important consideration (Balut et al., 2022), for example via partnerships with local volunteers, or via local bus services offering vehicles and drivers. A drop-in model was effective at addressing the difficulties associated with making vaccination appointments (Balut et al., 2022; Cox et al., 2023; Paudyal et al., 2021).

4. Improved messaging

Information that is objective, honest, and professional can improve vaccination intent in people experiencing homelessness (Cox et al., 2023). People obtained information about COVID-19 vaccination from a variety of sources – common examples are shown in Table 6.

Table 6. Sources of information about COVID-19 vaccination accessed by people experiencing homelessness

- Internet, websites
- Social media sites, including Facebook, Instagram, Reddit, etc.
- Television
- Radio
- Newspapers
- Written materials, flyers, fact sheets
- Podcasts

Note: Data from Balut et al. (2022); Berrou et al. (2022); Cox et al. (2022); Cox et al. (2023); Della Polla et al. (2022); Gin et al. (2022); Meehan et al. (2022a).

Messaging about COVID-19 vaccination for people experiencing homelessness might be improved by simplifying the information, reiterating key details, targeting the demographic (e.g. emphasising the risks of COVID-19 in congregate settings like shelters), providing clear details (e.g. vaccine actions, side-effects), and being specific about where, when, and how to get vaccinated (Cox et al., 2023). Messaging must be consistent across different sites and platforms (Currie et al., 2022; Goode et al., 2021). Involving people in the development of information is an important consideration (Specht et al., 2022), as is the provision of information in multiple languages where relevant (Bentivegna et al., 2022). Providing information face-to-face is also highly effective. This might involve running ‘information days’ (Bentivegna et al., 2022), walk-up information booths at shelters (Cox et al., 2022), and question-and-answer sessions with health professionals (Balut et al., 2022; Cox et al., 2022). Discussions with health professionals should be precise, clear, and non-judgemental (McCann, 2021). Access to interpreters, if required, is vital (Currie et al., 2022).

5. Harness vaccination motivators

People experiencing homelessness identify a number of reasons why they are motivated to receive a COVID-19 vaccine. Wherever possible, these should be harnessed in written and verbal messaging about COVID-19 vaccination. Common reasons are presented in Table 7.

Table 7. Reasons people experiencing homelessness identify for receiving a COVID-19 vaccination

- To protect oneself from COVID-19 infection (i.e. fear of poor health outcomes)
- To protect others from COVID-19 infection (i.e. sense of civic responsibility)
- To return to 'normal', to resume regular social activities
- To meet a vaccination requirement (e.g. for work, for travel)
- To access services, including homelessness shelters

Note: Data from Cox et al. (2023); Della Polla et al. (2022); Gin et al. (2022); Jiménez-Lasserrotte et al. (2023); Knight et al. (2021); Meehan et al. (2022a); Mosites et al. (2022); Roederer et al. (2023); Roederer et al. (2022).

6. Concurrent service provision

COVID-19 vaccinations for people experiencing homelessness were often delivered alongside other health and social services. This maximised opportunities for vaccination, routinised vaccination, and helped make services generally more accessible (Gin et al., 2022; Paudyal et al., 2021; Shariff et al., 2022). Examples of concurrent services are provided in Table 8.

Table 8. Examples of services provided to people experiencing homelessness alongside COVID-19 vaccination

- Primary healthcare (e.g. blood pressure checks, medication refills, screening)
- Other vaccinations (e.g. for hepatitis A/B, influenza, streptococcus pneumonia)
- Chronic wound care and diabetic foot services
- Basic or emergency dental care
- Testing for COVID-19 and common bloodborne illnesses (e.g. hepatitis C)
- Social services to address housing needs, locate a place to sleep, arrange access to resources (e.g. food, water, hygiene products, harm reduction supplies)

Note: Data from Babando et al. (2022); Baral et al. (2021); Boelitz et al. (2023); Currie et al. (2022); Goode et al. (2021); Grune et al. (2023); Lashley & Stoltzfus, (2021); Lazarus et al. (2023); Meehan et al. (2022a); Rosen et al. (2022a).

Services were often provided while people waited in their post-vaccination recovery period, maximising the use of participants' time and avoiding the need for multiple visits (Lashley & Stoltzfus, 2021). Access to concurrent services was not dependent on a person agreeing to receive a COVID-19 vaccine (Rosen et al., 2022a). To maintain connection to services, some temporary programs encouraged registration with a trusted local doctor (Berrou et al., 2022).

7. Interdisciplinary partnerships

Interdisciplinary partnerships were vital in the delivery of COVID-19 vaccinations to people experiencing homelessness. Key stakeholders included frontline health professionals, homelessness services providers (e.g. shelter staff, outreach workers, social

workers), government health and public health departments, non-governmental organisations, academic institutions, and community leaders (Babando et al., 2022; Balut et al., 2022; Bentivegna et al., 2022; Berrou et al., 2022; Jiménez-Lasserrotte et al., 2023; Montgomery et al., 2021; Nilsson et al., 2022; Paudyal et al., 2021). Services with pre-existing trust with people experiencing homelessness were essential (Paudyal et al., 2021). Coordinating multiple stakeholders relied on strong governance structures and clearly-established roles (Berrou et al., 2022; Lashley & Stoltzfus, 2021), regular coordination meetings (Bentivegna et al., 2022; Goode et al., 2021), and processes to maintain people's confidentiality across multiple services (Baral et al., 2021).

8. Correct staffing

The frontline health professionals involved in the delivery of COVID-19 vaccinations to people experiencing homelessness included doctors, nurses, mental health providers, and community health workers (Rosen et al., 2022b). In many regions, health professionals were exhausted by the pandemic, and health students became vital in the delivery of COVID-19 vaccinations to people experiencing homelessness (Brown et al., 2021; Goode et al., 2021).

A trusting relationship between health professionals and people experiencing homelessness was imperative (Balut et al., 2022; Bentivegna et al., 2022). As a result, in some regions, health professionals received training in skills such as motivational interviewing and trauma-informed care (Balut et al., 2022; Currie et al., 2022). Maintaining staff safety (e.g. ensuring early access to COVID-19 vaccination, and limiting disease exposure through the use of personal protective equipment) was essential (Brown et al., 2021; Ralli et al., 2021; Rao et al., 2021).

9. Peer ambassadors

In many regions, peer ambassadors – sometimes referred to as ‘peer navigators’ (Lazarus et al., 2023) or ‘vaccination champions’ (Goode et al., 2021) – were utilised to encourage uptake of COVID-19 vaccination in people experiencing homelessness (Balut et al., 2022; Cox et al., 2023; Paudyal et al., 2021; Shariff et al., 2022; Shover et al., 2022). Peer ambassadors were seen as a trusted source of information about the COVID-19 vaccines, and were able to provide testimonials about their experience of being vaccinated (Choi et al., 2022; Gin et al., 2022; Lashley & Stoltzfus, 2021). They may have also introduced people to trusted health workers, or accompanied people to vaccination appointments (Choi et al., 2022; Roederer et al., 2023).

10. Incentives

In many regions, incentives were offered to promote uptake of COVID-19 vaccination in people experiencing homelessness (Babando et al., 2022; Balut et al., 2022; Cox et al., 2023; Rosen et al., 2022a). The author led a randomised controlled trial testing the effect of a small financial incentive, a \$10 grocery voucher, on uptake. At the time of publication, the results were in development, but promising. Other types of incentives offered are shown in Table 9.

Table 9. Examples of incentives offered to promote uptake of COVID-19 vaccination in people experiencing homelessness

- Gift cards (US\$50), cash (US\$20)
- Hot meals, restaurant lunch, donuts
- Clothing
- Relief from lockdowns, masking
- Paid time off from work
- Free childcare

Note: Data from Cox et al. (2023); Lashley & Stoltzfus, (2021); Rosen et al. (2022a).

Although there are ethical concerns about the use of incentives, a very small proportion of people experiencing homelessness reported feeling coerced or bribed by incentives (Rosen et al., 2022a). However, many people expressed caution about cash incentives (Cox et al., 2023).

11. Reminders

As the COVID-19 vaccines must be given as multiple doses at specific dosing intervals, reminder messages are an important consideration to encourage uptake of COVID-19 vaccination in people experiencing homelessness. The author led a second randomised controlled trial testing the effect of text message reminder wording on uptake; at the time of publication, the results were in development, and variable. For multiple reasons, reaching people experiencing homelessness with text message reminders can be difficult (Goode et al., 2021). Creative alternatives such as waterproof reminder cards, pop-up alerts on health clinic computer systems, and active recall by outreaching social workers are important to consider.

12. Other strategies

There are a variety of other strategies that might support the delivery of COVID-19 vaccinations to people experiencing homelessness. Key ideas are presented in Table 10.

Table 10. Other strategies to support the delivery of COVID-19 vaccinations to people experiencing homelessness

- Providing a place for people experiencing vaccination side-effects to recover
- Offering a choice of COVID-19 vaccine brand (e.g. Pfizer, Moderna, Janssen)
- Offering single-dose vaccines, where these are available, approved, and effective
- Ensuring access to vaccination is not reliant on health insurance/medical coverage
- Targeting people from demographic groups with known low rates of uptake
- Where vaccination appointments are required, designing streamlined systems, avoiding systems that are multi-step, require internet access, or ask for a home address
- For initial vaccinations spaced closely, booking the second appointment while at the first
- Being flexible – for example, if a person is experiencing difficulty with following instructions due to mental illness, discreetly moving them through ahead of others
- Avoiding the need for people to present identification or residency documents

Note: Data from Babando et al. (2022); Balut et al. (2022); Choi et al. (2022); Cox et al. (2023); Currie et al. (2022); Grune et al. (2023); McCann, (2021); Meehan et al. (2022a); Morrone et al. (2022); Mosites et al. (2022); O'Reilly et al. (2023); Rosen et al. (2022b).

A note about housing

A lack of suitable housing is a significant barrier to COVID-19 vaccination (Roederer et al., 2023). Housing improves access to healthcare, and it improves health behaviours, including in relation to uptake of COVID-19 vaccination and related public health advice (Babando et al., 2022; Balut et al., 2021). Even in people who are vaccinated, housing instability increases the likelihood of COVID-19 infection (Bean et al., 2021). Advocating for people's access to suitable housing is, therefore, a vital consideration for vaccination providers.

Lessons learned running a COVID-19 vaccination program for people who are homeless in pandemic conditions

In addition to the strategies discussed in the literature about COVID-19 vaccination in people experiencing homelessness, the author identified a number of additional lessons learned through running a COVID-19 vaccination program in pandemic conditions. Key new understandings relate to: (1) the need to take action; (2) logistical considerations; (3) funding; (4) record-keeping; and (5) generating data to inform evidence-based practice. These lessons are further described as follows:

1. Take action

When people experiencing homelessness are left behind by vaccination rollouts in the general population, advocates must be proactive in response. This is particularly important where other public health restrictions (e.g. masking, social distancing, travel restrictions) are set to ease, and a wave of infection is anticipated, as emphasised by Currie et al. (2022), *“if you insist on having a*

perfect project in place before you start, people will die". Our vaccination program was implemented relatively rapidly, and some mistakes were made – as shown in Table 11.

Table 11. Mistakes made in implementing a COVID-19 vaccination mobile outreach clinic for people experiencing homelessness in Australia

- We offered transportation via bus to some sites, but found it difficult to coordinate pickup locations/times, manoeuvre the vehicle, and move people in a timely way
- We overlapped, unknowingly, with other vaccination providers at some sites
- We had clinics where we ran short of vaccines, were unable to offer people their preferred vaccine brand, and gave no vaccines as the site was already saturated
- We evaluated and modified the program continuously as it was implemented. Although mistakes were made, 'doing' was a far more effective approach than 'waiting and planning'.

2. Logistical considerations

Implementing a COVID-19 vaccination program for people experiencing homelessness was logistically complex. Prior to starting, it was necessary to arrange and, if needed, expedite approvals for billing mechanisms, recruitment and training of staff, licensing and insurance, vaccine cold-chaining, and physical resourcing. Key resources are shown in Table 12.

Table 12. Examples of the resources required to implement a COVID-19 vaccination mobile outreach clinic for people experiencing homelessness in Australia

- Vaccines of a variety of brands
- Hand sanitiser, alcohol wipes, disinfectant surface spray
- Gloves, masks, face shields, gowns

- Drawing up and administration needles, syringes, normal saline
- Skin cleansing swabs, cotton balls, plasters for injection site, skin tape
- Lollipops, bottles of water
- Flyers/posters to advertise clinic
- Printing of reminder cards and consent forms, clipboards, pens
- Transport for clinic staff to sites
- Vaccine refrigerator with monitoring
- Tables, chairs, bins, sharps containers
- Laptop computer with internet access

3. Funding

Because of the resource-intensive nature of vaccination programs for people experiencing homelessness, proper funding is vital. Our clinic was funded in part via Medicare (Australia's universal health insurance scheme), support from a government health department for staffing, and a philanthropic grant, however, it was dependent on time and resources donated by staff. At the time of publication, the author is completing work calculating the costs (versus benefits) of the program, but it is apparent that each clinic cost multiple hundreds of dollars to run.

4. Record-keeping

Our clinic kept multiple records: patient details (in medical practice software), billing (via the Medicare portal), proof of vaccination (via the national immunisation register), reminder messaging (in a spreadsheet), and research/evaluation (in a second spreadsheet). Due to difficulties with access to technology and the internet in the field, information was often collected on paper and later transferred. This was time-intensive and only

achievable with administrative support. There is a clear need for more streamlined and integrated systems.

5. Data for evidence-based practice

Data to inform evidence-based practice for vaccinating people experiencing homelessness, including for COVID-19, is vital. Most of the studies cited in this chapter are descriptive – that is, they are based on observation, expert opinion, and professional judgement about what works. Our own inferential studies in development, are limited by small sample sizes and the fact they were conducted in pandemic conditions. Greater investment into research is vital.

Conclusion

The COVID-19 pandemic resulted in the largest global vaccination effort in history. As people experiencing homelessness are at greater risk of COVID-19 infection, and of poorer associated health outcomes, it was imperative that they were not left behind during vaccination rollouts. This chapter discussed five key challenges associated with delivering COVID-19 vaccinations to people experiencing homelessness. It then presented twelve solutions to these challenges, and a reflection on five other key lessons learned through running a vaccination program in pandemic conditions. This chapter forms an evidence-based guideline for future pandemic planning, in relation to delivering vaccinations to people experiencing homelessness. It will support health and social services during the next pandemic to respond rapidly with vaccination and protect some of the most vulnerable people in society and, thus, society as a whole.

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CHAPTER TEN

***HELP USA's Covid-19 Transitional Housing Peer
Vaccine Support Program***

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Abstract: HELP USA tracked Covid-19 vaccination rates of its transitional housing (TH)¹ clients between April 2021 and

1. In the New York City shelter system, transitional housing refers to sites in the system that are intended to provide temporary housing to clients while social workers facilitate their access to permanent housing. All sites discussed in this chapter are transitional housing sites. For the purpose of brevity we refer to these sites as “shelters” throughout the chapter.

September 2022. Through coordination with the local government, HELP USA was able to secure vaccinations for its TH sites. In August 2021, the city government began providing vaccinations at these sites throughout the city. By February 2022, clients' full vaccination rates at 19 HELP USA TH sites (61%) continued to trail the city's general population (77%). The share of clients in single adult facilities that had received their vaccinations at their sites remained low throughout the winter: only 35% had received at least one dose of the vaccine at their sites in December and in February, respectively. The on-site vaccination rates of clients in family sites were significantly lower than single adults. In response HELP USA implemented a peer support program at three sites. The objective was to increase client vaccination rates to New York City population rates by emphasizing individual "peer" appeals to increase access to and knowledge of Covid-19 vaccines (Kirzinger, Sparks, & Brodie, 2021; Zivot & Jabeley, 2022). Peer service models have enhanced the access of vulnerable groups to other critical services, such as HIV treatment, harm reduction programs and after-care stroke services (Kessler, Egan & Ann-Kubina, 2014; Iraywan et al., 2022). The full vaccination rates of one of the three sites exceeded the New York City rate and was comparable to the NYC adult rate. This chapter details the responses to HELP USA's transitional clients in three phases: a de-densification strategy in hotels before the availability of the vaccine in 2020; ensuring vaccines in shelters and tracking client vaccine rates after vaccines became available to the wider public throughout 2021; and the implementation of a peer vaccine support program to increase vaccine rates in 2022. The chapter presents findings of the peer program in context of HELP USA's three-year history of service provision for homeless clients throughout the Covid-19 pandemic.

Ethics Review Statement: HELP USA obtained consent from respondents for surveys we administered throughout the study period discussed in the chapter. Frontline social workers and the research team protected identities of all respondents by administering the survey anonymously. No names or personal identification were recorded.

Conflict of Interest: The authors of this study report no conflicts of interest.

Statement of Funding: The research team did not receive dedicated funding to conduct this research.

Introduction: HELP USA's first response to the Covid-19 crisis among persons experiencing homelessness (March – December 2020)

By the Spring of 2020, New York City accounted for five percent of the world's confirmed Covid-19 cases (McKinley, 2020). A June 2020 preliminary investigation of Covid-19 related mortality rates of persons experiencing homelessness in NYC estimated that the average number of monthly Covid-19 deaths among the city's shelter clients was 157% higher than the monthly average number of all-cause related deaths in 2019 (Routhier & Nortz, 2020).

In this context, the major challenge that NYC homeless shelters and service providers faced at the time was de-densifying facilities to protect social workers and residents from viral contagion and spread. In 2020, HELP USA, the employer of this chapter's authors, implemented a minimum staffing model. The organization permitted social service staff to partially work from home and condensed schedules of frontline staff to enable these essential workers to perform their jobs on site for as few days as optimal.

It was simultaneously imperative to protect clients. Alongside other service providers, we asked the local government to permit clients to live in vacant hotel rooms throughout the city. After his initial hesitation, Mayor Bill De Blasio consented to this option in May 2020 (Anuta, 2020). City agencies used federal pandemic relief aid to pay for these hotel rooms. HELP USA was one of the first homeless service providers to implement the shelter de-densification strategy. By June 2020, we had moved about 550 clients from congregate sites into two large Manhattan hotels.

This strategy likely saved lives. The NYC Coalition for the Homeless estimated the death rate per 100,000² to be 171.87 from April to June 2020 (Routhier & Nortz, 2020). We estimated that the death rate among HELP USA shelter clients was 133 per 100,000. De-densification was our primary Covid-19 prevention strategy until vaccines became available.

On December 10, 2020, the U.S. Food and Drug Administration approved the two dose Covid-19 Pfizer vaccine for people above 16 years of age (FDA, 2021). That week, the vaccine became available to first responders, hospitals, and care facility operators, which included organizations that provided essential services to persons experiencing homelessness (Cullinane, Yan, & Ellis, 2020). HELP USA immediately coordinated efforts to retrieve vaccine supplies. By January 2021, we had secured 150 vaccines as well as medical personnel to administer them to our clients and staff in a few neighboring single adult male shelters. Thus, we began our

2. Four clients were known to have succumbed to Covid-19 during these months. We serve an average of approximately 3,000 clients daily in our New York City shelters. We note that our estimate is based on clients who were known to have passed away from COVID. However, as in cases of other shelters and even non-homeless people who passed away, not every suspected COVID death was definitively verified by an autopsy. However, the rate of resident deaths remained low throughout the pandemic as we maintained the hotels and kept our shelters and transitional housing sites open, dispersing residents and staff alike.

efforts to expand the supply of and access to the vaccine across our shelters and track client vaccination rates.

The second response: Ensuring vaccines in shelters and tracking vaccine rates (January – December 2021)

HELP USA began administering Covid-19 vaccines in a few single adult men's shelters in coordination with government social service and medical providers in January 2021, after the city approved the distribution of the two dose Pfizer and Moderna vaccines in New York City shelters that month. In March 2021, the local government approved the distribution of the single dose Johnson & Johnson (J&J) vaccine in New York City shelters. However, officials halted the distribution of vaccines in April 2021 for the brief period that the federal government ordered a moratorium on the J&J vaccine. HELP USA's frontline shelter workers suggested that the interruption affected clients. More than a few remained 'hesitant' to receive the vaccine after the moratorium was lifted that month.

In this context, our research team began tracking vaccine awareness, demand, and uptake among clients in our single adult shelters across seven measures:

- 1. Were shelter clients aware that the Covid-19 vaccine was available at HELP USA shelter locations?*
- 2. Had clients attempted to access the Covid-19 vaccine at a HELP USA shelter location?*

3. *Had clients received the first dose³ of the Covid-19 vaccine?*
 - b. *Did they receive the first dose of the Covid-19 vaccine at a HELP USA shelter location?*
4. *Had clients received the second dose of the Covid-19 vaccine?*
 - b. *Did they receive the second dose of the Covid-19 vaccine at a HELP USA shelter location?*
5. *Did clients desire assistance from HELP USA staff to avail the vaccine?*

The objective was to track client vaccine rates to distribute vaccines across our shelters as early as possible. We also wanted to establish baseline measures of vaccine access and demand indicators to measure progress throughout the pandemic. These tasks were essential to serve the approximately 3,000 HELP USA clients in 19 NYC single adult and family shelters in multiple city locations as the uncertainty that defined the pandemic continued to unfold.

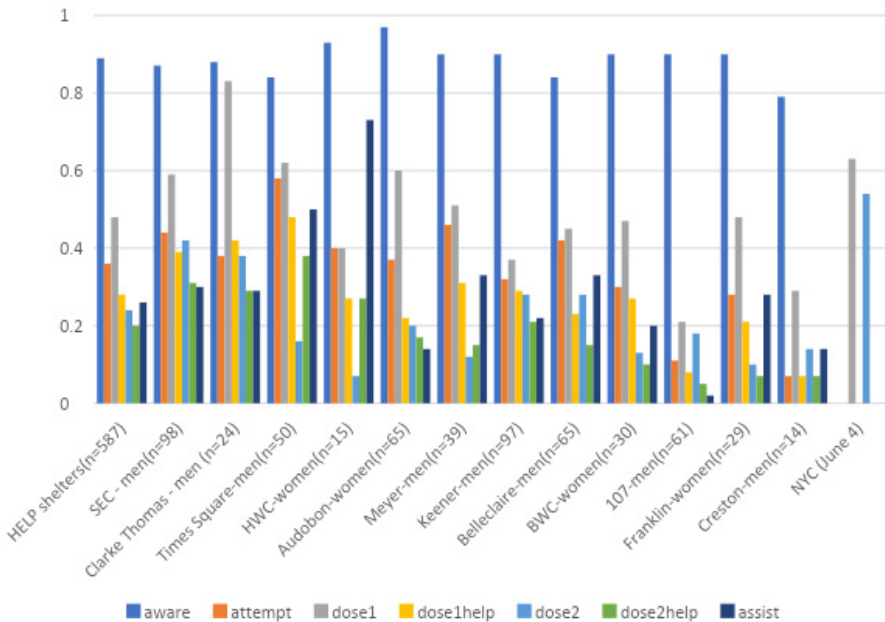
We tracked these measures over three survey periods. We conducted a baseline survey from April to June 2021 and two follow up surveys in December 2021 and February 2022. For the rest of this section, we'll summarize the key trends over 2021 (the first two rounds). We used these findings to coordinate vaccine distribution efforts with the local government throughout that year and to identify the need for a peer vaccine support program in shelters, which we designed and implemented in 2022.

The baseline study surveyed 587 clients from six single adult male and four adult female shelters as well as two temporary hotels.

3. According to the CDC, people who had received at least one dose (≥ 1 dose) were those who received at least one dose of COVID-19 vaccine, including those who received one dose of the single-shot J&J/Janssen COVID-19 vaccine. This study relied on the CDC definition for its calculation and discussion of rates of shelter clients that received at least one dose of COVID 19 vaccine (CDCa, n.d.).

These sites had an average daily census of 1625 people throughout the survey period. We found that by June 2021, 48% of clients were partially vaccinated (28% at a HELP USA shelter) and 24% were fully vaccinated (20% at a HELP USA shelter). By comparison, 63% and 54% of New York City adults were partially vaccinated and fully vaccinated by June 4, 2021 (NYC Dept of Health, n.d.). On May 10, officials reported that 10.9% of the city’s shelter clients were fully vaccinated (Raskin, 2021) (Figure 1). The provision of the vaccines in HELP USA shelters in January potentially led to higher vaccination rates among our clients compared to the city’s sheltered population. Our goal was to raise client vaccination rates to city levels.

Figure 1. Covid-19 Vaccine Demand and Coverage Indicators (April-June 2021) (n=587)



Coordination with local authorities was essential to ensuring adequate vaccine supplies. The baseline survey also revealed the challenge of low vaccine demand among clients. Most respondents (89%) knew that the vaccine was available in shelters but only 36% had tried to avail them at a HELP USA site and 26% wanted assistance from social workers to do so.

Vaccine attempts and partial vaccination rates were significantly higher ($p < 0.05$) among clients in male sites that had received vaccines before the moratorium. In the Times Square hotel ($n=50$), a temporary residence for some Meyer shelter clients (a men's shelter), 58% of respondents had attempted to avail the vaccine at a HELP USA location and 62% were also partially vaccinated (48% at a HELP USA site). In two neighboring men's shelters, HELP USA Supportive Employment Center (SEC) and Clarke Thomas, 59% and 83% of respondents were partially vaccinated (39% and 42% at a HELP USA site).

In August 2021, the Department of Homeless Services (DHS) announced that they would administer the Pfizer vaccine in New York City shelters and provide incentives - gift cards and metro passes - to vaccinated clients. The December 2021 survey ($n=539$) measured changes from baseline in vaccine demand and access indicators, particularly in context of the recent DHS vaccine service & incentive initiative. We identified six findings.

First, full vaccination rates of our clients more than doubled from 24% at baseline to 56% in December, but continued to significantly trail the NYC adult full vaccination rate of 83.7% (NYC Department of Health, n.d.). Clients' partial vaccination rates also improved from 48% to 72%, and the share that had received at least one dose of the vaccine at a HELP USA shelter increased from 28% to 35% (Table 1).

Second, client demand for vaccines at shelters remained low across our shelters and particularly among younger female clients. By December 2021, the number of clients that attempted to get vaccinated at their shelters (38%) and that had received the second vaccine dose at their shelters (22%) only improved by two percent from the baseline survey (Table 1).

Table 1. Vaccine Demand & Access: December 2021 findings in context of April-June 2021 baseline indicators

Survey Periods	Attempt (%)	Dose 1 (%)	Dose 1-help (%)	Dose2 (%)	Dose2-help (%)	Assist (%)	Boost (%)
April-June '21 (n=587)	36.12	48.26	28.11	24.19	19.76	26.24	
December '21 (n=539)	37.78	65.21	27.2	55.85	21.66	33.4	11.34
NYC adult pop (diff, CI)				83.7% (55.01, 50.76-59.18)*			
difference (Conf Int) + *diff & CI from Dec '21 dose2	1.66 (-3.98-7.31)	17(11.18-222.55)	0.91 (-4.3-6.1)	31.66(26.07-36.97)	1.9 (-2.84-6.68)	7.16(1.8-12.49)	n.a.

Note: differences in bold indicates significance (p<0.05)

The youngest clients were least likely, and the two oldest client groups were most likely, to be vaccinated (Table 2). Only 6% of clients aged 18–24 were fully vaccinated at a HELP USA shelter (Table 2). Three fourths of this group (n = 24; 76%) were women.

Table 2. Partial and Full Vaccination Rates by Age Group (December 2021 survey) (n=511)

Age group	Attempt (%)	Dose1 (%)	Dose-1h (%)	Dose2 (%)	Dose2-h (%)	Assist (%)	Boost (%)
18 to 24	24.24	60.6	11.76	41.17	5.88	35.29	15.15
25 to 34	39.1	61.26	22.52	53.2	20.91	31.53	3.63
35 to 44	33.67	61.61	26.53	52.52	18.18	24.24	11.22
45 to 54	37.61	64.15	26.85	61.68	24.3	32.11	9.52
55 to 64	45.45	68.64	35.54	60.17	29.41	41	16.38
65+	33.33	75	17.78	64.44	24.44	35.55	20.93
Total	37.78	64.77	26.11	56.64	22.37	33.08	11.49

The remaining findings highlighted relationships between the supply of vaccines throughout the year and corresponding vaccination rates across shelters.

The third finding was that more vaccines were administered in HELP USA shelters in the winter of 2021 (January-March 2021) than between August and October 2021 - the months following DHS' new vaccine services. The daily average of 4.77 administered first doses and 2.9 second doses in HELP USA shelters dropped to 1.4 first and 0.39 second doses from August to October 2021 (Table 3). However, vaccines were administered more consistently, at least one day each week, during the second period. In the first period, a high number of vaccines were administered in just a few days. For example, a total 87 first doses were administered to all HELP USA shelters in February 2023. No vaccines were administered in the 24 previous days.

Table 3. Weekly Average of Vaccines Administered in HELP USA Shelters (January – October 2021)

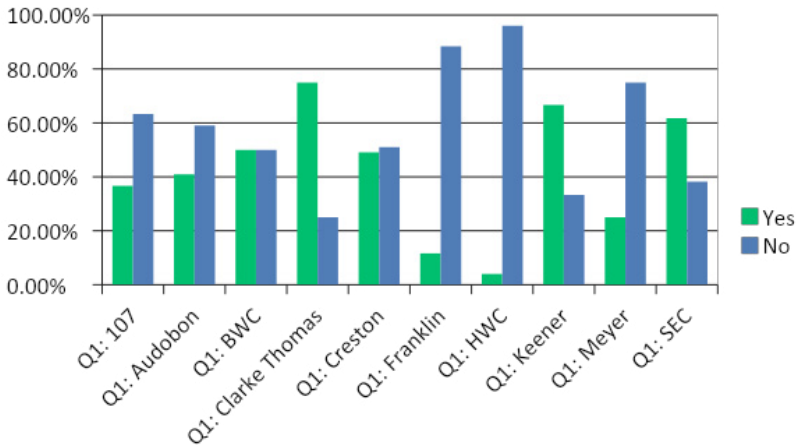
Week	Dose 1	Dose 2	Week	Dose 1	Dose 2
1/25-1/31	10.1	0	6/13-6/19	0.14	0.14
2/1-2/7	0	0	6/20-6/26	0.29	0.14
2/8-2/14	0	0	6/27-7/3	0	0
2/15-2/21	0	0	7/4-7/10	0.14	0.14
2/22-2/28	22	4.4	7/11-7/17	0	0.14
3/1-3/7	0.14	0	7/18-7/24	0.29	0
3/8-3/14	8.3	8.3	7/25-7/31	0.5	0
3/15-3/21	2.57	2.57	8/1-8/7	0.7	0
3/22-3/28	0.43	11.3	8/8-8/14	2.14	0
3/29-4/4	2.71	1.71	8/15-8/21	2.86	0.14
4/5-4/11	8.1	8	8/22-8/28	0.57	0.43
4/12-4/18	0	0	8/29-9/4	1.86	0.29
4/19-4/25	0.29	0.17	9/5-9/11	1.71	0.43
4/26-5/2	1.3	1.3	9/12-9/18	1.57	0.29
5/3-5/9	0	0	9/19-9/25	1.43	0.86
5/10-5/16	0.86	0.57	10/24-10/30	0.71	0.14
5/17-5/23	0	0.14	9/26-10/2	1.57	0.86
5/24-5/29	1.14	1	10/3-10/9	1.86	0.43
5/17-5/23	0	0.14	10/10-10/16	0.57	0.86
5/24-5/29	1.14	1	10/17-10/23	1	0.43
5/30-6/5	0.14	0.29	10/24-10/30	0.71	0.14
6/6-6/12	0.14	0.14			

The fourth finding related to patterns of vaccine supplies (as discussed above) within the context of higher vaccine rates in three neighboring men's shelters. Clients of the shelter with the highest partial vaccination (98%) and full vaccination (93%) rates by December 2021, a site called Keener (n=47), were more likely to have received their first dose after DHS' new vaccine

services were initiated. Indeed, 38% of these respondents became partially and fully vaccinated that October and November alone. Clients of Clarke Thomas (n=73) continued to have the highest on-site partial (56%) and on-site full vaccination rates (39%) in this follow-up survey and were more likely than clients in other shelters to have been vaccinated in the winter, before the J&J vaccine moratorium (24% had received their first dose in March). Lastly, a “leading” baseline survey shelter, SEC, registered declines in major indicators except their full vaccination rate (51%).

Fifth, the share of clients in women’s intake facilities that attempted to avail vaccines at their sites decreased significantly, from 28% to 12% in one site called Franklin, and 40% to 12% at the other called HELP USA Women’s Center (HWC). This decline correlated with the apparent dearth of visits to these sites by DHS vaccine administrators after August, when new services and incentives were announced. 88% and 96% of the female clients in Franklin and HWC reported that they had not witnessed an increase in visits to their sites by DHS vaccine administrators (Figure 2). Conversely, 75% and 67% of clients in the men’s sites, Clarke Thomas and Keener, had witnessed increases in these visits.

Figure 2. Share of Clients that Reported Witnessing an Increase in Vaccine Administrator Visits to their Shelter (Dec 2021) (n=539)



Sixth, only 29% of respondents had received a gift card from DHS administrators after becoming partially vaccinated. Over half (51%) of clients in Keener – the site with the highest partial vaccination rate – had received this incentive. Only 15% of respondents had received the gift card and metro card after becoming fully vaccinated.

These findings confirmed that overall vaccination rates increased significantly between the baseline and follow up surveys while on-site vaccination rates stagnated over this period partly due to inconsistent vaccine distribution levels across shelters. As a result, clients were obtaining vaccines from other locations. The higher volume of administered vaccines in our shelters in winter compared to later that year conformed to the pattern in the general NYC population (NYC Department of Health, n.d.). However, because client vaccine rates continued to significantly trail the adult NYC population, we realized that a dedicated peer vaccine support group program may help increase both the volume of vaccines

administered in shelters and coverage rates. The next section details why and how we designed and implemented the program.

The third response: the peer vaccine support program (February 2022 – September 2022)

By January 2022, multiple research studies had confirmed that vaccination was the safest individual and public health strategy against the contraction and transmission of Covid-19 (Thompson et al., 2021; Sadoff et al., 2021; Thomas et al., 2021; Zivot & Jabaley, 2022). However, half of Americans remained unvaccinated at that point and vaccination rates of persons experiencing homelessness were 11 to 35% lower than the general populations of major cities (Montgomery et al., 2021; Zivot & Jabaley, 2022). For example, 19.8% and 44.5% of homeless persons in Washington, DC and Chicago, IL were vaccinated compared to 54.8% and 55.7% of these cities' general populations, respectively (Montgomery et al., 2021).

As 56% of our single adult shelter population and 83.7% of NYC adults were fully vaccinated by December 2021, we surmised that our single adult shelter clients were relatively more protected against Covid-19 than similar populations in other cities yet still considerably less so than the general population of their own city. DHS' dedicated shelter vaccine program may have increased vaccination rates in some shelters, but this program's ability to increase those rates further may have plateaued. Indeed, nearly two-thirds (63%) of clients in our December survey reported that visits by DHS vaccine administrators had no influence on their decision to get vaccinated or remain unvaccinated.

Studies also confirmed that legal mandates as well as marketing and media campaigns actually increased vaccine "hesitancy" in some contexts as these methods were perceived as coercive and

unpersuasive (Zivot & Jabeley, 2022). Alternatively, programs that relied on community members to provide information on vaccines, share their successful experiences with vaccines, and offer unvaccinated people help to access them, increased vaccine rates (Zivot & Jabeley, 2022). This “peer” support model has increased the usage of services in numerous other contexts such as HIV treatment, harm reduction programs for persons using substances, and after-care stroke services (Kessler, Egan & Ann-Kubina, 2014; Iraywan et al., 2022; Kirzinger, Sparks, & Brodie, 2021; Zivot & Jabeley, 2022). In peer support programs among the homeless, successful outcomes have been attributed to discussions between peer leaders and clients about their “*shared experiences*”, such as on shaping models of recovery from homelessness (Barker and Maguire, 2017).

We therefore decided to implement a peer vaccine support program in select shelters in order to increase vaccination rates at these sites to city levels. We decided to include family shelters in this program, so we conducted a survey in February 2022 that included 533 respondents from eight family shelters that we had never surveyed and 766 respondents from the ten single adult shelters that were included in previous surveys. The full vaccination rates of single adults increased from 56% in December 2021 to 61% in February 2022. In the newly surveyed family shelters, 60% of respondents were vaccinated.

Female and male respondents had comparable full vaccination rates (61.8% and 60.4%, respectively). However, people between the ages of 45 and 64 (39% of the sample), as well as persons of Latinx (34% of the sample), and Asian/Pacific Islander (1.86%) origins, had significantly higher full vaccination rates (Tables 4 & 5). Additionally, the chronically homeless clients had higher vaccination rates than the recently homeless, as 64.75% and

55.9% of respondents who had experienced homelessness for more than two years and less than six months, respectively, were fully vaccinated.

Table 4. Full Vaccination Rates by Demographic Indicators (February 2022, n=1287)

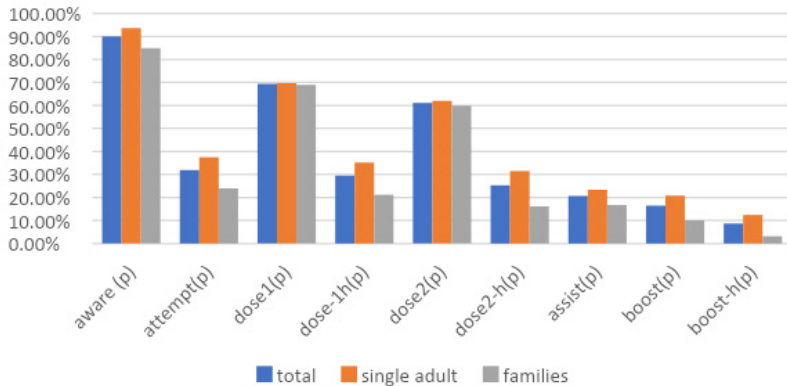
	% Surveyed	% Fully Vaccinated
Gender		
Female	48.88%	61.80%
Male	50.81%	60.40%
Non-binary	0.31%	75.00%
Age group		
6 to 17	2.55%	31.25%
18 to 24	11.99%	51.30%
25 to 34	27.38%	55.46%
35 to 44	22.58%	62.72%
45 to 54	16.86%	67.91%
55 to 64	14.15%	72.78%
65+	4.49%	66.10%
Race		
American Indian or Alaskan Native	1.16%	40.00%
Asian/Pacific Islander	1.86%	75.00%
Black or African American	54.85%	58.00%
Hispanic	33.59%	65.96%
White/Caucasian	5.82%	66.00%
Multiple Ethnicity	2.72%	50.00%
Length of Homelessness		
less than 6 months	19.84%	55.90%
more than 6 months but less than 1 year	18.84%	57.50%
1 to 2 years	28.76%	62.46%
more than 2 years	32.56%	64.75%

Table 5. Predictors of Full Vaccination Rates

	% Surveyed	Vaccinated	B	p-value	OR
Age group					
18 to 24	11.99%	51.30%	1.017	0.017	2.764
25 to 34	27.38%	55.46%	1.324	0.002	3.758
35 to 44	22.58%	62.72%	1.648	<0.001	5.195
45 to 54	16.86%	67.91%	2.017	<0.001	7.517
55 to 64	14.15%	72.78%	1.62	0.001	5.053
Race					
Asian/PI	1.86%	75.00%	1.264	0.041	3.541
Hispanic	33.59%	65.96%	0.788	0.035	2.199

As in previous surveys, the trend of increasing overall vaccination rates and low on-site vaccination rates continued in single adult shelters but it was also evident across family shelters (Figure 3).

Figure 3. Covid-19 Vaccine Demand and Coverage Indicators (February 2022): Family (n=759) and Single Adult Shelters (n=530)



In single adult shelters, the percentage of clients that had attempted to get vaccines at their shelters and that had received at least one vaccine dose at their shelter did not change between

December and February (38% and 35%, respectively). The share of clients that were fully vaccinated at HELP USA shelters improved from 22% to 32%. Awareness of vaccine availability in shelters, attempts to receive vaccines in shelters, and rates of people who had received at least one dose or had become fully vaccinated, were considerably lower in family shelters than in single adult shelters.

In this context, we used the following criteria to select shelters to implement the peer vaccine support program. Among single shelters, we chose one site, Creston (n=46), that continued to have low full vaccination rates. In this men's shelter, 52% of respondents were fully vaccinated and 20% had become fully vaccinated at their site. We also chose SEC (n=156), the men's shelter we discussed earlier, where full vaccination rates had improved (67%), but on-site vaccination rates remained low (25%) compared to other sites. Among family shelters, we chose HELP USA Haven (n=49), where 47% of respondents were fully vaccinated but only 1 person (2%) had become fully vaccinated at the shelter. In this shelter, attempts by respondents to avail vaccines at their site (7%) and awareness of this service (77%) were comparatively lower.

We adapted our 10-week peer support model from the following sources: Kessler et al.'s 2014 study on peer programs for stroke survivors, the World Bank & IMF's Peer Support Group Facilitator Guide (2020), the peer support handbook for health workers providing HIV treatment for youths created by Pediatric Adolescents' Treatment Africa (PATA) (PATA, 2017), and CDC guidelines on providing information on COVID-19 (CDC b-d, n.d.). Based on these guides, we identified four components of the program to meet our objective which was to increase client full vaccine rates to NYC levels:

- facilitate vaccine access through social support, foregrounded by compassion
- quell client distrust of institutions
- ensure safe spaces in shelters
- engage vaccinated shelter clients in the program to serve as peer navigators with paid compensation

Social workers from Creston, SEC, and Haven selected two fully vaccinated clients from their shelters to serve as vaccine peer navigators. These clients embraced open-mindedness, a hopeful attitude, honesty, and empathy towards other clients. Also critical were those clients that social workers believed could perform the essential tasks of the program. These tasks included acting as a support group leader and treatment buddy, sharing information on Covid-19 vaccines (including their own experiences), and conducting outreach and community work, including guiding, and accompanying clients to vaccine visits. One social worker from each site, a logistics coordinator (LC), helped peer navigators identify the unvaccinated clients in the shelter to engage through the program. Another social worker served as the vaccine coordinator (VC). As the name suggests, they coordinated visits of vaccine administrators to the shelter. One peer navigator facilitated access to local vaccinator visits for unvaccinated clients who expressly wanted to be vaccinated. Another peer navigator conducted information and support sessions for “hesitant” clients. After one week of planning and one week of training, the eight-week implementation phase began. Each four-member shelter program team held weekly reviews. The research team trained all peer teams, then met with them collectively four times throughout the implementation phase of the program.

In our May 2022 review session with the authors and program teams, peer navigators discussed four concerns that prevented “hesitant” clients from getting the vaccine. We can summarize these concerns as questions:

- *Is Covid-19 still a threat?*
- *Are vaccines safe and effective?*
- *Are side effects common and harmful?*
- *What is long Covid? Will the vaccine protect me from it?*

We collectively devised a strategy to address these issues. The research team produced a frequently asked questions (FAQ) brief with answers for each concern. The answer to the Covid “*threat*” question, for example, explained that New York City had recently experienced another surge of Covid-19 cases (3,500/day) and hospitalizations (130/day), prompting health officials to declare a “*high Covid alert*” status in the city (Goldstein, 2022). Peer teams posted the brief in community areas and used the prompts to engage with groups of clients (rather than individuals) during social events, mealtimes, and in shelters’ public and recreational spaces.

Findings of the Peer Support Program

The program concluded in July 2022. We resurveyed the three peer support program shelters (n=187) and nine shelters that did not have the program (n=599). By September, the full vaccination rate of the total sample (61%) had not changed since the previous survey round (February 2022) and remained lower than the all-NYC and adult NYC vaccination rates (80% and 89%, respectively). But the full vaccination rate of “*peer*” shelters (72%) was significantly higher than non-peer shelters (58%) (Figure 4).

On-site vaccination rates were also higher. Among peer shelters, SEC's full vaccination rate (86%) was comparable to the NYC adult rate and above the all-city rate (Figure 5). We ascertained the extent to which we measured like samples before and after the peer support intervention by analyzing the extent to which client "exits" from shelters in this study contributed to actual turn over in those respective shelters. Mobility is a prominent feature within the New York shelter system, as clients often leave and return to the same shelter within days or weeks. Most "exits" from shelters occur for "unknown" reasons, and are in fact coded in the city's official database as "exit unknowns". "Exit unknowns" could, theoretically, entail three possibilities:

1. leaving the shelter, remaining within the shelter system and returning to the shelter
2. leaving the shelter, remaining within the shelter system but not returning to the shelter
3. leaving the shelter system for reasons other than a housing placement.

From September 2021 to September 2022, 52% of total exits from our shelters (16,043 out of 28,531) were "exit unknowns".

Approximately 3.5% (n=993) of total exits during this period were due to a housing placement, which we can more safely assume entailed a permanent exit from the New York City shelter system. The remaining exits during this period could still entail a readmission to the shelter. These exits were coded as transfers to another shelter, admissions to healthcare facilities, and violations. We therefore evaluated the extent to which "exit unknowns" potentially indicated a "true shelter exit" (as illustrated by possibilities 2 and 3).

Because mobility is a dominant characteristic of NYC shelters,

it was crucial to understand the extent to which the potentially countless patterns of mobility may have resulted in significant population changes in the peer support (PS) and non-peer support (NPS) shelters that we surveyed before and after the peer intervention.

Our evaluation of this matter proceeded in four steps. First, we calculated the difference between the total number of unique clients in PS and NPS shelters each month as well as the number of unique clients in those respective shelters on the last day of each month (Tables 5 and 6). This figure provided us with the number of “*total theoretical exits*” (or, potential “*true exits*”) that could have occurred over respective time periods (Table 7). Second, we subtracted the number of total “*exit unknowns*” for PS and NPS shelters for each time period from the total number of theoretical exits in Table 7 to ascertain the possibility that all “*exit unknowns*” were “*true exits*” from the shelter. This tabulation is included in Table 8. Negative numbers (red cells) indicated that it was impossible for all “*exit unknowns*” to be “*true exits*” from shelters. This reflected the likelihood, confirmed by frontline staff, that the vast majority of clients more often leave and return to their respective shelters frequently. That is, the negative “*exits*” (Table 8) indicated that shelter populations surveyed before and after the peer intervention were similar in their mobility patterns.

To further evaluate this hypothesis, we ascertained the possibility that the total number of “*exit unknowns*” could have been “*true exits*” under the assumption that all “*non-exit unknowns*” were also “*true exits*”. This is the third step in our assessment. We subtracted all “*non-exit unknowns*” for each time period from the “*total theoretical exits*” (Table 9). Positive numbers (green cells) indicated the number of exit unknowns that were “*true*” exits under the assumption that we have just noted. This possibility

rose in months for PS and NPS shelters after May 2022 when massive waves of migrants from the southern border began entering NYC shelters after governors of southern U.S. states transported them to the city. This situation continues unabated. Negative numbers (red cells), recorded in PS and NPS shelters for pre- and post-periods respectively, indicated that it was impossible for (a) any “exit unknowns” to be “true exits” and (b) all “non-exit unknowns” to be “true exits.”

Fourth, we subtracted the total number of exits that were recorded in the official database (“exit unknowns” and all “non-exit unknowns”) from the total number of “theoretical exits” (Table 10). Again, “theoretical exits” reflected the difference between the total number of unique clients in shelters in particular months and the total number of unique clients in those shelters on the last day of the month. This calculation is essentially a sanity check, which shows that there were more “exits”, recorded in official data records, than “true exits”.

These steps confirm the high likelihood that our PS and NPS shelters comprise highly mobile populations that often repeatedly leave and re-enter shelters.

We must acknowledge one exception: movement between shelters is intrinsic to the function of “assessment” sites, for example, Franklin and HWC (two NPS shelters), which assess needs of clients and assign them residence in another shelter within 21 days. In this context, the total number of “theoretical exits” in these two NPS shelters exceeded the total number of “exit unknowns” for pre- and post-periods, indicating that it was possible for all exit unknowns to be “true exits” (step two in the above analytical check). In this case, different populations may arise over survey periods due to the inherent nature of these sites. However, the total number of all exits, which include transfers and violations

(and would not include housing placements), exceeded the total number of “theoretical exits” (the last analytical check), indicating the frequent movement of clients within the shelter system.

Figure 4. Covid-19 Vaccine Demand and Coverage Indicators (September 2022): Peer Support (n=187) and Non-Peer Support Shelters (n=599)

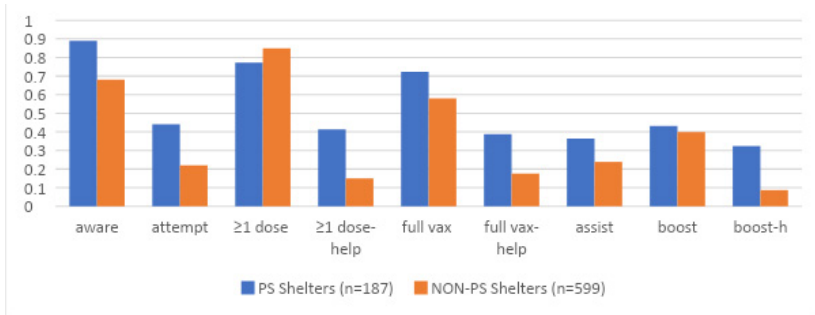


Figure 5. Covid-19 Vaccine Demand and Coverage Indicators (September 2022): SEC (Peer Support Shelters) (n=99) and Non-Peer Support Shelters (n=599)

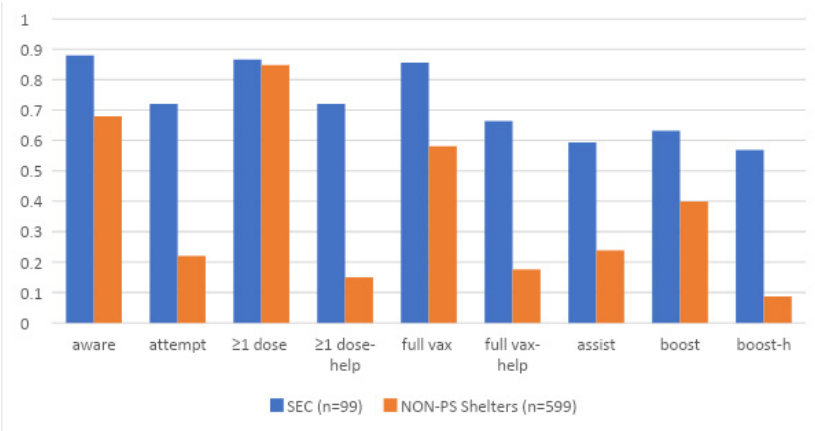


Table 6⁴. Total Unique Clients in Shelters

Site	PS	Non-PS
Sep '21	296	2423
Oct '21	302	2446
Nov '21	296	2431
Dec '21	299	2432
Jan '22	293	2432
Pre	383	4881
Feb '22	286	2376
Mar '22	290	2473
Apr '22	293	2459
May '22	282	2490
Jun '22	304	2605
Jul '22	321	2737
Aug '22	327	2814
Sep '22	352	3439
Post	556	8209

Table 7. Total Clients on Last Day of Time Period

Site	PS	Non-PS
Sep '21	304	1711
Oct '21	297	1736
Nov '21	310	1759
Dec '21	293	1698
Jan '22	290	1764
Feb '22	293	1718
Mar '22	291	1739
Apr '22	282	1703
May '22	264	1771

4. Data on shelter exits in Tables 5-10 was unavailable for one PS shelter (the family shelter, Haven).

Site	PS	Non-PS
Jun '22	298	1847
Jul '22	302	1905
Aug '22	313	1888
Sep '22	332	2023

Table 8. Total Theoretical Exits (“True Exits”) from Shelter

Site	PS	Non-PS
Sep '21	23	712
Oct '21	35	710
Nov '21	22	672
Dec '21	40	734
Jan '22	38	668
Pre	128	3117
Feb '22	25	658
Mar '22	33	734
Apr '22	43	756
May '22	47	719
Jun '22	32	758
Jul '22	49	832
Aug '22	47	926
Sep '22	51	1416
Post	255	6186

Table 9. Total Theoretical Exits (“True Exits”) - Exit Unknowns

Site	PS	Non-PS
Sep '21	-156	-220
Oct '21	-147	-274
Nov '21	-139	-272
Dec '21	-91	-128
Jan '22	-130	-129
Pre	-693	-1402
Feb '22	-128	-147
Mar '22	-137	-410
Apr '22	-136	-104
May '22	-156	-316
Jun '22	-202	-448
Jul '22	-238	-543
Aug '22	-144	-562
Sep '22	-122	216
Post	-1335	-2927

Table 10. Total Theoretical Exits (“True Exits”) - Non-Exit Unknowns

Site	PS	Non-PS
Sep '21	-14	-339
Oct '21	2	-210
Nov '21	-21	-209
Dec '21	2	-177
Jan '22	-4	-233
Pre	-65	-1547
Feb '22	5	-188
Mar '22	-12	-283
Apr '22	5	-206
May '22	6	-275
Jun '22	-3	35

Site	PS	Non-PS
Jul '22	20	225
Aug '22	13	161
Sep '22	10	91
Post	-28	-1053

Table 11. Total Theoretical Exits (“True Exits”) - All Exits

Site	PS	Non-PS
Sep '21	-193	-1271
Oct '21	-180	-1194
Nov '21	-182	-1153
Dec '21	-129	-1039
Jan '22	-172	-1030
Pre	-886	-6066
Feb '22	-148	-993
Mar '22	-182	-1427
Apr '22	-174	-1066
May '22	-197	-1310
Jun '22	-237	-1171
Jul '22	-267	-1150
Aug '22	-178	-1327
Sep '22	-163	-1109
Post	-1618	-10166

Conclusion: Harnessing findings of the peer vaccine support program for recommendations

The first conclusion that we can draw is that the peer support program increased demand and access to the vaccine in the SEC shelter amid the potential “*fatigue*” and hesitancy that peer workers had identified in this population. Peer workers in the SEC

were especially active in identifying fatigue, and holding discussions based on the FAQs, with numerous clients. They reported that these conversations helped convince younger clients to get vaccinated and that their presence may have facilitated vaccine appointments of older clients who were generally more willing to get vaccinated. As we recall, client vaccination rates among older clients were progressively higher than in younger cohorts. In the SEC, 42% of surveyed clients in February were between the ages of 45 to 64 while 48% of clients were between 18 and 44 years of age. By comparison, peer workers in Creston and Haven reported that hesitancy remained a problem among younger cohorts. In Creston, 41% of surveyed respondents were between 18 and 44. In Haven, 57% of respondents were in this age range (and only 11% were between 45 and 64). Among non-peer shelters, Clarke Thomas and Meyer had full vaccination rates above the city's full vaccination rate – 88% and 83% compared to 80%. These two neighboring adult male shelters had received vaccines in early 2021 and also had a high share of older clients.

The second conclusion is that the improvement in on-site vaccination rates in the SEC indicated that the peer team effectively engaged with the initially hesitant clients to enable access and increase uptake to vaccines that were delivered to shelters and administered by the government. Thirdly, and relatedly, the SEC peer team's ability to connect clients to the service at the shelter indicated a successful method of enhancing clients' agency to demand and retrieve an essential public service. The effective level of peer engagement with clients at the SEC led to a higher rate of service access compared to other sites. This can be attributed to the convergence of four factors that a literature review of peer support studies among homeless populations has identified as increasing the quality of life for such clients (Barker & Maguire 2017). The shared experiences between peer support

workers and clients (e.g., living in the same transitional housing facility) and role modeling (“*possess[ing] similar traits*” as clients served), engendered trust among clients and rapport between both parties, which motivated clients to discuss their hesitancy, consider information provided by peer workers and, in some cases, proactively seek assistance of peer workers to attend vaccine appointments. In this context, the peer workers provided a consistent base of social support – an outcome that scholars have shown can “*integrat[e]*” homeless clients into a “*service community*” (Barker & Maguire 2017, 608-609). Service integration was essential because delivering the vaccine to homeless clients required coordination between government agencies and non-government service providers. This is known as a public-private partnership (PPP) model and is often undermined by conflicts and coordination problems that inhibit the access of services to targeted, and particularly vulnerable, populations (Swyngedouw, 2005).

Lastly, peer workers encouragement of attendance at vaccine appointments through individual outreach efforts and group engagement during social events and in shared spaces, contributed to comparatively higher on-site vaccination rates at the SEC. Barker and Maguire (2017) confirmed that successful methods of encouraging the attendance of people experiencing homelessness at service appointments had positive outcomes on such clients’ well-being. In our final group meeting, peer workers revealed that the “*social event*” and “*shared space*” approach was more successful in the SEC than other peer sites, particularly Haven, which indicated that group approaches may work better in single adult male sites than in family sites.

The peer vaccine program enhanced capacities of the local government and our non-governmental service agency to deliver the vaccine in the SEC because frontline social workers provided a

structure and support base that enabled peers to transform their knowledge of homelessness into a specialized form of outreach that addressed the needs and concerns of clients. Rooted in the establishment of trust with persons experiencing homelessness, this peer model can, under certain conditions, more sustainably produce behavioral changes that lead to well-being than traditional case management approaches (Barker & Maguire, 2017; Craig et al., 2008; Moore et al., 2015; World Bank & IMF, 2020). Municipal governments that contract non-government agencies to deliver services to people experiencing homelessness should implement peer programs for annual flu and Covid-19 vaccine drives. The peer programs should ensure training for and provide resources to logistics and vaccine coordinators as well as client peers with two objectives in mind: to establish a structure and support base that enables peers to work effectively with frontline workers and encourages clients to avail services under positive and enabling circumstances; and to address additional needs of clients that may arise from their frequent mobility in and out of shelters.

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SECTION THREE

City, Regional, and State Level Responses

Dr. Rebecca Schiff

While Sections 1 and 2 of this volume took an in-depth look at populations and services, Section 3 turns to geography. This section takes a deep dive into specific geographic contexts, with detailed exploration of experiences at municipal, regional, and state levels. The chapters in this section focus on how COVID-19 responses, in the context of homelessness services and people experiencing homelessness, emerged and evolved at varying geographic and political scales. With case studies from Canada, the United States, and Switzerland, the experiences and lessons learned in this chapter have implications for a broad range of geographies from rural and remote regions to large cities, small cities and examination of state / provincial government responses to the pandemic.

This section begins with an often-overlooked geography in homelessness research: rural and remote regions. For decades, homelessness has been considered primarily an urban issue with the majority of research focusing on homelessness in cities. Rural

homelessness has received some attention, which has grown in recent years. The first chapter in this section focuses specifically on rural homelessness. Wilkinson and Schiff report on the results of a national survey of rural homelessness service providers conducted during the COVID-19 pandemic. Their chapter focuses specifically on innovative ways in which rural providers continued to support persons experiencing homelessness despite the significant challenges of the pandemic.

This section then focuses on municipal experiences and response with two chapters: the first - an examination of Dublin, Ireland and the second - an examination of Winnipeg, Canada. The first of these chapters, by O Carroll and colleagues, focuses on the ways in which homelessness services in the city of Dublin, Ireland demonstrated a strongly collaborative response to the COVID-19 crisis. This chapter describes the approach taken collaboratively to the pandemic by the Health Service Executive, the National Social Inclusion Office, and the Dublin Regional Homeless Executive. They conclude with insights into the ways in which this response demonstrates the importance and impact of collaborative response during a pandemic crisis.

The next chapter on city-level response focuses in on Winnipeg and Indigenous-led responses to homelessness in the context of COVID-19. In this chapter Distasio and colleagues pay particular attention to the leadership of End Homelessness Winnipeg – an Indigenous led organization which was vital to the collaborative pandemic response across the homelessness-serving sector in that city. The findings of their research point to several recommendations for pandemic response as well as for larger systemic issues in the housing response system.

This section concludes with an examination of state / provincial level responses and experiences during the COVID-19 pandemic.

Rodriguez and colleagues offer an expansive examination of experiences across the U.S. state of Indiana. Between 2020-2022, they gathered perspectives from representatives of 5 different community-based homelessness serving organizations in the state. They also conducted interviews with 34 individuals who were using homelessness services during the pandemic. Findings from this study identify multi-level challenges facing people experiencing homelessness during a pandemic. They also highlight 5 key lessons / considerations which can inform future state level responses and pandemic planning.

CHAPTER ELEVEN

Impacts of COVID-19 on Homelessness Services in Rural Communities: Provider Perspectives

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Abstract: In rural and remote communities, homelessness is an even greater challenge due to a lack of affordable housing, a lack of employment opportunities, and a lack of social services. COVID-19 exacerbated these challenges and created new ones related to pandemic preparedness and response. Part of a larger, mixed-methods study on the impacts of the COVID-19 pandemic on rural homelessness, this chapter examines qualitative data collected through that project. This chapter begins with a brief overview of the current state of knowledge about rural homelessness in Canada and the associated challenges faced by rural communities that are working to address/end homelessness. The

chapter then describes results of semi-structured interviews with homeless service providers (HSPs) from across Canada. Interviews were aimed at understanding the impact of the COVID-19 pandemic on rural homelessness and services available as well as the needs of rural service providers in relation to pandemic planning and preparedness. The results of the analysis are organized to reflect the two key aims of the interviews and are presented in this chapter as: 1) pandemic experiences in rural/remote communities and 2) needs & recommendations. Overall, the findings of this study demonstrate that rural and remote communities faced significant struggles in response to numerous challenges during COVID-19. This important research calls for increased attention to the issue of rural homelessness, pandemic planning for vulnerable populations in rural/remote communities, and ways to improve support for homeless service providers during crises.

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Introduction

Supporting the unique needs and vulnerability of homeless populations was a major component of the Canadian Federal response to the COVID-19 pandemic. In spite of that, rural and remote communities, and homelessness service providers, received a small and disproportionate fraction of this federal funding. Historically, prior to the recent pandemic, there had been limited research on rural communities' pandemic preparedness in the context of homelessness. *Pandemic Preparedness and Homelessness* (Buccieri & Schiff, 2016) was the first book to bring together the work of Canadian researchers exploring the vulnerability of homeless populations in the event of a pandemic, and was utilized by the Public Health Agency of Canada (PHAC) in their *Pandemic Preparedness Guide for the Health Sector* (PHAC, 2018). Prior to the Buccieri and Schiff (2016) volume, there was little other literature examining pandemic preparedness in the homeless sector. The chapters in Buccieri and Schiff (2016) primarily focused on analyzing the impact of the H1N1 outbreak within the context of urban homelessness in Canadian cities, with little attention to rural locations. Similarly, the PHAC guide contains no mention of rural communities and their unique needs during pandemic crises. There is clearly a large gap in current supports for and understandings of pandemic responses in the context of homelessness in rural settings – a gap which led to the research presented in this chapter.

This gap may be in part due to longstanding perceptions of homelessness as mostly an urban phenomenon (Bruce 2006; Waegemakers Schiff et al., 2015). Homelessness, as defined by the Canadian Observatory on Homelessness, “*describes the situation of an individual, family or community without stable, safe, permanent, appropriate housing, or the immediate prospect, means and ability of*

acquiring it.” (Gaetz et al., 2012, p.1). Thistle (2017) expands on this definition for Indigenous Peoples experiencing homelessness, stating, “*Indigenous homelessness is not defined as lacking a structure of habitation; rather, it is more fully described and understood through a composite lens of Indigenous worldviews*” (p. 6). Moreover, he explains that homelessness:

is not simply a response to such circumstances, but is best understood as the outcome of historically constructed and ongoing settler colonization and racism that have displaced and dispossessed First Nations, Métis and Inuit Peoples from their traditional governance systems and laws, territories, histories, worldviews, ancestors and stories. (Thistle, 2017, p.6)

In Canada, the assumption of homelessness as an urban phenomenon has been reinforced by homelessness interventions that have primarily focused on targeted (mostly urban) communities. However, the past decade has seen a steady increase in research and reports on rural homelessness. Recent research on rural homeless enumeration has found that rates of homelessness in rural/remote communities across Canada are quite high (Schiff et al., 2020, 2022). According to Schiff et al. (2022), in many rural communities, rates of homelessness are higher – sometimes as much as four times the rates found in enumerations in major urban centres.

People experiencing homelessness (PEH) faced unique challenges during the COVID-19 pandemic including increased risk of exposure to the virus (Knight et al., 2022), reduced access to essential services and sanitation facilities (Conway et al., 2020; May & Shelley, 2023), and organizations transitioning to telehealth or other avenues of virtual support that were inaccessible (Conway et al., 2020), and limited access to healthcare (Maretzki et al., 2022).

These challenges were exacerbated in rural/remote communities, which often encompass vast geographies with lower population density, PEH living in isolated areas (MacDonald & Gaulin, 2020), lack of infrastructure including public transportation (Buck-McFadyen, 2022), and limited availability of shelters and addictions and mental health services (Forchuk et al., 2010; Friesen, 2019; MacDonald & Gaulin, 2020)

Taken together, there are numerous challenges in rural/remote and northern communities, which require consideration in order to provide adequate supports for pandemic preparedness in the context of rural homelessness. For rural communities to be better prepared for future pandemics, it is critical to understand their capacities and needs for pandemic planning. Additionally, understanding the impact of the ability of rural Homeless Service Providers (HSPs) and homeless individuals to access resources that are provided by their urban counterparts, and supports needed to develop pandemic plans that meet the unique needs of these communities is crucial to ensuring their preparedness. This research is aimed to address these gaps by assessing the experiences of rural and remote communities during the COVID-19 pandemic.

Methods

This work is part of a larger, mixed-methods study on pandemic preparedness in the context of homelessness in rural/remote communities. The study contained a survey (quantitative) component as well as semi-structured interviews as the qualitative component. This chapter focuses specifically on the qualitative data collected through semi-structured interviews. Ethics approval for this project was granted by the Research Ethics Boards at Lakehead University and Trent University.

Prior to beginning the project, members of the research team developed a semi-structured interview guide. Questions in the interview guide were divided into 3 sections: The Local Context, The Impact of COVID-19, and Pandemic Response within a Rural and/or Remote Community. Questions about organizational and community indicators mirrored those utilized in the survey (quantitative) portion of the study, however additional questions were added to gather more in-depth information about the impact of COVID-19. The questions included focused on funding, client impacts, impacts on staff, daily operation of organizations, and challenges caused by dealing with COVID-19 (in the context of homelessness) in a rural/remote community.

Twenty qualitative interviews were completed with rural/remote HSPs over Zoom from May to June 2021. Two interviews contained multiple individuals with a total of 23 research participants. Interviews were conducted with providers from rural and remote communities in Alberta (n=2), British Columbia (n=1), Manitoba (n=1), Newfoundland & Labrador (n=1), Northwest Territories (n=2), Nova Scotia (n=1), Nunavut (n=1), Ontario (n=10), and PEI (n=1). Communities represented had populations as low as 1,145, and an average population of 20,969.

Figure 1: Participant Communities (By Province)



Of those participants who provided demographic information, 80% identified as female, 15% identified as male, and 5% identified as non-binary. In terms of ethnicity, 75% self-identified as Canadian Anglophone, 15% identified as Indigenous, 5% identified as other, and 5% did not disclose. All interviews were conducted one-on-one, with two exceptions, as noted above. Participants provided information about their role within the organizations, and a portion of the sample included individuals in leadership roles (i.e., program directors). Overall, participants represented a variety of positions including but not limited to program directors, program coordinators, case workers, client service managers, CEOs, and city staff. Since interviews were conducted one-on-one, the presence of leadership in the dataset did not hinder the responses of their direct reports. The diverse sample composition allowed for a mix of perspectives on the topic of homelessness and pandemic preparedness in rural/remote communities.

The length of interview sessions varied based on participant

feedback and ranged from approximately 30 minutes to 1 hour and 50 minutes in duration. Using the audio and video recordings from Zoom, interviews were transcribed by members of the research team and graduate students. When transcriptions were complete, the research coordinator who conducted the interviews reviewed the transcripts for accuracy. A thematic coding framework was then developed by the research team, with two parent themes based on the initial research aims: 1) HSP experiences during the COVID-19 pandemic and 2) pandemic planning and preparedness needs among HSPs. These themes correspond to the sections outlined in the interview guide, with sub-themes developed through iterative coding done using NVivo software. Findings are presented in the next section and correspond to this coding framework.

Findings

1. Pandemic Experiences

Funding

For many rural communities, funding for homeless services is limited. While 29% of the Canadian population are rural residents (Canadian Rural Revitalization Foundation, 2021), in 2019 only 8% of federal funding was assigned to the “*Rural and Remote*” stream (National Alliance to End Rural and Remote Homelessness, 2021). Other streams of federal homelessness and housing funding also disproportionately favour large cities. This includes the Rapid Housing Initiative which includes a “*Major Cities Stream*” and no stream of funding specific to rural, northern, and Indigenous applicants. With this information in mind, we sought to understand what funding rural and remote homelessness organizations in Canada received during the COVID-19 pandemic.

The majority of participants reported receiving government funding (federal, provincial or municipal) during the COVID-19 pandemic. Other sources of funding reported by participants included health organizations, private donations, and fundraising. In some instances, participants reported being funded by multiple sources:

We're funded through federal government so Public Health Agency of Canada... as well as Alberta Health Services and the provincial government...we also get grants from United Way funding. We have a community association in [this town] that we've accessed funding from...we also access funding through the [municipal government], and I believe that funding comes from the province. (Participant #16 – Alberta)

Acquiring government funding (especially federal) can be difficult, particularly for nonprofit organizations in the homeless sector (Valero et al., 2021).

The inadequacy of funding was also felt by participants:

The funding is so inadequate and barely enough to run a program, let alone, making sure the program is doing what it needs to do, and have accountability back to the funder and community. So, if that's the situation in urban centres, it is even worse in rural centres that I have been witnessing. (Participant #8 – Nova Scotia)

Many rural homelessness organizations received funding specifically related to the pandemic. As a result of the additional funding, some participants reported new programs and initiatives that emerged during the course of the pandemic:

We actually just got funding for - from July through to December for something we were calling an in-reach worker, that will work within the hospital system. So, the hospital will have a person that

will go to and they'll connect anyone leaving emergency into services, right? So, we're experimenting with that. So, I - my hope is to prove - to get a proven model out of it, that we can then get funded and grow. (Participant #10 – Ontario)

Overall, many participants reported receiving COVID-specific funding during the pandemic, from federal government, provincial government and other sources. Many reported that their organizations and communities were able to use the funding to provide additional COVID related supports to clients. These supports included hiring new or additional staff and providing clients with internet access and electronic devices including tablets and mobile phones. However, capacity to take advantage of funding and resources, particularly related to human capital and service provision, continues to be limited in rural/remote communities:

Anyway, capacity is completely devastated amongst the rural communities...they cannot fill out the stupid form, let alone report on, you know, every single receipt that they need. They're just trying to keep their families' head above water and we're asking too much of these rural communities to be able to self-generate, when we've defunded them over and over and over and over again. (Participant #9 – Manitoba)

2. Impacts on Clients

When describing pandemic experiences from the organizational perspective, some participants provided their perspective on the ways that clients were impacted, which were overwhelmingly negative. The majority of participants described negative effects on clients related to isolation as a result of COVID-19 restrictions. In many cases, these restrictions limited the contact clients were able to have with service providers, leading to social isolation:

So, not being able to connect with clients was a big one because... well, clients weren't able to gather anywhere, then we weren't able to access them through those typical means, a lot of our clients experiencing homelessness don't have a phone. (Participant #16 – Alberta)

Another respondent shared, “We saw a tremendous amount increase in isolation and the impact that that sheer volume of loneliness has on people.” (Participant #1 – Ontario).

Due to restrictions, organizations had to adapt their service delivery, as mentioned previously. Restrictions constantly changed throughout the pandemic and there were times when many communities were in lockdown. Participants described the impact of those organizations being closed, and services being inaccessible, “One thing I would say is that when pandemic hit, a lot of the churches in [this town], also had soup kitchens and meals. And when the pandemic hit, they all shut down.” (Participant #17 – Ontario)

Another shared:

But the tangible resources...things got pushed back, detox only had so many beds now...Groups, like men's groups all went to virtual, when I'd say the majority of our clients don't have access to technology sources, right? So, things that were in place that were meant to improve the quality of life for people experiencing homelessness or overcoming addictions, now those services and programs were almost unattainable. (Participant #20 – Alberta)

The challenges in accessing services created by the restrictions had significant effects on clients' health. A few participants noted that COVID exposure and overdose risk increased for their clients:

Our clients were also impacted because of the outbreaks in the shelter. So basically, almost all of our clients either got COVID or were in close contact multiple times of COVID... At other times we

reduced the capacity in our supervised consumption site. Our overdose numbers as a province increased significantly during COVID.
(Participant #16 - Alberta)

While the majority of participants reported negative effects on clients, some reported positive effects as well. The majority of positive effects on clients were related to new services being implemented by organizations or governments. Two examples noted by participants on the east coast were rent caps and eviction bans put in place by the government to support individuals struggling during the pandemic. Participants also described the benefits of new services provided by HSPs which included greater client connectivity through cell phones being provided to clients, clients being able to contribute to programs through new volunteer opportunities and fewer clients losing their housing due to rent increase freezes and eviction bans put in place by some provincial governments.

3. COVID Testing and Infection

Participants reported varied experiences related to COVID infection among clients as well as testing. Some participants reported no COVID-positive tests among their clients while others reported several outbreaks of COVID infection. In many cases HSPs implemented routine screening and testing for clients and staff, as well as organizational protocols for clients who tested positive, which primarily included isolation and quarantine.

Many participants (n = 17) described concerns raised by clients related to COVID-19 testing and vaccination including clients refusing to get tested, limited adherence to COVID-19 protocols, and lack of vaccine uptake. As two participants shared:

There was a few occasions where clients - they did not want to be tested. It created a really difficult situation. So, we have to think about the safety of all clients who access shelter. So, the couple of people that were refusing to get tested, if they were symptomatic, we had to kind of be firm and safe. If you don't get tested, you can't access services. Some clients too at first, were really reluctant to the hand washing, to the mask wearing, to the screening questions but it kind of became routine for them. And staff really had to verbalize and encourage the clients like, we're doing this for your safety. (Participant #20 – Alberta)

I think for clients, there's a lot of misinformation, right? Around getting a vaccine, how do you get COVID, is it real?... People experiencing homelessness in general, there's a lot of mistrust, because almost everyone in their life that they've known has let them down one way or another. So, they don't really trust health officials, authorities (Participant #10 – Ontario)

Fortunately, some organizations were able to address vaccine hesitancy and uptake challenges by removing some of the barriers for clients. In many cases, these barriers included transportation challenges, low health literacy, and limited information about vaccines.

Overall, participants described challenges with getting clients to accept COVID tests, follow protocols, and get vaccinated. As some participants described, this was linked to a deeper mistrust of the health systems and authority figures, that affected care seeking behaviours of people experiencing homelessness. While these challenges are more complex than limited compliance, organizations were able to address these issues and keep their clients safe during difficult times.

4. Staff Impacts

In addition to the effect the pandemic had on clients, staff within homeless serving organizations were also impacted. In order to understand how staff were impacted, participants were asked about positive and negative effects on staff, concerns raised by staff, and pandemic-specific training.

In terms of negative effects, the most significant theme reported by participants was the impact to the mental well-being of staff within their organizations. Participants described these impacts as burnout, stress, fatigue and languishing due to the challenges of working during the pandemic:

I think COVID highlighted how much that lack of planning creates such stress on front line staff, the ones that are kind of like in the throes of it. They don't feel heard or supported. They don't feel that they're given the right - just the right - the right resources to do their jobs on a day-to-day basis. They're not given the space to practice adequate selfcare. So, the burn out, I felt, COVID was kind of highlighting something that existed that we easily ignored pre-COVID. (Participant #8 – Nova Scotia)

In addition to the negative effects participants reported, they also shared concerns raised by staff within their organizations. Participants reported negative impacts on staff morale (n=10), staffing challenges and turnover (n= 8), staff being anxious or scared about contracting COVID-19 (n=5), management not being responsive to the needs of staff (n=2), and staff taking on additional duties beyond the scope of their training or abilities (n=5), among other challenges. As one participant summarized:

At the beginning of the pandemic, there was such a push that we provide our services... So, there was so much pressure to maintain our presence in the community... but staff were - myself included...

stressed... of course, we're supposed to be providing services to others. Yet at the same time...there was a little bit of a misstep as far as not recognizing that staff just needed to...take stock of this new situation that was occurring, rather than feel like these new impending pressures to perform in whole new ways. (Participant #15 – Newfoundland)

The responses of participants highlighted significant impacts on staff health and well-being. The mental health impacts to staff in the homeless sector due to the pandemic are also being examined through other research (Carver et al., 2022; Waegemakers Schiff et al., 2021), although there is less documentation specific to rural and remote communities.

Overall, few positive effects on staff were reported by participants. The positive effects reported by participants included COVID funding being used to provide a pay increase for staff, greater cohesiveness among staff, and support from other community organizations. One participant reflected on a sense of pride in the community and the greater solidarity and strength of the team of staff at their organization:

I think I'm just very proud of my community. And I'm very proud of the surrounding communities that we came together for the first time in a long time. It's been a fight to try and get there because like I said, we're always fighting over proposals or money from the government. But we came together...it's got us nations finally talking and I think it's beautiful. It's got this team stronger. We're more of a family now than we've ever been, even the ones working at home, they call daily and ask how we're doing. Do we need help for deliveries? I've never seen this much help in a long time. And it's beautiful. (Participant #13 – Ontario)

5. Pandemic-Specific Training

In addition to adapting service provisions, trying to find funding, and supporting staff, organizations also had to provide pandemic-specific training for their staff. While some organizations received training, most participants reported that this was not something their organization had been able to offer. The type and extent of training also varied significantly. In some cases, organizations had provided information on safety protocols, with no follow up, while others had ongoing discussions about pandemic procedures but did not provide formal training.

Among those whose organizations did receive training (n=9), the majority of participants reported that they received training related to personal protective equipment (PPE). In some cases (n=2), the training included online resources (webinars, modules), and in other cases health organizations provided on-site training. “[The health region] helped us with doffing and donning procedures and training for doing that stuff.” (Participant #9 – Manitoba). A participant in Alberta also shared:

The Alberta Health Services staff came in, to do like a demonstration for all the frontline staff on how to properly take off and dispose of PPE that may be contaminated through close contact, or if we had to put someone in isolation. (Participant #20 – Alberta)

Overall, training was not provided to staff in all organizations, information was often provided through online resources with no follow-up, and was primarily related to PPE. As mentioned previously, some participants reported increased mental health issues, overdoses, and COVID cases among their clients. Staff in many organizations were also dealing with mental health issues, burnout, stress and fear related to COVID-19. Additional training on topics such as mental health first aid, crisis intervention, and

crisis and emergency risk communication could have been beneficial in helping staff to deal with the challenges of the pandemic (Chirico et al., 2021; Brooks et al., 2017).

6. Organizational Infrastructure and Resources

At the beginning of the pandemic, supply chains for numerous items were affected by national lockdowns which slowed or even temporarily stopped the flow of raw materials and finished goods, disrupting manufacturing and limiting supply of necessary goods. As a result, access to PPE (e.g. masks and gloves), as well as other essential products (e.g. hand sanitizer) was limited. Some participants reported significant issues with obtaining PPE at the beginning of the pandemic, however this was not consistent across the participant pool. Many participants reported having timely access to PPE at the beginning of the pandemic when the supply chain was greatly affected, and up to the point of interview during the third wave of the pandemic.

I think there were some challenges in securing some PPE at the beginning. But with the organization being fairly on top of things, I don't think it was ever really felt at our level... we still had those things in our inventory (Participant #11 – Ontario)

Due to the implementation of government protocols such as social distancing, many organizations had to re-evaluate the design and setup of their facilities and adapt their services accordingly. Measures such as decreasing the number of available beds, building plexiglass barriers, and reorganizing office space to allow for one-way traffic were reported by participants.

It's really changed how we can implement any of our programs, really, [mostly] because of the physical distancing. So not being able to have so many individuals in a space, we've had to get creative...

our [program] used to be able to serve about 43 men now it's down to 35 because we had to take some beds out and change the distance [between them]. For the females we went from 12 beds to 8. (Participant #20 – Alberta)

In addition to having to adapt their services based on the layout and design of their facilities, organizations were also tasked with making isolation and quarantine arrangements. Several participants described using off-site isolation and quarantine locations for their clients including hotels, community centres, and repurposing buildings such as schools and hotels:

We did actually become part of a working group that put together a self-isolation center. So it was through the county, it was collaboration through the county, mental health, and then us, and we had a couple hotel rooms; we still actually have it available for anyone who tests positive, if they're living in a, you know, in a shared accommodation, if they're living at the shelter, then they have a safe place to go. (Participant #11 – Ontario)

Needs & Recommendations

During the final interview questions, participants were asked about needs and recommendations to better support rural/remote communities during a pandemic and particularly in relation to pandemic preparedness. For most participants, additional funding, affordable housing and taking real action on rural homelessness were key areas of need. As one participant emphasized:

Give us more money. I think it's having a plan, not just in place, and not just in writing, but an action. Where it's not just about homelessness in COVID, it's about homelessness in general, and how housing as a human right... We've known for a long time and it's pretty slow

going. People can't wait. You can't wait to have somewhere to live. So, money definitely would be the big one, but then also making sure that the action items are acted upon. (Participant #11 – Ontario)

Additionally, participants emphasized a need for community infrastructure such as internet, cell towers, and improved transportation:

At the beginning cellphone service was a big issue, especially up here. My phone drops calls all the time, so you have to try and figure out another way to call people back and then getting clients even a phone so that they could call us back. (Participant #5 – Ontario)

You know, even before the internet, I'd love to see transportation in this area... it's an ongoing issue, and it's been an ongoing issue for - since the community started, the community started growing as well. Transportation, and but also just building that affordable housing and making sure that, you know, especially like in places like [the town I live in] where the building is happening so rapidly, and so quickly that, you know, within those spaces, there's affordable options for the people who already live here. (Participant #11 – Ontario)

Expanding the capacity of rural/remote communities and homeless-serving organizations was also a key recommendation shared by participants. Some participants identified barriers related to securing staff in their communities due to geographic challenges:

I'm thinking about staffing, you know...So, if you're going to try to find staffing for services, you know, when we lost staff due to contact tracing and [testing] positive. We have a two-week requirement of the Government of Nunavut that you isolate in a specific hotel, outside the territory...before you can come back into Nunavut, or into Nunavut to move for a job. This makes it difficult to hire people up. If you need to hire somebody up quickly. And so, when our low barrier shelter

closed, because the supervisor was tested positive and was airlifted out, we have no way to really recruit somebody with experience that we could get quickly into place. (Participant #14 – Nunavut)

Finally, participants described the need for more support services - particularly mental health supports - in order to improve community capacity, as described by the interviewee from Newfoundland & Labrador:

It's an ongoing issue as far as mental health support... we've known for some time that our suicide rates are so high, and we're often scrambling for psychologists and mental health therapists who remain long enough in the community. So yeah... More mental health supports...For my mind, that's the number one, some more health resources, especially in the mental health field. (Participant #15 – Newfoundland & Labrador)

All of the needs highlighted by participants are linked to the unique contexts of rural/remote communities, discussed previously, and reflect a need for system level changes related to funding and supports for homelessness organizations as well as supports needed at a larger scale – including for mental health and healthcare. In order for these communities to be able to adequately meet the needs of their clients, more attention needs to be paid to the unique challenges that exist in rural/remote communities, recognizing that existing funding arrangements as well as financial, infrastructure and human resources require attention to achieve health equity in these regions.

Conclusions and Implications

While the COVID-19 pandemic impacted communities around the world, we set out to understand the experiences of homeless

service providers in rural and remote Canadian settings. This chapter highlighted findings from semi-structured interviews with rural and remote homelessness service providers. In describing their pandemic experiences, providers spoke about the type(s) of pandemic funding they received, impacts of COVID-19 and related policies on clients, organizational infrastructure, COVID protocols and pandemic planning, pandemic-specific training, and impacts on staff. Providers also shared needs and recommendations to better support rural/remote communities during a pandemic.

Based on these findings, we present the following key recommendations:

- 1.** Communities have a keen sense of their own needs. Funding should be provided on an “open-basis” that is less prescriptive and allows the resources to be directed to the areas deemed most critical for supporting community members.
- 2.** Public health units/departments should continue to reach out to rural and remote communities and provide timely and tailored information to homelessness service providers in these areas. They must also make efforts to use non-internet based means of communications, such as the telephone.
- 3.** It is important to listen to people with lived experience of homelessness. For some, health-related fears or resistance may be addressed by talking to them about their concerns and sharing information. For others, mistrust of government or health systems may be the driving factor. These reasons must be heard and respected. General uptake of vaccines may be improved by offering site-specific clinics, such as in shelters or programs that offer food onsite.
- 4.** Rural and remote communities need designated funding and resources to be able to supply deeply affordable housing.

The affordable housing stock must be increased and must be made available to those in even the lowest income brackets.

5. Dedicated funding is needed in rural and remote communities to help them ensure their programming is as broad and inclusive as possible. Smaller towns may not have the capacity to have entire services dedicated to sub-populations but with additional funding they may be able to offer increased tailored supports within existing agencies.
6. Funding for navigator and outreach positions is critically important for isolated and vulnerable populations, such as seniors and people living in abusive situations. Having these supports available are particularly important in rural and remote settings, as other resources may be limited and having someone “check in” on isolated individuals can be life-saving.
7. Homelessness service providers in rural and remote settings work hard to support and empower people experiencing homelessness in their communities. They should be recognized and commended for their efforts.

The findings in this study provide evidence of the degree of struggle that rural and remote communities endured during COVID-19, but they also offer insight into the remarkable strength and creativity that exists. We must commend these homelessness service providers for the work they did while also recognizing that they should not bear the weight of the lack of funding. Particularly in small communities, the impact of the pandemic has been significant. These are strong and resilient communities that must be supported to continue the work of ending homelessness in rural and remote parts of Canada.

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CHAPTER TWELVE

***The Opportunity of Crisis: Lessons learned
from the pandemic response amongst people
experiencing homelessness in Dublin***

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Abstract: Crises are times of danger but also opportunity. When the COVID pandemic approached Ireland it was presumed that due to multiple vulnerabilities people experiencing homelessness (PEH) would suffer greatly. In order to reduce the impact, the Dublin Health and Housing Agencies collaborated with the Voluntary Housing, Homeless Health, and Harm Reduction Agencies, with a plan to protect PEH. This involved early triage, testing and isolation of COVID positive and suspect clients, tracing and isolating

contacts, shielding clients who were most vulnerable due to age and medical conditions, providing advice for accommodations on how to prevent spread of infection, and providing opiate, benzodiazepine and alcohol treatment programmes to support those isolating and in shielding. A communication strategy was deemed essential to ensure an effective roll out of the strategy as well as allowing for rapid adaptation in light of new information on the pandemic. The strategy also focused on ensuring staff felt valued and safe. These strategies proved to be very successful with infection rates almost half of the housed population and very few COVID related deaths. The success resulted in a national commitment by the Ministers responsible for Health, Housing and Addiction to work on addressing homelessness collaboratively. The impact of the post-pandemic removal of protections developed during the COVID response is discussed. The factors that enabled such an effective response are also outlined.

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health workers, key workers, hostel staff, outreach workers, harm reduction, and addiction support workers and teams for the tremendous care they provided to their clients during the pandemic. Lastly, thanks to all the people experiencing homelessness who cooperated with services and supported their fellow people who are homeless during the pandemic.

Background

It is said that the Chinese character that denotes crisis literally translates to the phrase ‘danger with opportunity’. This chapter describes how the response to the COVID crisis in the homeless population in Dublin not only demonstrated how a strongly collaborative effort between health, housing, and social services can protect the health marginalized communities during times of crisis, but also how a crisis provides the opportunity to transform and improve models of service so that they better serve the needs of the community they are developed for.

On December 31, 2019, reports of a series of episodes of an unusual pneumonia emerged from Wuhan, a maritime city in China. The World Health Organization declared that this infection was caused by the COVID-19 virus in February, 2020. On March 11, 2020, WHO announced that the world was facing a new pandemic. On midnight of March 27, 2020, a series of restrictions were introduced to help prevent the spread of the virus, an action that popularly was referred to as ‘the lockdown.’

This was a time of fear both for members of the public and for frontline workers in the health and social services. It was a time that also demanded a firm and rapid response while at the same time being a period of uncertainty as no one really knew how to best respond to this international threat. Dr Mike Ryan, the

Executive Director of WHO, advised against immobilization due to fear:

If you need to be right before you move you will never win. Perfection is the enemy of the good when it comes to emergency management. Speed trumps perfection and the problem in society we have at the moment is everyone is afraid of making a mistake, everyone is afraid of the consequence of error. But the greatest error is not to move, the greatest error is to be paralysed by the fear of failure. (World Health Organization, 2020, n.p.)

It was well accepted that a particularly vulnerable group to the potential impact of the pandemic would be people experiencing homelessness (PEH) (Lewer et al., 2020). We know PEH have probably the worst health indices in the western world. They have lower life expectancy than their housed fellow citizens. The rise in the levels of disease and chronic illness has been compared to a cliff face at the end of the rising slope of morbidity one finds in impoverished areas (Story, 2013). In Dublin, most PEH are living in crowded, congregated hostels with up to 8 people sleeping in bunk beds per room. They eat in crowded food halls with up to 100 people at a time. Many of them attend large addiction treatment clinics where they wait in congested waiting rooms.

What was not in doubt was the willingness and desire of services to respond to this approaching pandemic. There was a flurry of activity with different groups organising sectoral meetings called by different organizations and run by various leaders. No clear leadership or direction was emerging. Decisive action was taken by the Health Service Executive (HSE), National Social Inclusion Office (NSIO), and the Dublin Regional Homeless Executive (DRHE). The NSIO is a subsection of the Primary Care Division whose stated aim is “to reduce inequalities in health and improve

access to mainstream and targeted health services for vulnerable and excluded groups in Ireland” (Health Service Executive, 2023b, n.p.). Ireland is subdivided into a number of community care areas and each area has its own social inclusion office. The HSE and local authorities have “joint responsibility to provide a coordinated and integrated response to delivering homeless services to this growing group” (Health Service Executive, 2023a, n.p.). NSIO and DRHE committed to working together to address the crisis. Collaboration is a recognised key element in responding to crises (Sriharan et al., 2022).

The Response in the Homeless Sector to the COVID Pandemic

The NSIO appointed an HSE Lead for the Dublin COVID Response, whose first actions were to set up a meeting, set up a coordinating committee with the DRHE, and recruit an HSE Clinical Lead and a Public Health Adviser to this committee. The DRHE is responsible for the provision of support services and accommodation to PEH. Their core objectives are to:

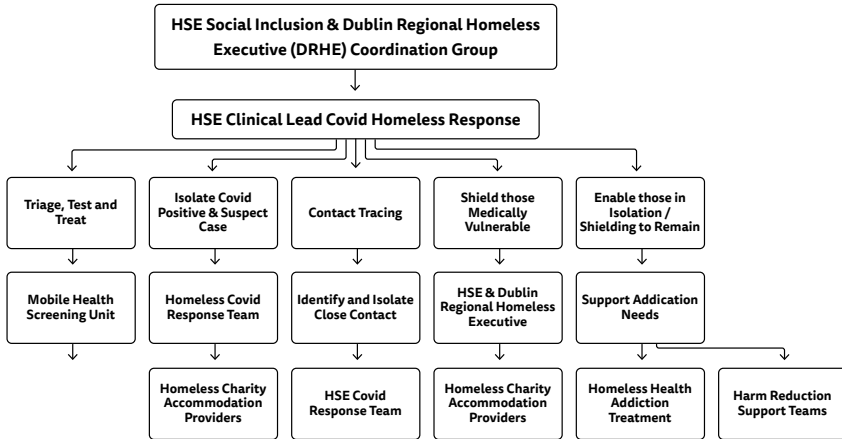
- Prevent homelessness
- Eliminate the need for people to sleep rough
- Reduce the length of time people experience homelessness to less than six months
- Meet unmet housing needs of PEH through an increase in housing options that deliver affordable, accessible housing with supports as required
- Ensure the delivery of services that meet the needs of people experiencing homelessness (Dublin Region Homeless Executive, 2023).

The coordinating committee began by creating a plan of action for the management of the COVID Response in the Homeless Sector. It was agreed from the outset that the plan would not be set in stone but would adapt and evolve based on both emerging evidence about the best response to COVID-19 infection, and feedback from the sector on the impact (or lack thereof) of the strategy on the ground. Secondly, they developed a communication strategy to facilitate the rapid transmission of emerging findings on COVID-19 to the sector, to discuss proposed policy changes with all the organizations in the sector, and lastly, to have a direct line of communication with those working on the frontline to ensure they understood what was being done to address the pandemic and to provide a forum to have fears and concerns addressed. Simultaneously, the government placed an eviction ban and a rent freeze to protect people in insecure housing.

The plan (see Figure 1) involved identifying a series of actions that needed to be taken, and assigning organizations from either the Housing, Health, Addiction or Harm Reduction Services for PEH to each of these action areas. Firstly, clients who were at risk of having or developing COVID-19 needed to be identified, triaged and tested. This included both people with symptoms that were indicative of potential COVID-19 infection and close contacts of confirmed COVID-19 infection cases. A drop-in testing centre for COVID 19 was set up. In addition, a mobile screening unit (normally used for screening PEH for TB and blood-borne viruses) was adapted in order to provide mobile testing for COVID-19. A contact tracing team was also set up using employees from different housing and harm reduction organizations to identify those contacts who required isolation. This team was trained by public health officials. The contact team would also visit accommodations for PEH where outbreaks occurred to identify if there were any risks in the accommodations that could be minimised

(e.g. reducing numbers in dining areas by phasing different meal-times, allowing people into common areas at different times to reduce interaction, advising staff to have meetings over Zoom rather than in person).

Figure 1. Plan of Action



The next task was to decide what to do with clients who either tested positive or who were awaiting the results of their COVID test (which could take up to five days in the early days of the pandemic). The DRHE identified a number of Airbnb apartment complexes and hotels that were at risk of closure due to the collapse of the tourist industry and obtained them at a reduced rent. Two voluntary homeless accommodation providers agreed to staff these isolation units and were provided with funding for social care and nursing staff. A primary care service for PEH agreed to provide physician supervision via video link to monitor patients while they were in isolation in case they deteriorated and needed treatment or a referral to the hospital.

The HSE Clinical Lead along with a Social Inclusion consultant developed a marking system to help identify those clients

experiencing homelessness who would be most vulnerable if they contracted COVID-19 infection. This formula was based on scoring people based on their age band and on what medical conditions they had with higher scores being given to conditions that would make the client more vulnerable. As data emerged in the scientific literature this scoring system was adapted and changed (e.g. it emerged that people with diabetes were particularly at risk of poor outcomes, including higher mortality rates when infected with COVID-19, so the score for diabetes was increased). This scoring system was applied to every homeless person in the sector resulting in a series of clients with scores between 0 and 10. The DRHE then obtained further Airbnb and hotel accommodations and any client who scored 2 or higher, and did not have their own door accommodation, was then placed in these new apartments/rooms (termed shielding units), so that they had their own door accommodation and access to their own bathroom. Further, they were provided with meals delivered to their accommodation each day. This meant they could self-isolate and protect themselves from infection.

The next part of the plan was to develop supports to ensure clients would be able to effectively self-isolate in the isolation and/or shielding units. Many clients had active addictions and needed to leave their accommodations to obtain illicit drugs (heroin, benzodiazepines, and cocaine, in particular) or alcohol. Many patients using heroin were not on opiate substitute treatment and the wait time for access to such treatment was up to 13 weeks. Benzodiazepine addiction was rife with many clients taking amounts of illicit tablets that were equivalent to between 200 and 1200mg of diazepam per day. The HSE's National Clinical Lead for Addiction Services issued a directive allowing clinics and homeless primary care services to take on more patients, resulting in reducing wait times for access to Opioid Substitution Therapy (OST) to three

days. In addition, isolation services developed the facility to start someone on treatment immediately. A primary care and addiction service for homeless people initiated many people onto opiate substitute treatment and provided medically supervised benzodiazepine and/or alcohol detoxes (with daily supervision of dosages) for people in isolation or shielding. It was also noted that clients who were in Private Emergency Accommodation (PEAs) had significantly less access to health and social care services than those in services operated by the Non-Government Organizations (NGOs), so a harm reduction agency pivoted its nursing and social care team to provide the majority of inreach services to PEAs.

The EMCDDA highlighted that *“access to medication is likely to be particularly challenging for those self-isolating, under lock down, or in quarantine”* (EMCDDA, 2020). The HSE enabled general practitioners to send prescriptions electronically to pharmacies reducing the need for patients to call into clinics for their medication scripts. National guidelines were amended so harm reduction services could provide a call out service to deliver methadone, suboxone, and other medications to clients so that they did not have to visit their treatment centre or pharmacy, and also provided harm reduction advice via video/phone. There was a concern that people in isolation or shielding would suffer from anxiety or depression due to social isolation. To address this, shielding unit staff organized socially distanced events to allow clients some form of interaction, harm reduction services offered social supports over the phone, and a voluntary homeless charity offered access to video counselling. Finally, it was important to have a safe transport system for clients to access isolation or shielding units. A vehicle was obtained by a harm reduction agency and adapted with screens to be able to transport clients to the isolation units. This was operated by members of a harm reduction team and HSE employees.

Finally, a team that included experts in infection control was set up to visit each of the homeless accommodations and identify any risks that could lead to spread of infection. Risks could include overcrowded dormitories, overused common areas, staff not complying with public health advice, etc. DRHE obtained further accommodations so that some of the overcrowded hostels could have their clients moved to reduce overcrowding and the risk of infection spreading. Services where common areas were overused or had non-compliant staff would be advised on protocols and offered training where required.

In a time of high anxiety and fear, effective communication is essential to allay fears and maintain a sense of sectoral cohesion (Sriharan et al., 2022). The HSE and DRHE set up a series of regular meetings (initially 1-2 weekly) between the different groups as follows:

- The HSE, DRHE, Public Health Advisers and the Clinical and Operational Lead
- The Clinical Lead, Public Health Advisers and all Health Service Providers in the homeless sector
- The Operational and Clinical Leads, and accommodation Providers
- The Operational and Clinical Leads and Addiction Service Providers for homeless persons

These meetings were used, firstly, to inform people of the latest public health advice and how the plan of action was being rolled out, and secondly, to obtain feedback on where the plan of action was not working and to elicit suggestions on how to address these blocks.

In addition, it was decided from the start to have a direct line of communication between the committee and frontline workers.

This was achieved by sending out circulars via individual organizations, circulating video talks from the Clinical and Operational Leads, and conducting interactive, informational webinars for all frontline staff. This direct line of communication was believed to be essential to ensure frontline staff felt they were being listened to, and that at all times action was being taken to protect them and their clients.

- As the plan rolled out emerging issues were addressed. Effective leadership in crisis requires the ability to adapt to emerging threats and take action often with little or no evidence to justify those actions (Sriharan et al., 2022). For example:
- It emerged that certain shielding unit clients were very behaviourally disturbed and would often call into others' rooms or fail to socially distance even when warned. Two specific units with high staff to patient ratios were set up to ensure these clients followed protocol.
- At the start the only reliable option for testing was to send a PCR test to a National Virus Reference Laboratory. The result would come back anytime between 3-5 days later. While awaiting test results clients had to be isolated. Some of these people were parents and often whole families had to be transferred to an isolation unit. As technology improved, new, more rapid tests emerged. The Oversight Committee reviewed all new testing and eventually obtained a LAMP testing unit (with high specificity and sensitivity) that had been approved by the HSE. This new machine was mobile, could be brought to the person, and delivered results in less than an hour. This meant a significant reduction in the number of people requiring isolation, and allowed the closure of a tranche of isolation beds. The HSE commissioned a harm reduction agency to deliver the mobile LAMP testing service. In 2022 this service won the Health Service Excellence Award for "Improving Patient Experience".

As a result of a needs analysis conducted by the HSE, Social Inclusion Lead, and the Clinical Lead, it was identified that many rough sleepers had not entered accommodation due to chaotic drug use, so a proposal for a street to stabilization centre was developed and commissioned by the HSE.

Evaluation of Homeless Sector Response to COVID Pandemic

The effects of the strategy on both protecting PEH from COVID as well as on the overall health and wellbeing of PEH were monitored through audits and research. Audits on the number of people reporting symptoms, screened, isolated, and shielded, along with COVID positivity, hospitalization, and mortality rates, were conducted weekly by HSE social inclusion staff and results were reported to the coordinating committee. Other relevant data such as numbers of OST treatments, overdoses, and treatment interventions were also reported. Specific research was conducted on the experiences of services users during the pandemic and the results of this were used to improve the response in the sector.

At the start of the pandemic it had been presumed that there would be a higher incidence of COVID among PEH due to crowded circumstances and this, along with the poorer health profile of homeless people, would lead to a greater mortality rate (Lewer et al., 2020). The results of these initiatives to protect homeless people exceeded expectations. Between March and September 2020:

- Over 1000 symptomatic patients were tested, of whom just over 70 were positive.
- Screenings of 450 asymptomatic residents and 165 staff in hostels were conducted to estimate the level of asymptomatic

infection in the sector. 10 residents (2%) and 5 staff (3%) were found to be positive.

- Over 700 symptomatic clients were placed in isolation.
- Over 550 people were relocated to shielding units, of whom 340 were in newly acquired accommodation units.
- Over 120 clients were decanted from overcrowded hostels into new facilities.
- All rough sleepers were offered hostel or shielding accommodation, depending on their health status.
- Wait times for methadone dropped from 12-14 weeks to 3 days. Over 180 new people began methadone treatment.
- Over 70 people were started on benzodiazepine maintenance treatments.
- A predictive model provided by University College London suggested that there would be at worst 23, and at best 6, COVID-related deaths. Only two people died from COVID-19-related causes.

The service users report conducted from May to June 2020 found, very interestingly, that 46% of service users felt their physical health was better than a year previously, 40% felt their mental health was better than the previous year, and 44% felt their quality of life had improved from the previous year. Seventy percent said they felt safe or very safe, and 46% said they felt safer than a year previously. Of those who were in shielding units, 48% said they had experienced improvements in their health and wellbeing (HSE Dublin, 2020).

By January 2021 there had been 1,375 patients placed in isolation, of whom 195 had tested positive for COVID-19. At that time the prevalence of COVID-19 in the Dublin population had been

estimated by public health to be 5.46%. In the Dublin population of PEH it was only 2.67% and in the Shielding Units it was only 0.91%. By way of comparison, in Boston in April 2020, 36% of residents of a Boston shelter (excluding those with a previous COVID positive result) tested positive for COVID-19 (Baggett et al., 2020). In France, it had been reported that 50.5% of COVID tests from a sample of PEH residing in hostels in Paris and Seine-Saint-Denis taken in June 2020 had tested positive for COVID-19 antibodies (i.e., they had been exposed to COVID-19 infection) (Dublin Regional Homeless Executive, n.d.). Clients in shielding units generally reported favourably on their experience in the shielding units though some expressed feeling isolated and lonely. Some who were very happy with the shielding units expressed fears of returning to homeless accommodation once the pandemic was over (HSE Dublin, 2020).

Quotes from Service Users in Shielding Accommodation (HSE Dublin, 2020):

Positive Comments

“I have mostly stayed off drugs and have been able to make more contact with my family because they see that I am getting better.”

“I have begun to read more and appreciate limited exercise more.”

“Being here has improved me, having my own room is the main factor, sharing a room I can’t handle, if I am having a panic attack it’s not good sharing when others are using and attempting suicide. All I want is my own room.”

“It has improved since cocooning because I feel safe. For example I can take off my runners without fear that they will be robbed.”

“I am a wheelchair user. There is a lift here which has helped my

joints i.e. I don't have to hobble up a stairs. Having my own room has improved my mental health. I could only grieve properly since I came here as I was sharing a room before."

"Cocooning has helped reduce my drug use. Knowing I can close my bedroom door at the end of a day is a big thing, safety is huge."

"My mental health has improved because I feel safe."

"I can do what I want in my own room, (I have) privacy to speak with my family and children."

Negative Comments

"I am more depressed and unsure of the future. Feeling more negative about life."

"Mental health has deteriorated as I haven't seen psychiatrist and no AA meetings to go to."

"I worry about going back to hostels as they are full of addicts and my last hostel I shared with 3 drug users and smoked heroin and crack day and night."

In July 2020, based on the success of the collaboration between housing, health, and addiction services during COVID, the Ministers for Health, Housing, and the National Drug Strategy, committed to a continued collaboration in addressing homelessness policy issues.

Vaccination Programme

In 2021, vaccines became available for the protection of clients from COVID-19. As vaccines became available there was a veritable clamour from health and patient advocacy organizations

seeking to have their patient group prioritised. The actions of the HSE and DRHE had been very successful in protecting PEH, so ironically, despite their recognised vulnerability, they were considered to be lower down the priority order. The coordinating committee developed an evidence-based submission emphasizing the importance of prioritising both PEH and staff. This was successful in moving PEH up the priority scale. Then, a plan had to be devised to deliver the vaccines to the sector. Previous experiences delivering influenza and other vaccinations to this sector had encountered many difficulties, including being able to get access to clients and persuading clients to have a vaccination. Many PEH are traditionally suspicious of vaccinations and do not place as much emphasis on health prevention as their housed counterparts who place more value on maintaining their health (HSE Dublin, 2020).

A plan was devised, which included obtaining a central city site, with 6 vaccination teams (using health professionals employed by organizations in the homelessness and addiction sectors) and support key workers. A promotional campaign was launched with posters, leaflets, videos, and most importantly, it armed all those who worked on the frontline with the necessary information and skills to promote vaccination. A fleet of transport vehicles visited each hostel. A policy of only vaccinating the most enthusiastic 50% of clients first was adopted as it was hypothesized that post vaccination they would return and help persuade the more reluctant 50% to be vaccinated. The campaign succeeded in vaccinating 90-95% of shielding unit residents; 85-90% in single homeless accommodations; but only 40-50% of familial homeless residents.

Post COVID Pandemic

The unexpected success in protecting the homeless population in Dublin from the effects of COVID raised the questions: What was the learning for homeless health and housing services, and what initiatives should be maintained going forward? As a result of deliberations between the HSE and DRHE the following actions were taken:

- The HSE and DRHE committed to continuing their joint approach to addressing homelessness and ill health.
- A number of the shielding unit accommodations were maintained ensuring many patients could remain in their 'own door' accommodation.
- The nursing and social care teams that were developed to support the PEAs were maintained.
- The rapid access to opiate substitute treatment was maintained.
- Access to community benzodiazepine and alcohol detoxification services were maintained.
- There is a commitment to continued funding for the street stabilization centre.
- The HSE commissioned a review of the COVID initiative to be conducted by a research team in TCD to collate the learning from the homeless COVID response.

Unfortunately, the housing interventions (i.e. the rent freeze and eviction bans), and the economic factors that resulted in increased rental accommodation (the loss of tourism for hotels and Airbnb accommodations), were reversed post-pandemic. There was evidence that these factors had resulted in a reduction of the overall number of people in homelessness (see Table 1). Interestingly, the number of families in homelessness had reduced while the

number of singles had increased. This probably reflects that families often become homeless due to difficulties keeping up with rents, while singles often become homeless due to familial strife and/or illicit drug use. The effect of the loss of these protections meant that post-pandemic the numbers of PEH started to rise again (C. N. Cheallaigh, personal communication, n.d.).

Table 1. Number of People in Homelessness March 2020 to March 2023

	Families	Adults in Families	Children in Families	Singles	Total Adults	Total Individuals
March 2023	1,203	2,065	2,638	4,072	6,137	8,775
March 2022	901	1,543	2,109	3,343	4,886	6,995
March 2021	681	1,020	1,669	3,073	4,093	5,762
March 2020	1,103	1,609	2,491	2,906	4,515	7,006

Lastly, a number of the shielding units were closed and PEH lost their own door accommodation. This had been predicted by one of the clients who had been in shielding, who commented:

Health would be a lot better and no supports would be needed if we had our own house. I do not want to be sent back to a hostel where I will go backwards and be on the streets in a few months. I really do believe sharing with other people will be harmful. It's dangerous some have weapons on them and this makes my anxiety worse, I'm not able to stand up for myself. I want to make something of my life now and show them I've turned over a new leaf (HSE Dublin, 2020).

Discussion

As noted at the start of this chapter, crisis brings danger but it also brings opportunity. The opportunity was grasped by those involved in responding to the Dublin homeless COVID crisis. The shared vision and unity of purpose across the homeless sector enabled everyone to effectively support PEH from the ravages of the pandemic by rapidly overcoming barriers and leading to successful provision of services and care.

A number of questions arise from this narrative. Firstly, why did it take a crisis to enable actions that would have benefited clients prior to the crisis? Possibly, a crisis refocuses us on our primary purpose to help our clients address the multiple psychological, health, social, and economic inequities they face. This refocusing enables us to firstly, redistribute funding to where it is most needed; secondly, re-evaluate the administrative and governance requirements that act as barriers to the delivery of care and treatment; and lastly, develop a sense of solidarity in the sector that allows for a common vision, a common mission, and concerted and effective action. Alternatively, the action taken during COVID to protect PEH could have been provoked more by a desire to protect hospital beds and/or prevent spread of infection through the general population, and so the system removed barriers to care-delivery for the benefit of the housed people.

The second question relates to why the rent freeze and eviction bans were removed when they were succeeding in reducing homelessness. Ireland has been governed by a centre-right government since 2011, whose approach to addressing homelessness has been to rely on the neoliberal belief in the ability of the private rental and housing markets to resolve access to housing (C. N. Cheallaigh, personal communication, n.d.). The justification

given by the government was that non-removal of the eviction ban and rent freeze would result in more private landlords leaving the market thus reducing the supply of rental accommodation (Hearne & Murphy, 2023). The result was a rise in the number of PEH including children. This produced pressure on the hostel system, which caused the DRHE to increase the number of beds per room, causing a returning to the pre-pandemic overcrowding in the hostels. Thus, it seems a return to housing and economic policies where protection for tenants is removed and housing is diverted to the tourism sector will impact the numbers of homeless people and overcrowding in hostels.

The last question is: What were the factors that enabled such a successful response to the COVID pandemic in the homeless sector? There were a number of strengths within Irish homeless and health services that preceded the COVID pandemic that contributed to a positive response (see Figure 2). These included the following:

1. HSE National Social Inclusion Office (NSIO):

Ireland is unique in having a social inclusion directorate within the national health service provider, the HSE. The NSIO provides supportive services to those who are marginalized in society including those with addiction issues, PEH, migrants, refugees, international protection applicants, Irish travellers and Roma, the LGPTI community, and those experiencing domestic, sexual, or gender-based violence. The advantage of having a NSIO in the HSE was:

- They took direct responsibility for the health services for marginalized groups and as such they were 'at the table' to ensure the response was supported by policy and to advocate for funding to be allocated to such groups.
- They funded addiction and migrant services.

- They were able to coordinate addiction, migrant and homeless responses (of note, there were many migrants and people who used drugs who resided in homeless accommodations).
- Social Inclusion in Dublin was able to recruit harm reduction agencies and addiction services who had become idle due to the crisis to provide extra staffing support in the homeless sector.

2. Homeless Health Services:

Dublin had a well-developed network of primary health services for PEH and migrants. These services provided primary care services for PEH and migrants through a network of inreach, drop-in centres, and mobile outreach services. Some of the clinics also provided addiction treatment. Several voluntary housing charity agencies also had nursing services for their own clients. The HSE also had two multi-disciplinary nursing and allied health professional teams providing services in the north and south sides of the city respectively.

- 3.** Dublin was also unique in having a secondary care inclusion health service in its two main inner-city hospitals. Inclusion health consultants, along with their teams of doctors, nurses, social worker and allied health professionals, had been set up to meet the needs of marginalized patients admitted to hospital. Prior to the pandemic these teams had demonstrated that due to being more welcoming and experienced in managing the issues faced by homeless people, PEH were less likely to leave the hospital early and so did not need readmission to finish incomplete treatment. They have also been able to reduce the percentage of hospital bed days (Hearne & Murphy, 2023). During the pandemic, the social inclusion teams met with their primary

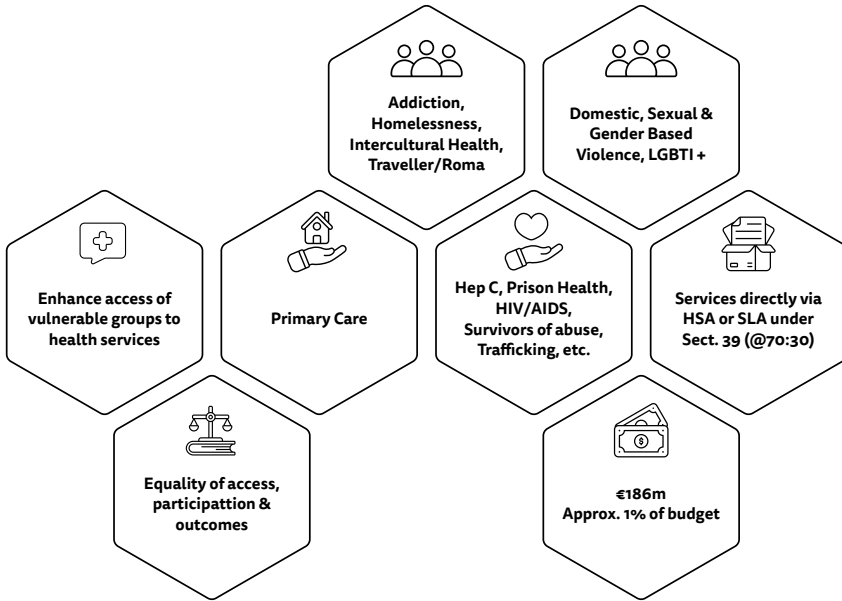
care colleagues and the Clinical Lead to contribute advice and information and also to coordinate care between the primary and secondary care sectors.

4. There was a clear mission to protect PEH from the COVID pandemic established at an early stage which was communicated to all agencies and all staff. This resulted in a common sense of purpose and a strong feeling of belonging amongst staff and clients.
5. The establishment of a coordinating committee between the DRHE and HSE along with the appointment of a Clinical Lead resulted in clear governing structures. This team consulted on a weekly basis with HSE Public Health to obtain up to date information on the pandemic and the best available advice on how to respond. This ensured there were clear and informed leadership structures for the sector and a coordinated sector response.
6. Leadership was distributed evenly across the team. Whilst there were clear avenues of responsibility leading to the Clinical and Operational leads, their decisions often derived from discussions with their teams and with the wider sector. Distributed leadership has been demonstrated to be more effective in responding to crises (Sriharan et al., 2022).
7. The sectoral communication strategy was very effective in transmitting the vision and mission to all the housing, health, and harm reduction agencies involved in the homeless response, as well as directly to staff in the sector. The clear communication channels between the various sectors ensured agencies were aware of how the response was being rolled out and any changes in advice or strategy. In addition, the communication with staff across the sector allowed for a 360-degree feedback loop, serving to inform the plan

and any emerging threats. Such information was relayed rapidly to the national coordinating committee and often acted upon. Staff consistently reported a sense of being valued and supported throughout the response. Technology was used effectively as part of the communication strategy, which included using social media, videos, podcasts, webinars, and Zoom/Teams meetings to send and receive important messages.

- 8.** The collecting of data and feedback from service users was critical in responding to the pandemic. This constant monitoring of data allowed the coordinating committee to respond swiftly to any emerging needs.
- 9.** Specific innovations such as the use of shielding units, the assignment of specific shielding units for people with challenging behaviours, the use of a mobile testing service, and the use of LAMP technology once it became available, all contributed to the efficiency and effectiveness of the strategy.
- 10.** The support of the political establishment was vital. Homelessness is a significant political issue in Ireland. Politicians were aware of the vulnerability of homeless people with an approaching pandemic and ensured there were adequate funding and resources available for the COVID response for PEH. This support was fostered by early reporting of the positive outcomes of the response. Many senior politicians visited the services and asked for learnings from the homeless response to be applied to other sectors. The response bucked the journalistic adage “good news is not good news” and became a positive news story in a time when most news was pessimistic and negative.

Figure 2. COVID Pandemic Response in Dublin



Conclusion

The pandemic crisis elicited a strong coordinated response from homeless housing, health, and addiction services, which succeeded in protecting PEH from the worst effects of the COVID pandemic. The crisis demonstrated how systemic barriers to care can, on occasion, be overcome easily if the system decides to remove them. It also demonstrated how changes in the economics of housing and rental markets can impact both the number of PEH and the level of crowding in homeless accommodations.

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CHAPTER THIRTEEN

***Pathways to Addressing Homelessness in
Winnipeg***

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Abstract: Winnipeg based organizations came together during the COVID-19 pandemic to support and distribute resources to people experiencing homelessness (PEH). Coordination of services was through the Indigenous led organization, End Homelessness Winnipeg (EHW). The Indigenous response led by EHW was vital in this model's success. The COVID-19 pandemic amplified the deep faults present in current systems, exposing how the needs of PEH are continually not met. Although the coordinated

model introduced by EHW worked in many ways to support PEH in Winnipeg during the pandemic, it also exposed which larger systemic issues still exist and impact PEH.

Ethics Review Statement: The survey protocols for the agency survey and individuals interviewed were reviewed and approved by the University of Winnipeg's Ethics Committee.

Conflict of Interest Statement: We confirm that we do not have any personal or business interest in or potential for personal gain from any of the organizations or projects linked to this research paper.

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Keywords: Homelessness, COVID-19 pandemic, housing, Indigenous homelessness, coordination

Introduction

This study is set in Winnipeg, Canada, a midsized city with a population of 750,000, including 91,000 persons identifying as Indigenous (Statistics Canada, 2021). Winnipeg has one of the highest rates of urban Indigenous homelessness in Canada with approximately 68% of individuals experiencing homelessness identifying as Indigenous, despite comprising 12% of the urban population (Homeless Hub, 2021; Statistics Canada, 2021; Brandon, 2022).

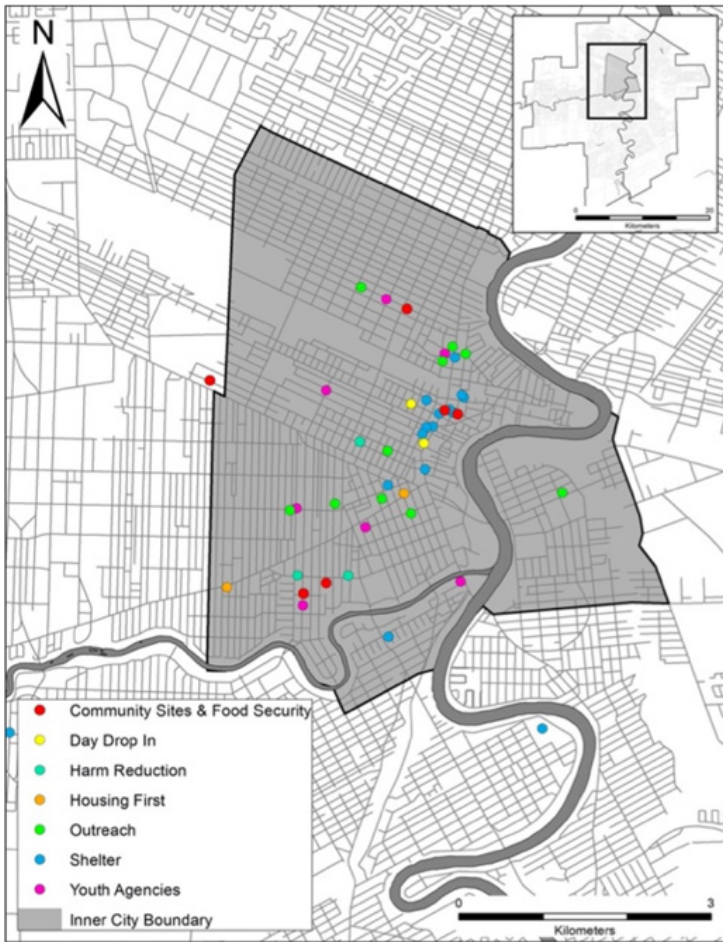
The objective of this chapter is to discuss how Winnipeg based organizations came together in a coordinated fashion to distribute resources and supports to people experiencing homelessness

(PEH) during the COVID-19 pandemic. We include a focus on how End Homelessness Winnipeg (EHW), an Indigenous organization responsible for coordinating federal funding and resources, stepped into a coordinating role during the critical early stages of the pandemic. Unique to Winnipeg's response was the advancement of an Indigenous leadership model to coordinate the homelessness sector in Winnipeg and ensure the needs of the population were addressed in a culturally responsive manner (Bingham et al., 2019; Distasio et al., 2019; Goering et al., 2011; Nejad et al., 2019; Thistle & Smylie, 2020). The success and limitations of this effort is examined alongside the impact of ongoing systemic issues that continue to prevent many from recovery and securing housing.

Why Winnipeg?

Winnipeg has been classified as a divided city (Distasio & Kaufman, 2015). These divisions are most often exposed along economic and social lines that separate parts of Winnipeg. Most prominent is the divide between Winnipeg and its inner city (as shaded in Figure 1). The inner city of Winnipeg can be characterized as a sustained and concentrated area of poverty and decline for over 100 years, but equally it's an area of resolve and community resilience. As seen in Figure 1, most service providers are in the inner city – in response to the concentration of PEH in this area.

Figure 1. Map of Service Providers Mobilized during the COVID-19 Pandemic



With respect to housing market activities, the Canada Mortgage and Housing Corporation (CMHC) noted that the 2020 vacancy rate was 3.1% with average rent at \$1070 (CMHC, 2020). Persons desperately seeking housing often find it tough to afford the average market rent and supported or subsidized units that are in high demand are short in supply. Manitoba's minimum wage remains one of the lowest in Canada, and EI rates are currently at 53% of the Statistics Canada Market Basket Measure poverty

line (Bernhardt, 2022, Plaut, 2020). These factors contribute to the inaccessibility of housing for people with low incomes or those on social assistance.

1. The Rise of Community Based Organizations

Starting in the 1950s, rapid suburbanization and the subsequent movement of wealth into bedroom communities saw central neighbourhoods experience sustained decline. In response, the inner city of Winnipeg became site of Canada's largest urban intervention project – the Core Area Initiative (CAI) – beginning in 1980 and contributing to 25 years of policy intervention programs from all three levels of government. Since the 1960s, Community Based Organizations (CBOs) have played a major role in neighbourhood resilience in Winnipeg's inner city, with a strong and entrenched network that strives to embrace the principals of citizen engagement, community economic development and supportive service provision (Distasio & Kaufman, 2015).

These factors set the inner city of Winnipeg apart from the rest of the city. The presence of CBOs has proven to be invaluable in the coordination of the homeless sector during the COVID-19 pandemic. As seen in Figure 1, many of these providers have their primary location within the inner city of Winnipeg, near the people they serve. Programs utilized by PEH go much beyond housing and shelter. An overview of the types of programs in Winnipeg that offer services to PEH are shown in Table 1.

Table 1. CBO Programs with Services for PEH in Winnipeg, May 2022

Program type	# of Programs
Homelessness Prevention	12
Housing and Shelters	179
Financial Supports	35
Addiction Services	24
Counselling and Mental Health	17
Crisis Services	19
Education Services	13
Total number of programs	299

Like many cities in Canada, the shortage of affordable housing contributed to an increase in PEH regardless of the number of supporting agencies (Evans et al., 2021). Table 2 shows several types of housing and programs that exist in the city. There is a varied mix of housing types - from emergency, transitional, and supportive to more permanent and independent options. Eleven CBOs work to help refer clients into units provided by Housing First (HF).

Table 2. Housing Programs in Winnipeg, May 2022

Housing Program Type	# of Programs
Housing First	11
Emergency Shelter	11
Transitional Housing	21
Supportive Housing	16
COVID-19 Isolation Units	1
Non-Profit Housing	16
Non-Profit Housing: Seniors	40
Non-Profit Housing: Indigenous Peoples	3
Non-Profit Housing: Newcomer Women and Children	1
Co-Op	17

<i>Housing Program Type</i>	<i># of Programs</i>
Co-Op: Seniors	3
Personal Care Homes	21
Supported Living Services for Adults with Disabilities	6
Transitional Housing for Indigenous Peoples Requiring Dialysis	1
Housing Referral Services	11
Total number of housing programs	179

2. Who are PEH in Winnipeg?

Estimates of PEH populations are often flawed when accurately identifying the number of individuals experiencing homeless. Yet, under the federal government’s funding requirements, cities receiving federal funding must undertake counts (Echenberg & Munn-Rivard, 2020). The Winnipeg 2022 count estimated that on any given night, an average of 1,200 people experience homelessness in Winnipeg (Brandon, 2022). Furthermore, researchers believe that for every individual experiencing absolute homelessness, another three individuals can be considered part of the hidden homeless population (Isaak et al., 2019). Table 3 gives a brief overview of the demographics of PEH in Winnipeg.

Table 3. Demographics of PEH in Winnipeg

Demographic	PEH in Winnipeg
Indigenous identity	% of Winnipeg population: 12.2%
	% of PEH in Winnipeg population: 68.2%
Gender identity	Male: 62.6%
	Female: 35.4%
	2SLGBTQQIA+ identity: 10.8%
Chronic homelessness	Homeless for 12 months in last year: ~55%
	Homeless for more than 18 months in last 3 years: ~45%
Most common income sources	EIA/Welfare/Social Assistance: 39.3%
	Informal income (panhandling, bottle returns, etc.): 24.9%
Highest level of education	Less than high school: 48.7%
	High school or GED: 28.6%

Note. Data from EHW (2021). Brandon (2022). Statistics Canada (2021).

While unique pathways into homelessness exist amongst different subgroups, such as intimate partner violence for women and intergenerational trauma among Indigenous peoples, some of the most common causes of homelessness can be seen in Table 4.

Table 4. Causes of Homelessness in Winnipeg

Cause	Percentage
Not enough income for housing	29.2%
Conflict with partner/friend/family/CFS/other	25.5%
Substance use issue	18.3%
Conflict with roommate, landlord/complaint/building sold, renovation	17.3%
Unsafe housing	7.7%
Mental health issue	6.3%
Incarceration	6.0%
Left the community/relocated/my choice/end of lease	6.0%

Cause	Percentage
Physical health issue	3.3%
Experienced abuse by partner, family	2.7%
Pandemic	2.5%
Hospitalization/treatment program	1.7%
Experienced discrimination/intergenerational effects of residential schools	1.5%

Note. Data from Brandon (2022).

Trauma and mental health struggles were common experiences amongst those surveyed. In 2022, it was found that 85.4% of youth experiencing homelessness have symptoms of mental health distress, and that experiencing homelessness shortens a person's lifespan by 7-10 years (Brandon, 2022). An additional barrier to securing housing is lack of a form of personal identification, with 35.5% of participants not having any form and 29.6% not having a health card (Isaak et al., 2019).

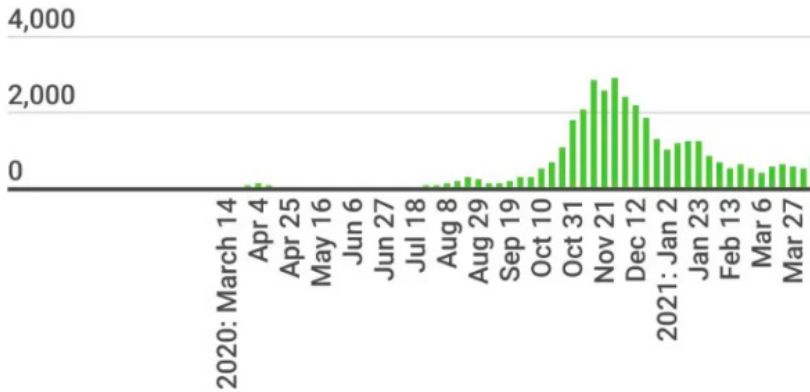
3. The COVID-19 Pandemic in Winnipeg

In a 2020 report, Canada's Chief Public Health Officer, Dr. Theresa Tam, reviewed the ways in which COVID-19 impacted Canadians unequally. Dr. Tam discussed the presence of discrimination and colonialism in Canada – saying that the resulting systemic racism that BIPOC (Black, Indigenous, and People of Colour) experience results in poorer health. This information is applicable within the Winnipeg context, as the COVID-19 pandemic is identified as a cause of homelessness, disproportionately impacting Indigenous peoples (Brandon, 2022). The importance of this information will be highlighted in the study of the response to the COVID-19 pandemic.

Due to the position of Winnipeg as a service centre for many surrounding towns and communities, Manitoba-wide statistics

of COVID-19 should be considered. A graph of case numbers for the province of Manitoba (of which approximately 60% live in Winnipeg) can be seen in Figure 2.

Figure 2. Weekly Cases of COVID-19 in Manitoba, March 2020-2021



Note. Data from Winnipeg Free Press (2022).

While strides were made in Winnipeg with the efforts of CBOs, Plaut (2020) stated the Province of Manitoba failed to fill the service gaps that CBOs could not meet. As well, Grift & Cooper (2020) stated that, “[t]he pandemic exposed how unprepared Winnipeg’s inner city was to deal with a large-scale emergency, primarily as a result of decades of underfunding and policies that increased social and economic marginalization by governments” (pg. 52). This understanding of the longstanding governmental disinvestment in the inner city is vital in considering the importance of CBOs in the COVID-19 pandemic response.

Indigenous Principles and Homelessness Services

Caplan et al. (2020) describes how challenges faced by Indigenous peoples in Canada must be conceptualized through a colonization-based lens. The intentional attempt to separate Indigenous

peoples from their cultures is manifested in present and historic trauma. Many Indigenous peoples have rich and diverse belief systems that embrace the interconnectedness of all elements of creation which is reflected in holistic thinking; mental, physical, spiritual, and emotional balance through mindfulness; and reflection, awareness, and identification of healing journeys. Caplan et al. (2020) thread this through the interconnectedness to Indigenous homelessness, saying that, in Canada, homelessness is not only interlaced with systemic issues, but intentional displacement, disconnection, and disruption from webs of “*all my relations*” (Caplan et al., 2020, pg. 2756). The authors say that because of this, cultural healing and reconnection remains at the forefront for many Indigenous PEH – traditional education, ceremonial participation, culture keepers, and community cohesion are identified as important parts of this process. These concepts are all considered in our analysis of the COVID-19 response in Winnipeg being done in a culturally responsive manner.

End Homelessness Winnipeg (EHW)

While much of the above paints a difficult portrait of PEH in Winnipeg, there is reason for hope and optimism. EHW was established in response to a community mandate to implement a 10-Year Plan to End Homelessness (Sanders, 2019; EHW, 2022). In 2019, a significant change was implemented as EHW restructured its approach and governance model by becoming an Indigenous organization. In addition, EHW took on the role of Community Entity (CE)¹ for Winnipeg (Sanders, 2019). As such, EHW works

1. Community Entity is a term used to designate the organization as being responsible for the management and distribution of federal programs and funding under the Reaching Home Strategy. For more information see <https://www.infrastructure.gc.ca/homelessness-sans-abri/directives-eng.html>

with CBOs and the private and public sectors to coordinate local approaches to end homelessness while administering federal funding.

Implementing an Indigenous Led Response to Homelessness

EHW's evolution to an Indigenous organization was described by former EHW President and CEO, Lucille Bruce, within the context of the overrepresentation of Indigenous peoples who comprise nearly 70% of PEH in Winnipeg. The contention was that EHW must work directly with, and clearly reflect the needs of, Indigenous peoples to find *“long-term solutions that will make a difference from a culturally relevant perspective”* (Rosen, 2019, para 5). In our interview, Bruce stated that the organization embraced the principles of Truth and Reconciliation from the National Inquiry into Missing and Murdered Indigenous Women, Girls, and Two-Spirit Peoples to the United Nations Declaration on the Rights of Indigenous Peoples. This ensures that EHW is culturally grounded in all its operations. This critical change comes after nearly four decades of non-Indigenous led organizations providing and managing funding for PEH, despite the overrepresentation of Indigenous persons. As such, EHW's position as an Indigenous organization ensures that these deeply rooted principles are implemented in the response to homelessness among Indigenous peoples in Winnipeg.

An Indigenous perspective has proven invaluable in the homeless sector's response to COVID-19. As raised by EHW, this position informed the model of grassroots decision making with an emphasis on working together instead of in silos, which was done pre-pandemic, and ensured a level of trust from the community. For example, testing and vaccine sites took place at many local

Indigenous organizations, such as the Manitoba Metis Federation, Thunderbird House, Aboriginal Health and Wellness, the Ma Mawi Wi Chi Itata Centre, and the Aboriginal Council of Winnipeg. This approach led to a collective impact model that respected the principles of Truth and Reconciliation and promoted Indigenous led services. The way EHW brought Winnipeg organizations together through Indigenous led responses to coordinate services during the COVID-19 pandemic was vital in its success.

Methodology

The research in this report was conducted using a variety of approaches and methodologies. It is important to note that our work began during the height of the COVID-19 pandemic and progress was repeatedly interrupted by escalating cases and restrictions. The outcome became a methodological approach that needed to be nimble and flexible. For example, we shifted from in-person interviews to a self-administered survey for service providers. Our view was to respect the volatility and uncertainty of daily work patterns of agencies that had to deploy a variety of work scenarios (e.g., hybrid, in-person, remote). As such, we developed an online research instrument that included both short and open-ended questions. We deployed this survey using a Qualtrics Cloud based platform that was secured by the University of Winnipeg. The survey was distributed to the 65 agencies that were part of the local response group.

Interviewing persons at risk of, or experiencing, homelessness was delayed by many months because of the challenges of safely meeting either in public places or at various agencies. As restrictions lifted we conducted 54 in-person interviews with persons at risk of or experiencing homelessness. Interviews were conducted in partnership with 10 agencies that assisted the research team

with finding participants. The survey instrument focussed on exploring the housing journey over the pandemic. In return for participation, we provided a takeaway meal and a small honorarium of twenty dollars. The protocols for the agency and individual surveys were reviewed and approved by the University of Winnipeg's Ethics Committee.

Results: Winnipeg's Localized Response to the COVID-19 Pandemic

EHW's role in the response to COVID-19 was discussed with CEO Lucille Bruce and Betty Edel (Director of Housing Supports). Bruce contemplated the ways the pandemic brought the issue of homelessness in Winnipeg to the attention of the public. The visibility of people sleeping in bus shelters due to lack of safety in emergency shelters meant people could no longer ignore this issue. Bruce said this led the media, the private sector, and the public to ask questions about why people were in bus shelters and why more housing was not being built. This heightened coverage brought discussions about homelessness into public discourse.

Figure 3. Bus stop being used for shelter in front of the Manitoba Legislative Buildings at -40 Celsius

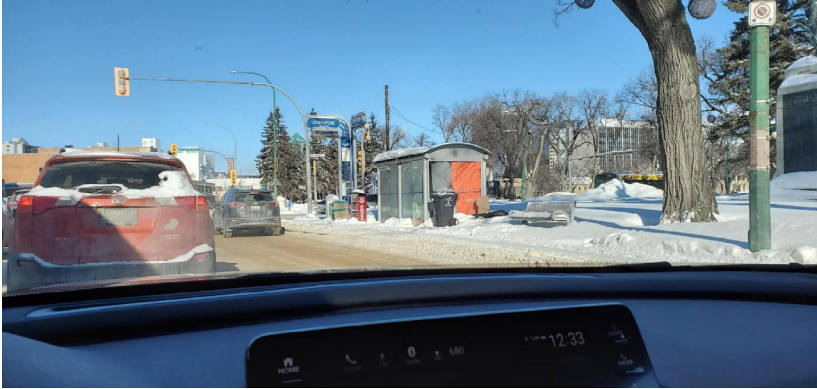
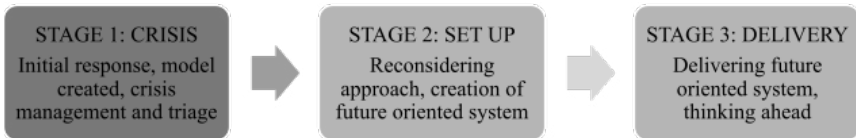


Figure 3. Bus Shelter, Manitoba Legislative Buildings (J, Distasio)

The following section focuses on Winnipeg's response during the first year of the pandemic and how Winnipeg organizations came together in unprecedented times. The response has been structured into three categories: Crisis, Set Up, and Delivery.

Figure 4: Phases in Winnipeg's Homeless Sector COVID-19 Response



1. Stage 1: The First Wave (March - June 2020) - Crisis

In March of 2020, the board of EHW was requested by the Winnipeg Regional Health Authority (WRHA) to shift priorities and coordinate the COVID-19 response in Winnipeg. On March 17, 2020, EHW had its first meeting with approximately 60 local stakeholders to discuss strategies (Plaut, 2020). This quickly resulted in six groups being formed: Youth, Shelter, Housing First, Food Security, Drop-ins, and Harm Reduction (Figure 5).

The groups initially met twice a week, with the management from EHW meeting twice a day. On March 20, 2020, the province of Manitoba declared a state of emergency which mandated the closure of schools, wellness centres, and public spaces; limited gatherings; and restricted the operation of non-essential businesses (CBC News, 2020).

Figure 5. EHW Working Groups



This model was created in a matter of weeks. The working groups allowed for information sharing about governmental responses to COVID-19, resources that were available, and gaps in services. Up-to-date information sharing became critical during the early weeks of the pandemic. EHW also communicated public health directives and guidelines, which were changing almost daily, to ensure that all CBOs were operating within the new mandates.

Additionally, EHW took on the role of coordinating incoming COVID-19 funding by creating a plan to flow money to essential services. Bruce discussed how the working groups were utilized effectively for this plan, asking them to identify emerging needs and where investments were needed. Edel also discussed the

importance of communicating “*who was funding who*” (B. Edel, personal communication, 2020) to ensure no one was missed. Bruce and Edel attributed the success of this effort partially to EHW being a not-for-profit, saying this allowed them to bypass bureaucracy and act quickly and efficiently.

At this early point in the pandemic, Personal Protective Equipment (PPE) such as face masks, face shields, gloves, gowns, etc. were in high demand and low supply. EHW took on the role of securing and distributing PPE and also cell phones to CBOs so they could be given to people who no longer had access to phones or internet due to building closures and/or the change to remote work. EHW also helped Main Street Project and the WRHA establish an isolation shelter for PEH awaiting COVID-19 test results and for those who had tested positive. This was supported by securing space from the City of Winnipeg and support from Manitoba Housing (Plaut, 2020).

By the end of April 2020, then premier of Manitoba, Brian Pallister, announced a plan to re-open the province (CBC News, 2020). Phase 1 was met with criticism from the public and public health officials, due to the epidemiological evidence that the pandemic would continue and that measures such as masks and social distancing had to be implemented, not removed, to prevent an overload to the healthcare system (Plaut, 2020). Bruce and Edel discussed how EHWs role as the CE helped the community recognize the importance of coordinating key services and supports.

2. Stage 2: Summer 2020 - Set Up

The downturn of cases in May 2020 sparked Phase 2 of Manitoba’s reopening plan on June 1, 2020, allowing restaurants, gyms, pools, and a large variety of businesses to reopen (CBC News, 2020). On June 21, 2020, Phase 3 was initiated, increasing gathering sizes,

returning to full capacity at daycares, and lifting some travel quarantine requirements (CBC News, 2020). On July 14, 2020, Manitoba accomplished a full week with no new reported cases of COVID-19 in the province (CBC News, 2020). With lower COVID-19 positive cases and less immediate crisis management, attention turned to returning to “normal” work in this sector.

Since March 2020, EHW had invested \$20 million of funding. Edel discussed how EHW quickly realized that simply “*throwing millions into crisis*” (personal interview, 2020) was not going to be helpful in the long term. CBOs identified a lack of public and governmental awareness around the needs of PEH. Many praised the City of Winnipeg and the province for providing resources and funding to expand shelters, but CBOs agreed that this thinking was short term and did not address the larger demand for quality, safe, low-cost housing (Grift & Cooper, 2020). Therefore, EHW pivoted to putting funds they were receiving into capital projects, knowing that if people had homes, issues such as lack of shelter would not exist. They also started to prepare for extreme weather by investing money into warming spaces. They utilized networks to anticipate needs. Although the city had now “*opened*”, they anticipated another shut down, so access to daytime spaces with computers, washrooms, and food had to be planned for. Bruce and Edel emphasised the importance of community outreach, and made plans for visiting encampments, offering to help PEH to find housing and connect to resources. They recognized that this service needed to be 24/7 to ensure the safety of PEH. At the end of July 2020, Manitoba announced reopening Phase 4, despite an upturn in cases (CBC News, 2020).

3. Stage 3: The Second Wave (September 2020 to March 2021) - Delivery

In September 2020 with the return to school pending, Manitoba had an increase in cases and the City of Winnipeg issued new restrictions effective September 28, 2020 (CBC News, 2020). One of these was a mask mandate for indoor spaces (Unger, 2020).

Many issues that impacted PEH also came to light with the colder weather. Lack of safe consumption supplies and strict naloxone distribution regulations contributed to the increase of drug use and overdoses in Winnipeg (Plaut, 2020). Additionally, physical distancing and reduced access to services like in-person support groups had an impact on social isolation – putting added strain on persons with substance use disorders (Tam, 2020). CBOs had to modify services to a delivery-based model due to space closures. Many CBOs discussed the loss of connection with people they service due to physical space closures and therefore no walk-ins (Plaut, 2020).

With the start of cold weather came a huge influx of people sleeping in bus shelters and encampments. EHW was asked by the City of Winnipeg to investigate this, so they gathered outreach experts, asking them to make connections with the PEH and discuss why they were choosing to sleep there despite other places, like shelters, being available. They quickly learned that people did not want to stay in emergency shelters due to fear of contracting COVID-19 so they felt safer sleeping in bus shelters or tents. They also learned that it was not just people who were homeless that were gathering in these spaces, but other people who had utilized currently closed public spaces for socialization. EHW then invested in daytime spaces, as they had anticipated needing to do over the summer.

By the beginning of 2021, there was hope that the COVID-19 vaccines would bring an end to the pandemic. As previously discussed, EHW was involved in ensuring that vaccines could be offered by Indigenous organizations. In April and May of 2021 Indigenous-run vaccine sites, staffed with elders and traditional knowledge keepers, and practising traditional ceremonies, opened in Manitoba, with the intent of providing a safe, trusting, and welcoming space for people who may be hesitant about the vaccine (MacLean, 2021). The immunization site at the Aboriginal Health and Wellness Centre was located next to Winnipeg's three largest homeless shelters, and immunization teams were soon also visiting shelters, making vaccinations accessible for PEH, while catering to the large Indigenous portion of this population (MacLean, 2021).

Although the work EHW and the broader homeless sector did in response to COVID-19 did not end at the one-year mark of the pandemic, there was a sense of a “*new normal*”. The work EHW led in coordinating efforts in this sector proved invaluable. In reflecting on the effectiveness of this response, Bruce pondered how continued coordination could be used to end homelessness in Winnipeg, as it was so effective in the pandemic response.

Reflection

The COVID-19 pandemic homeless sector response changed the way homelessness was addressed in Winnipeg. EHW helped shape the CBO response through working groups and encouraging coordination and communication on all levels. As a result, CBOs in Winnipeg were brought together in the early days of the pandemic, creating a strong response network. Table 5 briefly compares pre-pandemic and post-pandemic responses to homelessness, providing an overview of what EHW's coordination achieved in the first year of the pandemic.

Table 5. Changes in responses to homelessness during the pandemic

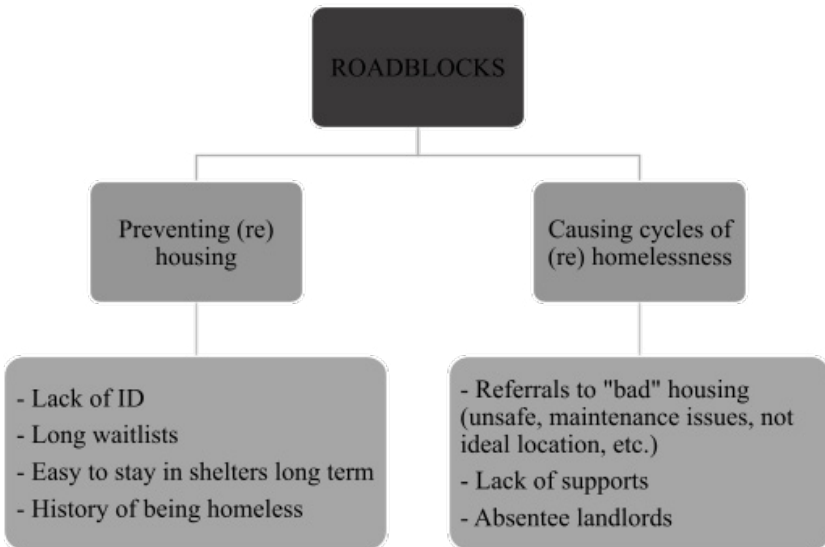
Category	Pre-Pandemic	During/Post-Pandemic
Funding	Worked independently and competed for funding.	EHW helped introduce a more equitable funding model that ensured no one was double-funded or missed.
Collaboration, Communication & Governance	Limited coordination of services and communication between CBOs.	Focused on intentional and coordinated communication and services between CBOs through working groups.
Outreach	Conversations and outreach mainly done with PEH in shelter spaces by CBOs.	Intentional outreach to PEH in the city to identify needs and work to meet those needs.
Programs	Relied on year-to-year funding to continue and start new programming.	Adapted/filled gaps. Equitable funding model helped relieve the some of the chase for funding for programming.
Staffing	High staff turnover due to difficult jobs and low wages. Non-profits often relied on volunteer boards. CBOs relied on year-to-year funding for positions to continue.	Issues continued and are exacerbated by the COVID-19 pandemic. Public discourse on who is “essential” and who is not. Issues with staff contracting COVID-19. Equitable funding model helped relieve some funding issues.
Social Spaces	Public spaces such as libraries and food courts informally used as social spaces by PEH.	EHW conducted outreach to PEH in bus shelters and encampments and opened warming spaces to meet needs.
Visibility & Public Discourse	PEH “hidden” in shelters. PEH less visible so public discourse not as prominent.	With shelter limits and many favouring encampments and bus shelters, PEH were more noticed by the public. Increase in conversations about where PEH are “allowed” in the city and the “criminalization of poverty”. Protests with encampments being shut down by the city

The intersection of CBOs and PEH experiences during the pandemic led to three main reflection points: the housing journeys of PEH; the roadblocks that prevented housing; and the bridges that connected people to secure housing.

1. Roadblocks and Bridges

Through surveys with service providers and interviews with PEH, we categorized experiences as “roadblocks” or “bridges” in an individual’s housing journey. Roadblocks to securing housing were put into two broad categories: those that prevented (re) housing, and those that contributed the cycle of re-homelessness. These roadblocks still mostly prevail for PEH post-pandemic, with solutions being deeply rooted in the need for systems change.

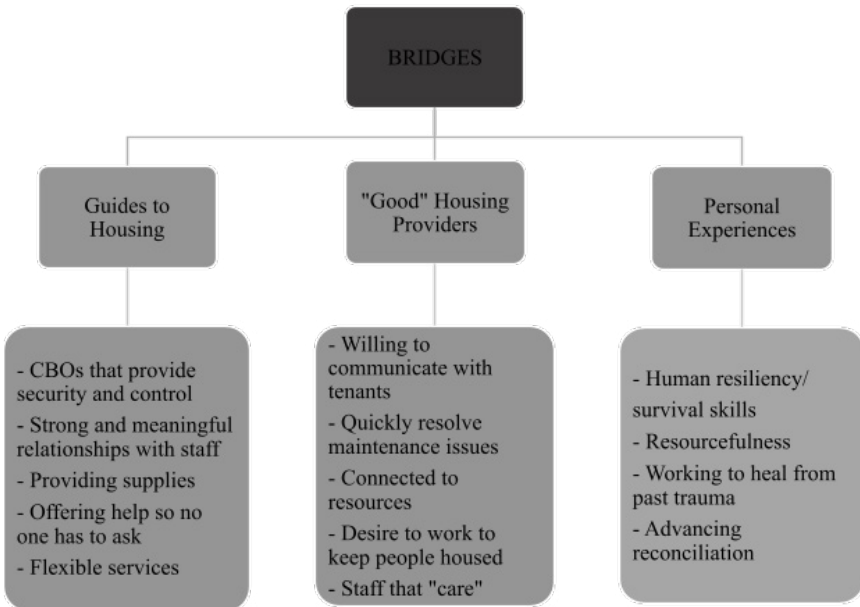
Figure 6. Roadblocks to securing housing



Bridges to housing were grouped into three categories: the help of guides to affordable housing, “good” housing providers, and the impact of personal experiences. Although access to services

was difficult for many during the pandemic, when a relationship was formed with a guide to housing services it was strong. The pandemic and space closures led CBOs to reach out to PEH, and for services to become much more flexible. This worked very well for many PEH, because as Bruce and Edel stated, crisis does not only happen between 9am and 5pm, Monday to Friday (B. Edel, L. Bruce, personal communication). The need to adapt services led to changes in service provisions that many CBOs expressed interest in continuing post-pandemic.

Figure 7. Bridges to securing housing



As can be seen, many identified “roadblocks” and “bridges” are related to deep-rooted systemic issues. For example, “bad” absentee landlords are highly related to the lack of affordable housing options, which is related to government funding and political will. Similarly, issues with lack of personal identification are related to bureaucratic measures that often hinder searches for shelter.

Trauma is often related to experiences of residential schools or other harmful tools of colonialism. This creates a very complicated situation, where the impact of coordination can only come so far. What is needed is systems change alongside coordination to see real reductions in homelessness.

2. The Need for Systems Change

Though the pandemic response was effective in helping PEH in Winnipeg, Bruce and Edel stressed that broader system evolution is needed to see meaningful change. In relation to this, Shapiro & Stanton (2022) called for a post-COVID-19 world to be an opportunity for homelessness systems change.

The need for systems changes was identified through the interviews with 54 PEH, and 35 survey respondents from the 60 CBOs involved in the Winnipeg pandemic response. Five interconnected categories where systems change is needed were discussed. One was the impact of the financialization of housing (Madden & Marcuse, 2016; August 2022) and rent increases (Kaufman, 2011; Plaut, 2020). Also discussed was the rise in PEH sleeping in encampments and bus shelters. Connected to this were faults identified in income systems, from the EIA claw back for those who received CERB and subsequent calls for a Livable Basic Needs Benefit to replace EIA (Plaut, 2020).

Another theme was the faults in the healthcare system, with issues such as differential treatment based on racial identity and other social determinants of health as well as lack of health cards among PEH that were present pre-pandemic now being amplified (Shapiro & Stanton, 2022; Tam, 2020; Isaak et al., 2018).

The impact of the CFS system was also emphasised, with a significant overrepresentation of Indigenous children in care perpetuating intergenerational trauma from colonization through family

breakdown alongside the “Sixties Scoop” and residential schools (Hobson, 2022; Baskin, 2013). Finally, the use of law enforcement, for the perceived ‘inconvenience’ of PEH, to dismantle encampments highlights the move towards the criminalization of poverty as an (ineffective) solution to ‘end’ homelessness (Gaetz, 2010).

Figure 8. The Crossroads to Approaching Homelessness in a Post-COVID-19 world



Recommendations: Moving Forward Post Pandemic

There is little doubt that the pandemic’s reach has been far, wide, and devastating. As demonstrated in this work, COVID-19 adversely impacted marginalized populations around the globe. For Winnipeg, the effect on PEH was immense with networks and supports upended due to closures of general amenities, such as warm spaces, and the more serious disruption of basic health supports. The recommendations that follow are evidence and experience based and recognize that there is no ‘one size fits all’ solution to homelessness.

1. Recommendations from CBOs

The experiences of the 35 survey respondents, from the group of 60 service providers involved in the EHW working groups,

highlighted the needs of organizations during the COVID-19 pandemic. These 8 recommendations can be used while continuing to coordinate the response to homelessness in Winnipeg post-pandemic.

1. Ending homelessness must be prioritized.

Ending and preventing homelessness, through person-centred, individualized support must be the primary goal for both CBOs and government funding agencies.

2. Access to affordable, safe, quality housing is imperative.

It is critical that this is led by Indigenous organizations to reflect the current over-representation of Indigenous persons experiencing homelessness.

3. Community Response Network must shift to 24/7 access.

- CBOs and the government must ensure that the range of services and supports are carefully monitored and addressed to maximize the impact and also to direct attention to the most pressing areas of need and avoid duplication.
- Needs arise at any time of day, and therefore more support must be available 24/7. This requires coordination among agencies to ensure services are accessible at all hours of the day.

4. Enhance sector communication.

A communication strategy must be developed and approved locally to better share information and to direct resources or access funding.

5. Learn from what has not worked.

Some service providers felt that solutions offered during meetings were less effective in practice. A full review of processes that were effective and ineffective during the pandemic should help address future endeavors.

6. *Evaluate distribution of funding (both emergency and long-term).*
Some providers spoke of barriers that exist in the funding models which did not work smoothly across provincial and municipal jurisdictions.
7. *Develop a local funding model.*
Providers spoke to the need to rethink the model of funding distribution to make it less competitive. Perhaps such a review could focus on the model used to distribute and manage federal funding locally during the COVID-19 pandemic, which was viewed favorably.
8. *Continue to advocate.*
Service providers indicated that it was helpful to have EHW advocating for them when lobbying the government for policy changes and funding.

2. Recommendations from Persons with Lived Experience of Homelessness

The experiences of 54 individuals we spoke with described a system with the capacity to support persons in need of housing through a range of related supports. This system, however, is difficult to navigate, especially for those who lack personal resources and those struggling with mental health and addictions. The following are recommendations based on these interviews.

1. A review of the current model for delivering supports and services to persons at risk of, or experiencing, homelessness must be conducted.
 - This needs to include an emphasis on coordination of services, avoidance of duplication and improving access to quality and affordable housing.
 - Individuals seemed unaware of resources or frustrated from

a lack of access to services and had to resort to searching for housing on their own.

- There should be a coordinated approach to connecting individuals with available housing.
 - The search for housing became exhausting, complicated, and often unsuccessful, or resulted in substandard accommodation.
2. There must be further research on the pathways into homelessness to ensure adequate supports are in place at key points of entry into homelessness.
 - These points include youth aging out of care, individuals being released from incarceration, and individuals travelling to Winnipeg for medical care.
 3. The discharge of persons at risk (from corrections, CFS, hospitals, etc.) requires a clearly articulated plan for housing, either temporary or permanent, along with ready access to a support worker to facilitate this process outside of the discharging entity.
 4. There must be a focus on securing “good housing” the first time, to prevent cyclical or chronic homelessness.
 - Safety, security, supports, cleanliness, and being located near resources were factors among those who remained pleased with their home and wanted to stay for a long time. This must include ensuring that tenancy rights are at the forefront and protected.
 - Lack of accessibility, affordability and access to resources and supports were themes among those who left homes they were otherwise satisfied with.
 - Bad landlords and the geography of gangs and drugs were themes among those who became dissatisfied with their homes.

- 5.** Outreach, and building and maintaining meaningful relationships where PEH are offered help instead of needing to ask must be at the forefront of efforts.
 - The stigma around asking for help often leads to individuals trying to navigate the housing system by themselves.
 - Supports are needed to help navigate this system and ensure that people do not become homeless due to system failures.
- 6.** Multiple access points for persons seeking supports and/or services, and the sharing of real time information about available services and housing between agencies must be created.
 - An agency dashboard of services, supports and housing should be accessible to all agencies.
- 7.** Supports must be offered in the transition to living independently.
 - Living independently posed challenges for some participants who struggled with feelings of isolation and loneliness. Some people require ongoing supports to remain housed.
- 8.** There should be a focus on assisting PEH with obtaining personal identification. This has proven to significantly prevent and reduce homelessness.
- 9.** There should be more “guides” to help those looking for housing navigate the legal process of securing a home.
 - More needs to be done to ensure people know their tenancy rights. This is critical in preventing unjust evictions.
 - PEH should be offered better access to advocates and the right resources, or a “team” that can help. This is essential to navigate the many roadblocks in the current systems such as past rental history, credit issues or other concerns raised.

10. Resources to physically assist with moving into a new home should be available for PEH.
 - Information about access to furnishings and help moving should continue to be shared. Those who undertake the moving process without the knowledge of these supports or help accessing them can encounter significant difficulties.

Conclusion

The objective of this chapter was to discuss how Winnipeg based organizations came together in a coordinated fashion during the pandemic to distribute resources and support while responding to PEH. In the broadest context, the global community was not prepared to address the enormity of the pandemic and its devastating reach and impact. For Winnipeg, it was easy to blame the government, or service providers for their shortcomings. In reality, we all failed to meet the basic needs of PEH for decades. The pandemic simply amplified the deeper faults in an unequal system. However, the coordinated model introduced by EHW was successful under such circumstances.

The coordinated model and constant adaptation to the needs of PEH in Winnipeg was defined as positive by both PEH and CBOs. The Indigenous lens used by EHW was vital in this success, due to the overrepresentation of Indigenous peoples among PEH in Winnipeg. The COVID-19 pandemic identified what CBOs can do, and what they cannot do.

What is now needed to end homelessness in Winnipeg became clearer. To truly impact change, we must be decisive with the allocation of resources and focus on preventing homelessness by tackling root causes. A post COVID-19 context must also focus on continuing to help locate long-term housing solutions for those needing them.

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CHAPTER FOURTEEN

***Pandemic response in homeless populations:
lessons learned from a community-academic
partnership in Indiana, USA***

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Abstract: The COVID-19 pandemic disproportionately affected marginalized communities in the United States, and especially people experiencing homelessness (PEH). Compared to the general population, PEH are a particularly vulnerable population with higher rates of pre-existing health conditions exacerbated by inadequate access to health care. This, coupled with the necessity of being in high exposure settings, like shelters and other shared spaces, meant that PEH faced unique challenges and often worse impacts from COVID-19. Tippecanoe County, Indiana is home to one organization that serves at the coordinated point of entry to PEH. With homelessness as a top concern in the county, and in an effort to understand these impacts on PEH and the communities serving them, a community-academic partnership between a university and a local homeless services organization in Indiana, conducted ongoing community-based participatory research (CBPR) on the impact of COVID-19 in homeless populations as well as broader health needs and disparities. This chapter offers a summary and synthesis of the perspectives of various stakeholders and PEH through focus groups and/or interviews with PEH, homeless shelter staff and other medical and social service providers, to examine first-hand accounts of pandemic response and related challenges in a homeless population in Indiana over 2 years of the COVID-19 pandemic (mid-2020 to mid-2022). We present the collective findings and lessons learned across these community-based studies and highlight important themes, perspectives, and compounding factors that contribute to key insights for future pandemic response in homeless populations.

Ethics review statement: The studies mentioned in this chapter were approved by Purdue University's institutional review board. Informed consent was obtained from all participants.

Conflict of interest statement: NMR is a member of the board of directors of a non-profit homelessness service organization in Indiana.

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Introduction

The COVID-19 pandemic created unprecedented challenges for people experiencing homelessness (PEH) globally. Health care professionals cautioned that not only would PEH be more susceptible to adverse COVID-related outcomes, such as pre-existing health conditions, cramped living quarters in shelters, and barriers to regular care (Tsai & Wilson, 2020), but that more people are at risk of homelessness because of the economic consequences of the pandemic, further straining the shelters and health systems that support PEH (National Alliance to End Homelessness [NAEH], 2023). A subsequent scoping review of the health impacts of PEH in 96 studies across North America and Europe indicated

this to be the case, finding that PEH were often at a higher risk of infection, hospitalization, and mortality than the general population, and that the pandemic had “*a substantial impact on mental health, substance use, and day-to-day health among PEH*” (Corey, Lyons, O’Carroll, Stafford & Ivers, 2022). Several studies in their review also suggested an increase in homelessness (Appa et al., 2021; Finnigan, 2022; Irwin, Amanuel, Bickers, Nguyen & Russell, 2021) and impacts on shelter operations, such as admission restrictions (Cironi, Jones, Hauser, Olsen & Kissinger, 2021; Karb, Samuels, Vanjani, Trimbur & Napoli, 2020; Leonardi & Stefani, 2021; Rodriguez, Lahey, MacNeill, et al., 2021) and shelter closures (Barbu, Barranco, & Silk, 2021; Imbert et al., 2021; Rincón et al., 2020).

Homelessness in the United States has continued to rise since 2017 to nearly 600,000 individuals each year, with a 2021 point-in-time estimate of nearly 5,500 people experiencing homeless in the state of Indiana (NAEH, 2023). In Tippecanoe County, Indiana, homelessness was cited as one of the top five community concerns in a 2019 needs assessment by the Tippecanoe County Health Department (Ragland, Shen, & Lerch, 2019). Our community partner organization, a homelessness engagement center, serves as a coordinated point of entry for all PEH in Tippecanoe and surrounding rural counties, serving nearly 2,000 guests each year with services that include rapid re-housing, permanent supportive housing, access to basic needs and referrals to health and social services.

PEH have historically been overlooked in disaster planning and response and the COVID response was no exception, as it lacked sufficient institutional guidance, data, and resource allocation for homeless populations and the shelters that support them (NAEH, 2023). In response, a multisectoral community-academic

partnership was formed in April 2020 between this homeless shelter, the local health department, and a public university in Indiana to understand and address the multilevel pandemic-related challenges affecting people experiencing homelessness in Tippecanoe County. Our ongoing community-based participatory research has examined the impacts of COVID-19 and the consequent organizational-, community-, and policy-level pandemic responses on PEH (Rodriguez, Cromer, Martinez & Ruiz, 2022; Rodriguez, Lahey, MacNeill et al., 2021; Rodriguez, Martinez, Ziolkowki, et al., 2022; Rodriguez, Ziolkowski, Hicks, et al., in press). Our findings highlight specific multilevel challenges that disproportionately affected this uniquely vulnerable population, and key lessons learned from COVID risk and impact mitigation strategies in this community that can inform future pandemic response strategies for PEH.

Methods

This chapter synthesizes our findings to date resulting from our community-academic partnership (Rodriguez, Cromer, Martinez & Ruiz, 2022; Rodriguez, Lahey, MacNeill, et al., 2021; Rodriguez, Martinez, Ziolkowki, et al., 2022; Rodriguez, Ziolkowski, Hicks, et al., in press), established at the onset of the COVID-19 pandemic in 2020, with a local homeless services agency, local health department, and an interdisciplinary academic team consisting of public health, biomedical engineering, and anthropology researchers, to address the impact of COVID-19 and health disparities among PEH. Specifically, we sought to address the public health response in communal living settings and to conduct much needed research on the health needs of local PEH by using a community-based participatory research (CBPR) approach. This approach engages diverse stakeholders, including community

members and local organizations, in all aspects of research with the goal of increasing knowledge and understanding of a given phenomenon to inform interventions for policy or social change benefiting the community members (Israel, Schulz, Parker, & Becker, 1998; Minkler & Wallerstein, 2011). Through this partnership, we examined the perspectives of service providers, PEH, and community partners in Indiana from mid-2020 to mid-2022 during the COVID-19 pandemic. Detailed methods and primary results are described in their respective publications (Rodriguez, Cromer, Martinez & Ruiz, 2022; Rodriguez, Lahey, MacNeill, et al., 2021; Rodriguez, Martinez, Ziolkowki, et al., 2022; Rodriguez, Ziolkowski, Hicks, et al., in press). All studies involving human subjects were reviewed and approved by the University's Institutional Review Board for research ethics.

We initiated our research with service providers by conducting semi-structured interviews with 18 representatives from 15 community-based homeless services organizations from July 2020 to January 2021 (Rodriguez, Lahey, MacNeill, et al., 2021). Based on our findings, we proceeded to conduct semi-structured interviews to gather the direct perspectives of PEH about the pandemic's impact on their lives (Rodriguez, Martinez, Ziolkowski, et al., 2022). From January 2021 to July 2021, we interviewed 34 people who were utilizing services at a homelessness services organization. The development of interview questions and the overall study design for both research projects were guided by the socioecological model, which examines multi-level influences of individual, interpersonal, community, organizational, and policy factors on health behaviors and disease prevalence, and is used as a framework for intervention development (Sallis & Owen, 2015). We employed coding and thematic analysis techniques to identify patterns, recurring themes, and key findings from the collected data.

During these analyses, the United States Interagency Council on Homelessness (USICH) published a report on the impacts of the COVID-19 pandemic on PEH that conflicted with many of our findings (USICH, 2021). We conducted an analysis of the conceptual framings, methodologies, and conclusions claimed by this report and presented our findings and a call for critical accountability in an editorial for public health audiences (Rodriguez, Cromer, Martinez, et al., 2022). Most recently, we convened all community and academic partners for a COVID debriefing session to relay findings from our CBPR work, incorporate community involvement, and identify key lessons for pandemic response for homeless communities (Rodriguez, Ziolkowski, Hicks, et al., 2023).

When reflecting on the findings from our research and ongoing partnerships, we foreground key findings that speak to multilevel challenges for PEH during the COVID-19 pandemic, as well as lessons learned and recommendations for pandemic preparedness, with a specific focus on vulnerable communities.

Multilevel challenges for PEH in Indiana during the COVID-19 pandemic

Our research suggests five intersecting priority areas that are crucial for realizing effective pandemic responses and supporting homeless communities, service providers, and relevant academic collaborations.

1. Heightened vulnerability and barriers to care

The COVID-19 pandemic significantly impacted PEH by disrupting services that address chronic and acute illnesses, which amplified vulnerability to the impact of infection. PEH experienced limited and often foreclosed access to regular and essential health care, which exacerbated pre-existing conditions, substance use, socioeconomic precarity, health knowledge, barriers to COVID-19 vaccination and testing, and stigma. Disruptions in care contributed to negative health outcomes and heightened overall vulnerability. Organizational staff recognized increased vulnerabilities among PEH yet also experienced limited resources and capacity to adequately connect PEH to healthcare or to address pre-existing health conditions on-site due to heightened infection prevention and control guidelines. While alternative modes of accessing healthcare, such as telehealth, gained traction among the general public, use by PEH was hindered by limited access to technology and suitable spaces for remote appointments.

2. Restricted access to safe spaces for hygiene and isolation

Early COVID-19 pandemic response involved closing or restricting access to public and private spaces, which augmented difficulties for PEH in accessing safe and clean hygiene facilities. Public bathrooms, businesses, and community shelters implemented stricter control measures over their spaces, further limiting the ability of PEH to meet basic wellness and hygiene needs. Public facility closures also made it difficult for PEH to access essential resources, such as clothing, meals, and food donations. Instead of broader access to safe, clean, and supportive spaces for weathering the pandemic, PEH encountered heightened barriers, which compounded their experience of stigma and eroded trust in community health services and social service providers.

3. Low health literacy and limited access to reliable sources of health information

PEH have diverse health literacy levels and educational needs, which were further influenced by lack of access to reliable and trustworthy information during the pandemic. PEH who had been formerly incarcerated especially encountered severely limited access to pandemic-relevant information (Rodriguez, Lahey, MacNeill, et al., 2021). PEH reported relying on friends and community networks for information, while others sought information from social media and online communication channels. Service providers responsible for managing communal spaces and interacting with PEH struggled to effectively share relevant health-related information. Providers recognized that PEH had limited access to information compared to the general public, though were often unaware of specific communication needs and strategies for bridging those gaps. Lack of service provider understanding strained relationships with PEH. Lack of access to reliable sources of information about COVID-19 transmission and mitigation impacted PEH's willingness to participate in preventive measures, such as vaccination and testing. Researching the various information sources utilized by PEH and identifying their trusted sources played a crucial role in shaping effective public health responses.

4. Provider mistrust and poor staff-guest communication

Ineffective communication channels between service providers and PEH exacerbated existing levels of mistrust between them, despite efforts to strengthen relations through community health workers and public health announcements. Maintaining a consistent and reliable staffing presence in homeless services proved challenging during the pandemic, resulting in frequent turnover and disruptions to relationships between guests and staff. The

staff that were responsible for providing direct services to PEH had the added responsibility of enforcing COVID-19 policies, such as mask-wearing, and the authority to remove individuals from the shelter for non-compliance. This coupled with inconsistent public health guidelines and enforcement by homeless service providers contributed to increased misunderstandings, and left PEH feeling they were treated unfairly when met with threats of removal for policies they felt they were given little rationale for. The mounting frustration furthered tensions between PEH and staff, leading to difficulties in achieving PEH compliance with public health measures within communal spaces, and a deepening mistrust among PEH toward service providers.

5. Limited data and knowledge production

Lack of a clear understanding of epidemiological data and the actual prevalence of COVID-19 infections among PEH gave policy-makers a false perception of the effectiveness of public health policies. Structural barriers, limited access to healthcare, inadequate reporting metrics and systems, and insufficient public health protocols for community agencies working with homeless populations resulted in unreliable data during the pandemic, likely leading to underreporting of cases to local, state, and national health tracking systems. Systems for tracking other indicators of health and well-being of PEH, such as unemployment benefits and Medicaid, were also under-resourced and poorly managed prior to COVID-19. The pandemic exacerbated and strained these already inadequate data collection systems, leaving public policy efforts to address the underlying and pervasive issues faced by individuals in social and economic precarity without reliable and organized data. The confluence of these factors contributed to PEH not being able to access services and care during a heightened time of need.

Discussion and Key Lessons

1. Implement/strengthen interagency community partnerships

An existing culture of collaboration among agencies with different mandates and responsibilities enabled these entities to work, access, and pool together funds and resources more effectively under emergency conditions. For instance, existing relationships between agencies and the local government health department provided a framework for information-sharing, coordination of diagnostic testing and outbreak response, and collaboration for vaccine administration. Ongoing academic and agency CBPR efforts provided findings that informed action in real-time. Regular communication channels such as group meetings and check-in discussions among agencies enabled ongoing dissemination of relevant information about topics of mutual interest which was particularly useful given the rapidly evolving nature of the pandemic. Based on our experiences we recommend the following for partnership development: (1) establish a coalition of stakeholders with a common interest in promoting and improving the health and wellbeing of PEH, including researchers, practitioners, community leaders, community residents, policymakers, advocacy groups and other partners; (2) leverage existing partner networks to expand the coalition; (3) establish regular meetings to facilitate consistency, open communication, and transparency among partners. This is particularly critical as partners will likely have different mandates and responsibilities; (4) concentrate coalition focus on identifying issues, needs, and providing updates on approaches currently being used to address problems faced by PEH. Consistent communication and transparency among coalition members is essential to reach consensus on goals and approaches.

2. Meet PEH where they are

To mitigate service disruption during emergency situations, including mental health, substance use and rehousing services for PEH, efforts must adopt a community-centered approach that involves PEH in decision-making. Pandemic requirements necessitated that spaces and protocols be modified, however, this led to PEH experiencing isolation and disconnect from critical services. Instead, providing onsite services, when deemed safe, and expanding outreach strategies enabled organizations to support and resource PEH while still promoting pandemic-safe approaches. One of the most successful initiatives of our community-academic partnership was to hire and train two community health workers (CHWs) to build rapport with PEH, provide health education on-site at the shelter, and navigate PEH through accessing health insurance, healthcare appointments, stimulus checks, and COVID tests and vaccines. Our recommendations include: (1) meet PEH where they are by offering, whenever possible, onsite resources to improve accessibility and utilization of health and social services, in addition to creating and maintaining infrastructure for remote or telehealth services; (2) in order to address gaps in resource awareness, expand targeted outreach as a way of updating and connecting people to available services. This can be done by employing CHWs as navigators for PEH and expanding existing outreach teams to reach unsheltered pockets in the community; (3) relatedly, expand existing medical and social service teams to include people with lived experience of homelessness who can build rapport with PEH and inform effective and appropriate service delivery.

3. Tailor communication and education to support PEH and train shelter staff accordingly

Early in the pandemic, trusted sources of communication and effective channels for public messaging for PEH were lacking, which contributed to distrust, misinformation, and ultimately ineffective public health compliance. That coupled with inconsistency in practices led to the need to strengthen communication channels and build trust between staff and guests. We recommend that service providers focus on early and consistent messaging and provide on-going staff training that enhances inclusion and social justice. For instance, offer staff training that is culturally appropriate and builds interpersonal communication skills needed to work with vulnerable populations. Additionally, communication channels should be created that not only offer public health education but also provide those impacted a way to identify and articulate problems and possibilities on their own terms in order to ensure solutions and responses reflect the community. Whenever possible, as concerns, rumors, and misinformation emerge, proactively respond with accurate and reliable information that is tailored to the needs of PEH. Ultimately effective, and reliable communication and education is key in any emergency response, especially within communities that are hard-to-reach using traditional outreach efforts.

4. Improve data collection

Data surveillance of pandemic cases, tests, hospitalizations, and deaths among PEH was inconsistent and underreported, which severely undercounted the burden of COVID-19 as well as the subsequent negative health outcomes of the pandemic among PEH (Finnigan, 2022). It is still unclear to what extent federal and local governmental agencies are tracking COVID-19 data among PEH. Our research, however, documented the ways

the pandemic burdened PEH and the agencies that provide services to this vulnerable population, as well as the substantial role social factors such as unemployment, overcrowded living conditions, and poverty play in increasing PEH's risk to COVID. There remains a need to collect and report data in a standardized way to accurately understand mortality and morbidity among PEH. These tracking efforts must go beyond cases and death counts to also include standardized data metrics and systems that collect social determinants data and allow for system level analysis. This requires staff that are trained to collect, clean, analyze, and disseminate data in real time. University partners can serve as critical resources as these entities have established infrastructures and expertise in research methods. Lastly, we recommend that attention be paid towards collecting, analyzing, and disseminating data using approaches that build trust between individuals, communities, and the state to ensure accountability from all stakeholders.

5. Center the voices of the most vulnerable

Understanding the pandemic through first-hand PEH accounts can inform practices and policies that are client-centered. These insights are vital as they allow for the development of approaches that are more nuanced and more likely to be accessed, utilized, and adopted by PEH which is crucial for effective emergency planning of services and responses. CBPR allows for this work to be done as it is a methodology that collaborates with community members and centers their voices in project development and implementation. Additionally, by amplifying the voices of disenfranchised populations, CBPR can be used to enhance service providers' and local, state, and government actors' understanding of PEH experiences from a health equity lens. Given the important contributions PEH perspectives offer to emergency situations,

future efforts need to consider expanding the role of this acutely marginalized population in COVID-19 research, public health and social policies as everyone aims to benefit from designing more robust and relevant actions.

Conclusion

Homeless communities and service providers in Indiana faced numerous challenges that exacerbated PEH vulnerability during the pandemic. Disrupted health care services and access to safe public spaces impacted everyone, though impacts on PEH had deleterious effects on personal health and trust in service providers. These impacts were exacerbated by lack of access to reliable information among PEH and ineffective communication strategies among service providers. Gaps in data collection, monitoring, and reporting led to gaps in understanding of the multifaceted impacts of the COVID-19 pandemic experienced by PEH. Our research suggests that aligning pandemic responses to existing understanding about the specific needs of vulnerable populations could mitigate their unnecessary suffering and generate effective strategies that could better serve all. Community-based approaches that center the voices of PEH and organizations who serve them can improve our ability to monitor and respond to the specific needs of this uniquely vulnerable population. Additionally, a culture of collaboration among government and non-governmental agencies enables service providers to work together more efficiently during emergency situations. Toward this end, local and state agencies require resources to develop expertise in data analytics as well as sustainable coalition building for improved pandemic response.

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SECTION FOUR

Macro and Global Responses

Dr. Kristy Buccieri

In the final section of the book, we bring together a selection of chapters that examine pandemics and homelessness using a macro-lens. Through the previous sections we considered the experiences of individuals experiencing homelessness, the impact on service providers and homelessness sectors, and regional and community level responses. We now turn our attention to larger-scale questions about how our societies set priorities and make decisions that have state and even global implications. We offer in this section the opportunity to reflect upon guiding questions and considerations when making public policy decisions that impact the lives of people experiencing homelessness.

We begin this section with a chapter written by Dr. Ahmad Bonakdar, Managing Director of Research for Making the Shift with the Canadian Observatory on Homelessness. This chapter, entitled *Homelessness and the Manifestation of Social and Geographic Inequities: Lessons from the COVID-19 Pandemic*, encourages us to engage with the question, “*What does it mean to be fair and*

equitable?” Dr. Bonakdar explores the conceptual and philosophical origins of social and geographic (in)equity, with particular attention to their application to notions of fairness. In pandemic times, when social determinants of health are more challenging to meet, this discussion is timelier than ever.

In the second chapter of the section, Dr. Matthias Drilling, Dr. Jörg Dittmann, Martin Böhnelt, and Gosalya Iyadurai put questions of social and geographic equity into practice with a reflection on the response to COVID in Switzerland. The chapter, entitled *Haphazard Approaches to Pandemic Planning: Exploring ‘We’ and ‘the Other’ Dynamics*, examines the impact of the sudden introduction of drastic health measures on individuals and non-governmental organizations. Without proactive strategies and coordination in place, citizens were left grappling with these sudden shifts. Drilling et al., note, *“Being prepared for the next health crisis therefore means, above all, grappling with the social consequences of a pandemic - as justified as the health policy measures may be.”* This chapter provides a compelling case study for nation states, on the importance of weighing the impact of policies with the benefits.

In the chapter that follows, Dr. Geoffrey Messier, Professor of Electrical and Software Engineering at the University of Calgary, provides a visual representation of how state-level decisions, such as lockdowns policies, can create clear socio-geographic outcomes. Through the chapter, entitled *A Graph Analysis of the Impact of COVID-19 on Emergency Housing Shelter Access Patterns*, Dr. Messier draws upon analysis of aggregated shelter access data from more than 30,000 individuals in six major urban shelters to construct a series of visually striking graphs. This chapter demonstrates the movements of people seeking shelter through time and space, highlighting how the system responded to the pandemic through pre-post lockdown comparisons, and

directing us to take note of the factors that contribute to sustained usage by individuals seeking shelter.

The final chapter in this section, entitled *A Profile of COVID-19 and Homelessness in Canada's Rural and Remote Communities* features research findings from several members of the editorial team, including Dr. Rebecca Schiff as the project PI and Dr. Kristy Buccieri as the lead author. This chapter provides a statistical pan-Canadian overview of these regions, including their level of preparedness and the challenges they faced in the pandemic period. State level considerations always include a financial dimension, and this chapter highlights the funding that was received in these communities and how it was directed towards needed, and often innovative, programming to help support citizens experiencing homelessness.

All of the chapters in this section challenge us to ask what more our governments could do to protect the lives and well-being of people experiencing homelessness in our countries. While pandemics are universally negative, we know that those who are most vulnerable in our societies are the ones who face the worst outcomes. As you read this section, we encourage you to think about the country where you live and how your state responded during the COVID pandemic. What worked well? What could have been done differently? What can we learn going forward? There are many important and relevant responses to these questions in the chapters that follow.

CHAPTER FIFTEEN

Homelessness and the Manifestation of Social and Geographic Inequities: Lessons from the COVID-19 Pandemic

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Abstract: The long-standing presence of structural-level factors that contribute to homelessness, such as poverty, unemployment, widening income disparities, colonialism, discrimination, and a shortage of affordable housing, has significantly perpetuated cycles of inequity for individuals experiencing homelessness. Recognizing homelessness as a manifestation of systemic inequities allows scholars and practitioners to explore how the intricate interplay of social and geographic disparities can generate and exacerbate homelessness.

This article stems from concerns raised during the COVID-19 pandemic, which highlighted the highly visible and extensive nature of homelessness. These issues, in part, arose due to an

ill-prepared system that failed to adequately address the needs of individuals experiencing homelessness. I begin this article by briefly exploring the conceptual lineage of social equity and geographic equity, focusing on discourses that examine the normative underpinnings of these two concepts, with a particular emphasis on the notion of fairness as a critical aspect of equity. In light of the pandemic's onset, I examine how geographic equity does not stand in contrast to social equity but rather provides a complementary framework that allows for the expansion of the concept of equity to address the nexus of social class and spatial structures. I conclude this article by drawing attention to the implications of such examination for the homeless-serving sector and what lessons we can learn from the pandemic to better equip ourselves to respond to homelessness in the face of future crises.

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Introduction

The onset of the COVID-19 pandemic has engendered public controversy about the issue of homelessness. Almost three years after COVID-19 was declared a global pandemic, policy makers, service providers, and scholars have now started to pay greater attention to the enduring challenge of providing safe, decent, and stable housing for people experiencing homelessness. We have

witnessed the failure of the communal shelter system during the pandemic, which revealed underlying, deeply entrenched social issues. These perennial social issues can be framed according to notions of equity and fairness, as those issues have profound social and economic implications for people experiencing homelessness.

In this article, I begin by framing the concept of equity within the existing discourse on fairness and social justice. Focusing on social equity and geographic equity, I look at the normative underpinnings of the two concepts and argue that geographic equity does not stand in contrast to social equity but rather provides a complementary framework that allows for the expansion of the concept of equity to address the nexus of social class and spatial structures. Specifically, with the onset of the pandemic, I examine the complex interplay of social and geographic inequities and conclude by discussing what implications such an examination has for the homeless-serving sector and homelessness research scholarship and practice.

Fairness, Equality, and Equity

The concept of equity is closely linked to the notions of fairness and distributive justice (Rawls, 1958, 1971, 2001). As is propounded in John Rawls's theory of justice in a liberal and pluralistic society, fairness can be seen as the fundamental ingredient of the concept of justice. The two principles of justice as conceptualized by Rawls are particularly helpful in framing equity. The first principle discusses inalienable human rights and the basic liberties of citizens such as the right to vote, freedom of speech, and the right to hold personal property: "Each person is to have an equal right to the most extensive basic liberty compatible with a similar liberty for others" (Rawls, 1971, p. 60). The second principle

focuses on equality and consists of two parts, indicating that the distribution of income and wealth should be patterned so that it is to everyone's advantage: "*Social and economic inequalities are to be arranged so that they are both (a) reasonably expected to be to everyone's advantage, and (b) attached to positions and offices open to all*" (Rawls, 1971, p. 60). While these two principles come in a lexical order, with the first principle prior to the second, they should be treated as inherently equal. In Rawls's words, departure from the first principle "*cannot be justified by, or compensated for, by greater social and economic advantages*" (Rawls, 1971, p. 61).

Based on Rawlsian school of thought, fairness is key to understanding equality and equity. Both equality and equity underscore the need to ensure that fairness, justice, and respect for individual characteristics are observed. Nonetheless, despite their differences, the conflation of the two concepts is a common occurrence across policy and practice (Bronfenbrenner, 1973). While equality signifies the equal distribution of resources such that everyone has equal status and rights, equity requires fairness and that the specific needs of individuals be considered. In other words, equality denotes treating everyone the same with "*fairness, neutrality, [and] impartiality,*" whereas equity focuses on treating "*each individual differently based on needs and backgrounds*" to "*overcome existing barriers and differences in outcomes and representation of particular groups*" (Minow, 2021, p. 180). In this way, one critical distinction can be made between equality and equity, in that the former is more pertinent to achieving the same results given the same opportunities provided, while the latter indicates that having equal opportunities does not necessarily yield equal outcomes considering that individuals have different starting points and possess different needs based on their cultural, educational, and intersectional backgrounds.

Within the confines of social institutions, a system of justice that treats equity as an underlying principle will be founded on an approach of fairness in giving precedence to the welfare of the least advantaged. Particularly, when it comes to the distribution of income and wealth, this has been the subject of much research, predominantly by social psychologists (e.g., Adams, 1963, 1965; Deutsch, 1975, 1985; Walster et al., 1976; Walster & Walster, 1975). Equity, as Adams (1965) argues, is related to distributive justice, in the sense that individuals' perceptions of injustice manifest in their behaviors as reflecting dissatisfaction and low morale. In other words, the concept of equity presupposes a basic degree of fairness in social exchanges. As Tyler and Smith have demonstrated (1995, p. 8), *"if there are several workers in a company, their salaries are fair if they are in proportion to their relative contributions to the company."* In this sense, equity can be framed as the means to achieve equality by focusing on the less advantaged while treating everyone differently based on their needs.

Social Equity vs Geographic Equity

In and of itself, equity can be framed in many ways, with two concepts deserving particular attention: social equity and geographic equity. While social equity has received a fair amount of scholarly attention, geographic equity has less often been the subject of research. In the following, I briefly review each concept.

Looking at the historical lineage of the concept of social equity, one is directed to the so-called Minnowbrook conferences in which addressing societal inequities in the management and distribution of public resources was deemed essential to advancing societal goals (Gooden & Portillo, 2011; Gooden, 2015; Guy & McCandless, 2012). In addition to prioritizing efficiency and effectiveness, social equity, framed as fair treatment of all, has

found its way into mainstream discourses since inequities were heightened during the 1960s and 1970s. Scholars have since provided operational definitions of social equity intended to bring attention to the inherent disparities experienced by racial groups. For example, Svava and Brunet (2005) offered key dimensions of social equity, which are seen as the basis of a moral imperative: procedural fairness (providing a fair and due process for all), distribution and access (fair distribution of resources and removing barriers to accessing them), quality (providing consistent and fair delivery of benefits/services to all), and outcomes (providing fair conditions to all so that the goal of generating equal outcomes is met).

While existing scholarship has discussed social equity at length, the concept of geographic equity has not received much attention from scholars, in part due to the fact that social equity is a broad term that applies across all spectrums of political, economic, and geographic settings. However, with the prevalence of social inequities commonly experienced in geographic areas with high concentrations of underserved populations, the question is how much spatial relations impact the distribution of resources. For example, as central cities become more affluent and homogenous, geographic inequities become more salient in suburban areas with predominantly lower-income populations (Schmitt, 2022). Geographic inequities also manifest in an unequal distribution of transit services in low-income, central-city areas, which impact the quality and accessibility of the service for those who need it most (Garrett & Taylor, 1999; Iseki, 2016; Litman, 2022; Sanchez et al., 2004). The needs of socially disadvantaged groups are substantially different than those of non-minority populations, including a greater dependence on having access to an efficient, reliable transportation system. Geographic inequities, therefore, are closely associated with the disproportionate distribution of

costs and benefits across geographic areas as opposed to how fairly the advantages are distributed among various socio-demographic groups.

Homelessness: Essentially a Social Equity Issue?

The long-standing prevalence of the public misconception that housing is a privilege and not a right has permeated much of the public discourse on housing over the past several decades (Cronley, 2010). Yet, we see that there has been a welcome change in the public perception of the idea that housing is indeed not a privilege but an inalienable human right. In Canada, the first-ever National Housing Strategy introduced in 2017 was a promising step toward recognizing individuals' need to access safe, decent, and affordable housing as a human right. In line with Rawls's conception of justice, which would lead us to reflect on housing as a human right in relation to homelessness, one may find this understanding strange because "*it signifies an absence (namely, of home) rather than a presence.*" (Somerville, 2013, p. 385). This demonstrates that homelessness can be framed essentially as a social equity issue in the sense that a combination of causes, including increasing poverty, widening income disparities, unemployment, and a lack of affordable housing could lead to homelessness. It is important, however, to examine the causes of homelessness and how they are closely associated with larger social concerns.

Conceptualizations of the causes of homelessness often rest on the socio-ecological model, which posits that homelessness has emerged as the outcome of a complex interplay between individual/relational risk factors, structural inequities, and system(s) failures (Gaetz & DeJ, 2017; Nooe & Patterson, 2010). Specifically, structural inequities have largely been shaped by the rise of the neoliberal state in the 1980s, which is when the dynamics of

poverty and privilege were deemed instrumental in the emergence of homelessness as a social problem (Farrugia & Gerrard, 2016). With the dismantling of the welfare state came a series of neoliberal economic deregulation policies that shaped the narrative of 'privatized' space (Peck & Tickell, 2002). This privatized space disregarded minority groups' dire needs, including social housing, which for the most part resulted in a decrease in the social housing stock.

A critical analysis of the socio-cultural and political trends that shape the societal understanding of homelessness reveals the intricate role that individual and structural factors play in homelessness (Cronley, 2010). The interaction between individual- and structural-level factors is compounded by the diverse and unique pathways into homelessness that individuals experience (Ravenhill, 2008). Additionally, the overrepresentation of Black, Latino, and non-White populations experiencing homelessness in general (Jones, 2016; Morton et al., 2018), as well as the alarming rate of 2SLGBTQA+ groups among youth experiencing homelessness in particular (Ecker et al., 2019; Fredericka et al., 2011) demonstrates the deep-seated systemic discrimination and social inequities commonly experienced by minority groups. In Canada, a large body of research has consistently indicated the overrepresentation of Indigenous peoples among populations experiencing homelessness as resulting from intersecting forms of oppression, systemic racism, intergenerational trauma, and practices aimed at eradicating Indigenous cultural traditions (Anderson & Collins, 2014; Christensen, 2016, 2017; Thistle, 2017). This body of evidence points to manifestations of larger patterns of social inequity that have led to a rise in homelessness.

COVID-19 and Homelessness: The Rise of Geographic Inequity

While existing literature frames homelessness as a social equity issue experienced by socially disenfranchised groups and underserved populations, the onset of the COVID-19 pandemic brought more visibility to the intersection of homelessness and geographic equity. Lessons from COVID-19 across the world show that people experiencing homelessness were disproportionately impacted by the pandemic (Doran & Tinson, 2021; Tsai & Wilson, 2020). Particularly in Canada, pandemic outbreaks have been detrimental to the health of disadvantaged groups, including individuals experiencing homelessness (Buccieri, 2016). People with lived or living experience of homelessness are highly vulnerable to comorbidities (Richard et al., 2021) while having limited resources for self-care and lacking proper access to adequate housing. These groups experience social exclusion, health inequities, and systemic injustice, which perpetuate their feelings of detachment and social disaffiliation (Patterson et al., 2012).

With the outbreak of the COVID-19 pandemic, geographic inequities experienced by individuals with precarious housing manifested in several ways. First, the geographic distribution of services and resources across the city potentially impacted access to education, employment opportunities, and affordable housing as key social determinants of health. In other words, the place where people experiencing housing instability live, either by choice or necessity, directly impacts their ability to access basic services. Second, leverage by local municipalities and affluent neighborhoods largely impeded efforts aimed at ensuring a geographically equitable distribution of resources, giving policymakers a political incentive to spread resources across areas to satisfy local constituent concerns, rather than

to areas with a concentration of underprivileged people who most needed those resources. While, in theory, policymakers pursue normative goals within cities such as a democratic and socially equitable distribution of resources, in reality, certain areas receive more attention than others. Finally, the rise of not-in-my-back-yard (NIMBY) groups and local oppositions fueled by the power elites created barriers to local development proposals geared towards affordable housing and other community services that could help people experiencing homelessness move up the ladder of social mobility (Adams et al., 2023; McNee & Pojani, 2022; Scally & Tighe, 2015). While the pandemic was seemingly unrelated to the rise of NIMBYism, it heightened the feeling of isolation, which gave fresh impetus to the view that community and social housing may cause property values to decline.

The COVID-19 pandemic exacerbated the geographic inequities already experienced by struggling individuals facing housing precarity and homelessness. For example, in Canada, rural and remote communities inhabited mostly by Indigenous groups received little support from policymakers during the pandemic (Schiff et al., 2020). Additionally, little attention was paid to housing affordability, which led to growing inequities experienced by low-income households. Housing affordability, often measured by the percentage of the household's before-tax income that is spent on housing costs, has come to be understood as a challenge in Canada (Hulchanski, 1995). Examining recent policies set out by the Canada Mortgage and Housing Corporation (CMHC) demonstrates that we need to rethink the current indicator of housing affordability, which is currently set at a 30% shelter cost-income ratio. This is particularly relevant given that the pandemic made clear affordability was not just about housing costs but also about transportation costs (Bonakdar, 2023). Research has indicated that transportation costs are the second

largest household expenditure by as much as 15% of household income (The Center for Neighborhood Technology, 2022). During the pandemic many vulnerable households, such as those with low incomes, unstable jobs, or disabilities, were forced to live in distant areas with few employment options. Therefore, these households disproportionately experienced geographic inequities based on the fact that their place of residence provided limited access to health care services, educational resources, and employment opportunities.

Policy Implications: Supporting the Homeless-serving Sector

In this section, I underscore some policy implications that could help support the homeless-serving sector by drawing attention to the need for structural and policy-level transformations. As I discussed above, the first step to providing practical solutions to stem the tide of social and geographic inequities is understanding how the nexus between social class and spatial structures impacts individuals experiencing homelessness. This is an important first step since pandemic preparedness and proposing solutions to tackle homelessness require an understanding of how the equity of social benefits, as distributed among population groups (social equity), often comes at the expense of the equity of resources distributed across geographical space (geographic equity).

Three areas warrant particular attention. First, prioritizing hard-to-reach populations for the distribution of resources, particularly those living on the urban periphery far from healthcare services, can be one politically conscious approach to which policymakers should pay attention. This has been argued to be an effective strategy for safeguarding vulnerable populations with a high risk of

complications while lowering the possibility of virus transmission during pandemics (Buccieri & Gaetz, 2013). This would ensure a “fair” distribution of resources while alleviating the burden on the homeless-serving sector to provide services to individuals experiencing homelessness that lack the wherewithal to secure or maintain stable housing. One important corollary of prioritizing individuals experiencing homelessness in terms of access to immunization and healthcare services is that the chance of spreading infectious diseases could be reduced, as epidemics can easily spread in settings where people with housing instability tend to congregate, such as in shelters (Buccieri & Gaetz, 2013; Tsai & Wilson, 2020).

Second, empowering individuals experiencing homelessness by training them to use digital technology might reduce some of the geographic inequities these populations experience on a daily basis. Studies have indicated that common barriers to using information technology include limited accessibility and useability (Heaslip et al., 2021; McInnes et al., 2013). However, the proliferation of digital technologies adopted in the healthcare system provides opportunities to equip individuals experiencing homelessness with the tools to use digital technology and benefit from healthcare services despite having been pushed to geographically isolated places. For example, smartphone devices have demonstrated the potential to help people experiencing homelessness learn effective self-management (Thurman et al., 2021) and enhance their social ties with the city (Roberson & Nardi, 2010), while staying connected to their trust and support circles (Le Dantec & Edwards, 2008).

And third, while the pandemic caused disruptions in the workplace, it led to the rise of telework as a necessary condition to maintain productivity. In Canada, many workers were less likely

to use public transit to commute to work during the pandemic, which was in part due to the social distancing mandates and shutdowns that were put into effect by the public health authorities. However, this was not the case for financially vulnerable workers with lower levels of education involved in manufacturing, accommodation, and food services (Statistics Canada, 2020, 2021). Research has consistently illustrated the importance of providing safe and efficient transit services for unhoused individuals given that public transit remains the most common and affordable means of traveling for them (Ding et al., 2022; Murphy, 2019). Reducing transit fares and increasing the availability and coverage of transit services could potentially increase the mobility of people experiencing homelessness and provide access to employment opportunities, healthcare, and cultural activities (Canham et al., 2023).

These policy implications can have wide-ranging outcomes, although system-level change is needed to be effective. Accommodating the evolving needs of the populations experiencing homelessness necessitates the implementation of an integrated systems approach combined with targeted actions in all realms of the policymaking arena, in which serving the public's best interests should be a priority.

Navigating Challenges for Researchers in the Pandemic Era

Prior to the pandemic, researchers studying homelessness encountered challenges such as connecting with hard-to-reach participants and planning for dropouts. The pandemic has exacerbated these challenges, causing disruptions, delays, and frustrations in the research process. For example, because of the need

for social distancing, researchers had to follow more rules and safety plans to protect both participants and researchers.

The key question that remains is how social and geographic inequities can impact research involving individuals experiencing homelessness. To address this question, researchers should take into account the following key considerations.

As social and geographic inequities were heightened by the outbreak of the COVID-19 pandemic, many individuals experiencing homelessness were disproportionately affected by health disparities due to underlying health conditions and the higher risk of contracting and spreading COVID-19 with limited access to hygiene facilities. Research should therefore consider these pre-existing vulnerabilities as the pandemic has exacerbated their challenges. Particularly due to restricted movement and mandatory shutdowns, research can shed light on policies that have impacted diverse geographic regions, with variations influenced by location and social factors.

Further, mental health concerns, isolation, and increasing anxiety were common among young adults experiencing homelessness (Naidoo et al., 2023). These young people have faced limited social mobility due to the barriers they encountered during the pandemic, such as school disengagement, job loss, and a growing sense of isolation. What made the situation even more challenging for these young adults was that they often came from vulnerable households, including low-income families with unstable employment, or individuals with disabilities. Their only option was to reside on the outskirts of cities, far from employment opportunities, resulting in long commutes. Research should unpack how the pandemic affected these young people in terms of school disengagement, experiences of homelessness, housing instability, financial challenges within families, and mental health issues, including social anxiety.

To critically engage with the specter of social and geographic inequities faced by individuals experiencing homelessness, researchers should navigate challenges in the homelessness field with resilience and adaptability, seeking innovative solutions to collect meaningful data and contribute to the advancement of knowledge in ways that promote equity and drive policy change. Such research provides a foundation for developing targeted interventions and advocating for policies that improve the well-being of this vulnerable population.

Conclusion

The ongoing quest for striking a balance between social equity and geographic equity has long been an underlying ethos of the homeless-serving sector and has powered the continued efforts to reduce and end homelessness. The Rawlsian approach towards justice and the creation of an ideal, fair society in which everyone has an equal chance of upward mobility provides a guideline for addressing social inequities. Particularly as homelessness has essentially emerged as a manifestation of social inequity, there should be a legal “*duty to assist*” (Gaetz et al., 2018) as a moral imperative to render assistance to those mired in conditions that prevent them from achieving housing stability and living life to the fullest extent possible.

The COVID-19 era fed into a looming crisis that upended an environment in which homelessness has already been on the rise. The pandemic planning seemingly justified the significant restriction of individual freedoms to the extent that legal surveillance and containment were authorized as essential components of safeguarding citizens (Mosher, 2014). However, framing pandemic planning in this manner diverts attention from individuals experiencing homelessness, as these marginalized populations

face barriers in accessing healthcare services and are likely to “bear the greatest burdens of a pandemic” (Mosher, 2014, p. 923).

The pandemic exacerbated the geographic inequities people with a living experience of housing precarity face, affecting all sectors of the economy, particularly the accommodation and food services industry, with part-time workers bearing the brunt of the subsequent economic downturn. While the pandemic was officially declared to no longer be a public health emergency as of May 11, 2023 (Centers for Disease Control and Prevention, 2023), its far-reaching consequences will continue to bring efforts aimed at achieving equity to the fore. Despite a growing sense of despondency caused by the pandemic, opportunities exist for reflective practices in the ways we can raise the public’s awareness of social and geographic inequities experienced by marginalized and vulnerable populations at the lower ends of the social and economic spectrum (Bonakdar, 2023).

A sense of urgency calls for a radical shift in mainstream practices and policies to better equip the system(s) with tools that can address the long-standing social and geographic equity issues that were heightened during the COVID-19 pandemic. Although political expediency and attempts to satisfy local constituencies have permeated the process of policymaking, we have the opportunity to break free from the misguided former policies and begin to engage with more socially responsible practices in order to help achieve a fairer society with socially and geographically equitable access to resources that benefit all, including the most marginalized.

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CHAPTER SIXTEEN

***Haphazard Approaches to Pandemic Planning:
Exploring 'We' and 'The Others' Dynamics***

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Abstract: This paper investigates the social crisis that emerged among homeless people and other vulnerable groups in Switzerland during the COVID-19 pandemic. The sudden introduction of

drastic health policy measures, including a nationwide lockdown, posed significant challenges for aid institutions and support services catering to these populations. Through empirical research, this paper examines the state's response at the national and federal levels, the role of non-governmental organizations (NGOs) and foundations in mitigating the crisis, and the long-term effects beyond the pandemic period. The analysis explores the ad hoc responses and improvisations in the absence of comprehensive planning. The paper highlights the necessity of proactive strategies and better coordination between stakeholders to effectively address the needs of homeless individuals and vulnerable groups during crises. The insights gained from this research contribute to a deeper understanding of the social dimensions of the pandemic and provide lessons for policymakers, practitioners, and organizations involved in supporting people affected by homelessness.

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Introduction

Just a few days after WHO declared the pandemic, Switzerland implemented its first and only national lockdown, followed by drastic health policy measures such as extensive contact

restrictions, maintaining minimum distances, the closure of numerous service offerings, and limited access to public spaces. The homeless care services were unprepared for these protective measures. Overnight, low-threshold support facilities for homeless people, like soup kitchens and day and counselling centers, closed or significantly reduced their activities. Some drop-in centers installed mailboxes so that individuals could deposit the necessary documents for receiving benefits there, others tried to counteract the risk of isolation for the supported individuals by maintaining contact through phone calls. (Busch-Geertsema et al., 2020; Lovey et al., 2022).

In this manner, a supply and assistance structure became inaccessible from one day to the next. This represented a unique failure of the social welfare state. According to humanitarian organizations, approximately 12% of the population was affected in Switzerland (Caritas, 2020). The few local volunteer aid and non-governmental organizations that maintained their services were unable to bridge this gap. On the contrary, the pressure on the remaining service providers who maintained the low-threshold services led to targeted exclusion practices. Overwhelmed by the demands placed upon them and by the new groups in need of assistance due to the pandemic, service providers constructed categories of homelessness. Some homeless people continued to receive support, while others were excluded from assistance and stepped further towards extreme poverty and often hunger.

This chapter examines how such social exclusion processes occurred in a welfare state, and why a health crisis immediately led to a social crisis. The chapter also highlights the organizations that opposed these exclusion processes by describing various understandings of the role non-governmental organizations played during the pandemic. To answer these questions, the first

step is to illustrate how the Swiss welfare state positions itself on the issue of homelessness in general, as it is considered a root cause. Here, it is argued that even support for finding housing is hardly comprehensively supported on a national scale. An important cause of homelessness is thus not adequately addressed and monitored.

This chapter goes on to demonstrate that even under “*non-crisis conditions*” this system reaches its limits. But furthermore, the extent and profile of homelessness in Switzerland have changed in recent years. Today, it mainly affects individuals living in Switzerland without residency rights and, therefore, without entitlements to social welfare protection. For these individuals, the Swiss welfare state provides only emergency assistance as a temporary measure until deportation. Due to this, many manage to escape homelessness individually, living in precarious conditions, on the brink of poverty. These individuals were particularly affected by the pandemic, making the social vulnerability of people in Switzerland visible within a short period of time.

Empirically, this chapter draws on three research projects conducted by the authors of this chapter. First, the evaluation of a program by a Swiss foundation that launched an emergency COVID-19 program of around 40 million euros immediately after the pandemic, engaged in food assistance, food security, and low-threshold counselling for homeless and poor people, as well as providing financial support to local organizations and relief agencies throughout Switzerland (Drilling et al., 2021). Secondly, a research project focusing on social services for homeless people in two major Swiss cities during the pandemic (Iyadurai, 2022). Thirdly, the results of the first Swiss survey on homelessness (Dittmann et al., 2022), which was conducted during the pandemic and provides an overview of the homeless care situation in Switzerland.

How Homeless Care Functions in the Swiss Federal State

In Switzerland, there is no definition of homelessness, and thus there is no law that contributes to a legally framed field of provision for homeless people (Drilling et al., 2022). Housing remains a social goal in the Swiss Constitution but not a right, and so homeless people do not have recourse under a rights claim if they cannot find suitable housing under reasonable conditions. Because of the lack of a national definition and laws, responsibility for combating homelessness is shifted to municipalities. The municipalities lack a unified stance, and so the issue has only been addressed politically in some of the larger cities, and even then, with very different outcomes. Consequently, smaller communities primarily rely on migration to cities when someone becomes homeless in their municipality.

Switzerland has long maintained this blind spot in the governance of the welfare state, even in the international context, where it remains indebted to the definitive recognition of the international right to adequate housing. Although it has acceded to the UN Covenant I on economic, social, and cultural rights, it has not ratified the Optional Protocol (Drilling et al., 2020), a practice that has been repeatedly criticized by the United Nations.

Instead, the welfare state emphasizes the individual initiative, which means that alleviating homelessness is the responsibility of the individual. According to the Federal Constitution, individuals are only “supported” in their search for housing, and there is no individual entitlement to a dwelling (Art. 41). Those who are in need and cannot provide for themselves have a fundamental right to assistance in emergencies (Art. 12). In practice, this entails support with food, clothing, medical emergency aid, and, notably,

accommodation, primarily referring to emergency shelters and temporary housing (Drilling et al., 2020).

In the end, homeless individuals depend on the voluntary contributions of the state, but these are, as already mentioned, only available in larger cities. Specifically, this falls under the cantonal and local social welfare, which includes stipends for housing. However, not all precariously housed or non-housed individuals receive social welfare because they are either not entitled to it (e.g., undocumented migrants, asylum seekers, care workers, or non-EU citizens) or consciously waive it (e.g., fear of being threatened by deportation, feelings of shame) (Drilling et al., 2022).

In summary, at the beginning of the pandemic, homeless individuals experienced a common lack of understanding regarding the issue of homelessness and a poorly regulated and scarcely accessible infrastructure of assistance at the national, regional, and local levels. Those who were not eligible for social benefits were particularly vulnerable.

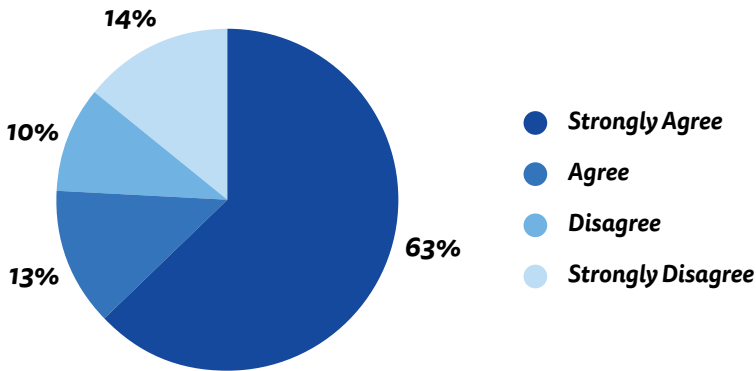
Homeless People and the Pandemic: A National Survey

What do we know about the profile of homeless individuals during the pandemic? The results of the point-in-time study by Dittmann et al. (2022), conducted in December 2020 and March 2021, focused on the eight largest cities in Switzerland and surveyed users of 62 support structures. A total of 1,182 individuals were surveyed on the day of the count. Of these, 46% were homeless at the time of the survey; 38.5% of them slept outside, while the remaining 61.5% stayed in emergency shelters on the day of the survey. Although the estimated total number of homeless individuals appears low based on these figures compared to other

European countries (Baptista & Marlier, 2019), the study reveals another finding: 80% of all 1,182 respondents had experienced one of the two forms of homelessness at some point in their lives. Homelessness is thus associated with a revolving door effect, which means that one episode of homelessness leads to a greater risk of reoccurrence. The revolving door effect was particularly exacerbated by the pandemic, as many individuals became dependent on service providers during this time. The study by Dittmann et al. (2022) highlights the strong connection between homelessness and a socio-legal crisis. Of all respondents, 61.1% did not possess valid residence documents and were therefore classified as “*undocumented migrants*,” resulting in a lack of social protection (Dittmann et al., 2022).

What was the impact of the pandemic on people experiencing homelessness? Dittmann et al. asked participants to subjectively assess the impact of the pandemic on their daily lives (Figure 1). Over three-quarters of people interviewed perceived a deterioration in their daily lives. The “*homeless*” group perceived a significantly greater deterioration than the group experiencing housing difficulties. This can be explained by the fact that homeless people are particularly reliant on institutional services for their basic needs, and these services were reduced or changed during the pandemic and especially during the lockdown. Notable differences exist based on gender and age, with women reporting that they experienced more deteriorated conditions than men. Young homeless individuals (18-25 years old) are also more likely to report an altered daily life, which is supported by other research in this age group. Concurrently, over half of the homeless people report spending much more time outside since the pandemic, as many social places they typically frequented were closed.

Figure 1. Since the beginning of the corona pandemic, my daily life in this city has become more difficult, Switzerland 2020/2021



*Valid answers=524

The Problem: Homeless Services are not 'Critical Infrastructure'

Coming back to March 2020, the government decided to close all state-owned facilities in order to protect the healthcare system. Grocery stores and healthcare facilities were excluded from the closures (Bundeskanzlei, 2020) as these facilities were deemed 'critical infrastructure'. Critical infrastructures are defined as "processes, systems, and facilities that are essential for the functioning of the economy and the basic necessities of the population" (Schweizer Bundesrat, 2023). In addition to the functioning of government authorities, water, energy supply, and transportation, financial services, and IT services are also included. There was a need to financially support the country's critical infrastructures and a high bipartisan willingness to accept an unprecedented increase in public debt to mitigate the economic consequences. Extensive credit programs, with largely open-ended limits, benefited both businesses and employees affected by job loss in atypical

and precarious employment relationships (Parnisari & Ruffieux, 2021).

At the same time, the public visibility of poverty significantly increased, demonstrating that a considerable number of individuals did not benefit from the quickly approved state-provided aid measures. They relied on support from other actors, particularly the few non-governmental and church-based volunteer organizations that maintained their services. Undocumented migrants, sex workers, working poor, economically disadvantaged migrant households, and individuals in casual jobs below the social security threshold were completely unprotected and sometimes faced situations of absolute poverty. For example, an estimated 8,500 people lined up weekly for a food package outside of a sports hall in Geneva, and an NGO focused on food assistance distributed shopping vouchers worth 25 euros to 35,000 individuals. Caritas Switzerland (2020) estimated the number of unprotected individuals at around 1 million, while the Foundation Swiss Solidarity (2021) reported that approximately 1.7 million people benefited from their COVID-19 emergency relief program. This represents between 12 and 20 percent of the Swiss population, depending on the estimation.

This parallelism between a crisis addressed by the state and one not addressed by the state highlights the contours of national crisis planning. The above-mentioned categorization of 'critical' and 'non-critical' infrastructure led to a radical transformation of the support landscape for individuals affected by, or at risk of, homelessness within a short period of time. From a national perspective, the low-threshold services were not deemed worthy of protection, and thus, health policy measures (such as "stay at home," social distancing, access restrictions, etc.) took precedence over social policy objectives (ensuring the social inclusion of

extremely vulnerable target groups, providing social counselling, creating opportunities for a successful life, etc.). Consequently, the service providers had to rely on self-help and regional and local cooperation. We will address this downsizing in the following section.

NGO Planning Practice during COVID 19: Diffuse Positioning and Radical Narrowing

At the onset of the pandemic, service structures for individuals experiencing homelessness recognized the evolving profile of homelessness but failed to adapt their actions accordingly. Particularly people without legal residence rights were the ones most affected by the consequences of the pandemic and sought out support facilities. This forced the actors within these facilities to quickly grapple with their access criteria and, more fundamentally, the consequences of lacking social welfare protection, limited entitlements outside emergency assistance, and unclear revolving door effects into and out of homelessness (including appropriate cushioning and support measures).

The extent to which survival during the pandemic depended on local social and policy context is evident in the example of the city of Basel, one of Switzerland's core cities. In mid-March 2020, the first central support facilities, such as daily food distribution centers, meeting houses, and various meal stations, closed their regular services and partially switched to short entry phases or take-away options. The cantonal Department of Health attempted to coordinate the services to some extent (Gesundheitsdepartement Kanton Basel-Stadt, 2020). The emergency situation necessitated that the still-opened organizations figure out their priority populations and who they needed to help. During this

phase, these organizations radically narrowed their definition of homelessness. However, this was by no means an easy task because they had neither the conceptual foundations nor a policy paper on combating homelessness, and there were no platforms for collaboration involving all support facilities. Thus, a period began in which each service provider defined for itself whom it considered helping in this emergency situation.

In one of the two day centers in the city, entry was only allowed for homeless people to shower and wash after a few days, while the other center closed completely and distributed food packages outside the door. The emergency shelter for women defined entry as *“for homeless women and women in precarious living conditions”* (Gesundheitsdepartement Kanton Basel-Stadt 2020). At the same time, a high degree of personal responsibility was expected from those seeking help. For example, one institution’s mass email requested that women with apartments and accommodations refrain from using their shelter until further notice, while others drastically reduced their capacity, allowing only three people inside the building at a time (compared to the usual 100-120 individuals).

The city’s regular support structure shrank overnight to a few places offering emergency relief facilities, only open during meal times, one institution that provided low-threshold counselling in one of the city’s parks, and the city’s emergency overnight shelters, which were closed during the day. A few weeks after the closures, the director of one facility summarized the situation as follows:

The transition to take-away blocked access to all indoor spaces, and people have been wandering around in the city People are tired and desperate. Especially the very cold days and nights until a week ago have taken a toll on them physically and morally. Their vulnerability in every respect is growing.

For people affected by homelessness or housing instability, the positions taken by the service providers also determined their opportunities for participation and belonging or exclusion, with the individuals themselves having no influence. All providers were aware that their access criteria, such as “homelessness,” “no housing,” or “precarious living conditions,” were not verifiable and left ample room for interpretation and arbitrariness.

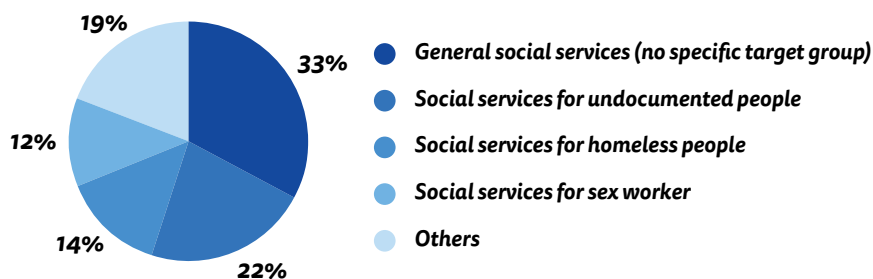
Only one facility out of several dozen in the city of Basel criticized the perceived arbitrariness. Under the title “Everyone Must be Included” (Soup and Chill Association 2020), they referred to the Universal Declaration of Human Rights and attempted to persuade other non-state actors to reconsider their stance, demanding that the canton revoke the requirement of residency status to access rights. However, this initiative fizzled out due to an ongoing conflict between state and non-state actors regarding the granting of social rights to people from Eastern and Central Europe. The situation during the pandemic was entirely different because travel to their home countries was not possible due to border closures and the suspension of many international bus and train connections.

However, the exclusion of the “other” was not limited to socio-political or human rights arguments. Criteria for inclusion and exclusion that had disciplinary intentions were also introduced (i.e., to force behavioural changes in individuals based upon ideological or moral beliefs). One of the field diaries records a situation in one of the food distribution centers,

If one of these individuals [people receiving a food package] did not expressly thank us, they were ‘punished’. This means they received only half a bag of groceries instead of a full bag. When the volunteers responded... that this was not right since everyone paid the same [a symbolic price], the comment was that people needed to learn to show gratitude.

A look at the evaluation of the COVID-19 emergency relief program by the Swiss Solidarity Foundation, which financially supported over 100 frontline organizations during the pandemic, reveals that the strategy of focusing on the “most affected” was implemented throughout Switzerland (Figure 2).

Figure 2. NGOs Supported by Swiss Solidarity Foundation in the First Months of the National Lockdown, 2020



One-third of low-threshold counselling and support services that have been supported by the Foundation changed their access criteria during the lockdown, and 17% of all food supply facilities that were surveyed redefined their criteria (Drilling et al., 2021). These adaptations ranged from a strict interpretation, “We only helped sex workers who work in Geneva” or an addition to existing criteria, “We prioritized people without housing” to expanding access opportunities by suspending existing criteria, “During the lockdown, even people without residency permits could use the services” and also, “We distributed essential food to structures that were not accepted as members but had requested it”. Others opened up to people who became temporarily unemployed, “We expanded the criteria due to COVID-related loss of income; usually, we focus on basic needs” (Drilling et al., 2021). From this perspective, the redefinition of homelessness in the early phase of the pandemic

also led to the assumption of responsibilities that would typically fall to the welfare state but did not reach these groups.

The focus on nutrition was a characteristic of the initial phase of the pandemic. As a result of this emergency situation, low-threshold counselling centers recalibrated themselves. Many of them became food emergency relief organizations. Around half of them stated in the evaluation that they distributed shopping vouchers, provided food, or simply handed out money, primarily for food and rent. *“People would come and say, ‘No, I have nothing at home. I have nothing (...). I immediately have nothing to eat, and I don’t even have money to stock up,’”* summarizes a social worker. However, even after all this focus on *“those who need it most”* and the oscillation around the core work during the pandemic, exclusion processes occurred. 56% of low-threshold counselling organizations reported refusing to provide support during the evaluation with help-seekers due to financial limitations, staff shortages, or because the new or existing help-seekers did not, or did not anymore, meet the existing or modified access criteria.

Governmental Planning Practice: The Narrative of “Our Homeless” and “The Others”

When the Swiss Federal Council decided in early April 2020 to extend the national lockdown and did not provide a definitive date for easing the restrictions, the role of government authorities changed. In the first few weeks, the authorities largely observed and occasionally supported the unfolding activities of aid organizations, civil society, and the private sector, realizing that the state itself could only address a fraction of the emerging needs. At the same time, the question arose as to why the national welfare state didn’t step in to allocate funds when they were hard to secure and

were distributed inconsistently at the local level.

In the city of Basel, an approach to dealing with people affected by homelessness was found, overcoming boundaries related to citizenship that were previously immovable before the pandemic. Conflicts pertaining to Switzerland's non-EU membership and homeless people from Eastern Europe, came into the foreground many years before the pandemic. Although these individuals were present in homeless support structures due to the lack of housing options, as *"outsiders"* they had to pay around 40 euros per night to stay in the municipal emergency shelter, an arbitrarily set amount that essentially made structural exclusion a result of an individual, financial problem. The authorities argued that the categorization was based on residency, distinguishing between *"individuals who have or have had their residence in Basel"* and *"individuals who are not registered in Basel."* Exceptions were made for days with extremely low temperatures, allowing non-residents to stay for one night at the local resident rate of 7.50 euros. However, if shelter users wanted to stay for a second night, they were reported to the migration authorities through the emergency shelters which could lead to their deportation. This categorization of *"local homeless"* and *"non-local homeless"* became relevant through the city's subsidy contracts with the support structures, causing many local service providers to not feel responsible for the *"work tourists"* as they were referred to.

With the extension of the lockdown, this situation of citizenship changed in the city of Basel. All individuals affected by homelessness who were on the streets were now considered vulnerable and a threat, regardless of their residency status or previous place of residence. As the municipal emergency shelter had to be decongested due to social distancing regulations, social services rented a hotel. However, since the city's regular budget

could not finance the approximately 65 rooms, a foundation provided short-term support by “donating” 300,000 euros to the city (Christoph Merian Foundation, 2020). Nevertheless, the people in need were not to be treated completely equally. The hotel operator was instructed to remove or store everything from the rooms (TVs, pictures, objects), reducing the furnishings to only a bed, a table, and a chair. The hotel lobby was also closed as no common areas were desired. Only individuals who previously used the emergency shelter were accommodated in the hotel because they were already known, and there were no concerns about vandalism. In contrast, people from Eastern Europe were quartered in the emergency shelter. This turned the hotel into accommodation for “local homeless” (with 24-hour access and an individual key per person), while the emergency shelter became a place for overnight stays for “non-local homeless.”

The categorization of “local” and “non-local” homeless individuals also existed in other cities but did not intersect with residency status but instead with the health condition of those in need. In the Swiss capital city of Bern, the need for emergency shelters, combined with the “stay home” directive, led to a transition to 24-hour operation. Institutions constructed the category of “Bernese homeless,” referring to individuals with whom they had established a special trust relationship because they had sought assistance from the institution even before the pandemic. “They are here; they are with us,” stated one service provider. Others referred to them as “regular guests” and “regular customers.” They are, according to another service worker, “simply here for a longer time (...). They are just a small group that is always the same.” However, mentally ill individuals who increasingly appeared in the city’s support structures did not belong to this category. They were even turned away from one of the emergency shelters because they were deemed “unsuitable” for the environment, while the

stay of so-called “regular guests” was not questioned. This exclusionary category is justified by organizational requirements to support mental health that could not be met during the pandemic. “We are very much challenged in mediating, educating, calming, and motivating (...),” was one of the arguments, “and they upset the others to the point that harmony is completely disrupted.” In the end, the service providers in the city of Bern justified their actions with moral-philosophical reasoning: “We have taken the liberty to say that we are full because it’s always a matter of pushing them away.”

Conclusion

The COVID-19 pandemic has clearly shown the consequences of prioritizing public health. By investing in robust healthcare systems, the outcome has been that equitable access to essential services failed.

Legal foundations upon which individuals affected by homelessness could have relied were missing. While the Swiss Federal Constitution mentions social goals, it does not establish specific entitlements. Although Switzerland has signed international agreements, they have never been implemented. Social legislation is delegated to the cantons and municipalities. In times of crises, such as the COVID-19 pandemic, people were thus left to fend for themselves overnight.

The absence of a national and cantonal strategy hindered parity with the coordinated health and economic policies. Switzerland allocated substantial funds to sustain its economy, incurring historic levels of debt. Financial support was provided for those who were employed before the pandemic, while the rest were subjected to stringent health measures, with services closed, supply chains disrupted, and food production losses leading to

distribution conflicts, leaving nothing for those reliant on daily supermarket leftovers. Consequently, crises like the pandemic also result in instances of hunger among homeless individuals.

Only major cities like Geneva, Zurich, Lausanne, Bern, or Basel responded to the crisis. Due to the lack of political awareness regarding homelessness in Switzerland, responsibility for affected individuals was initially handed over to NGOs and volunteer organizations. The state largely absconded from its role as a welfare state in the early stages. However, non-state actors also became overwhelmed, and many of them closed down too. Consequently, local systems became so strained that a categorization emerged between “*our homeless*” and “*the other homeless*.” The latter group included those who moved to cities due to the absence of support where they resided, or individuals working in areas without social protection (domestic workers, undocumented migrants, sex workers). The pandemic thus exposed an open wound in Switzerland.

After local authorities realized that the pandemic would persist, and following the publicity surrounding the extreme conditions faced by homeless individuals, they took initiative once again. In various cities, collaborations became possible that would have been unimaginable under “*normal circumstances*” (e.g., renting a hotel for homeless accommodation or suspending immigration-related consequences for migrants who had lost their jobs). However, the state continued the categorization, for example, by only permitting a specific group to access hotel accommodations (“*our homeless*”).

What fundamental lesson can be drawn from the pandemic? It has been demonstrated that the social impacts of health policy affected homeless people, and it became obvious that during a crisis, planning for security cannot be reimagined anew. The

pressure to act is simply too great, given the backdrop of uncertainty and time constraints. Being prepared for the next health crisis therefore means, above all, grappling with the social consequences of a pandemic, as justified as the health policy measures may be. The losers of this policy must be brought into focus, especially when the state decides to focus all financial efforts on the economy, and designates certain infrastructures over others as “critical”. This requires a strong lobby.

It has also become clear that crisis mechanisms emerge and need to be tested in the pre-crisis period. In federated states, this particularly pertains to the interaction between state and non-state actors. During the pandemic the state initially neglected non-critical infrastructures, and NGOs were neither prepared for this nor able to speak with one voice for their clients. Where there are no laws and definitions establishing who can participate in what and who should be supported when and how, it leads to processes of othering even among NGOs. Some of these methods are destructive because they do not help people in need and may leave them even more vulnerable than before.

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CHAPTER SEVENTEEN

A Graph Analysis of the Impact of COVID-19 on Emergency Housing Shelter Access Patterns

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Abstract: This paper investigates how COVID-19 disrupted emergency housing shelter access patterns in Calgary, Canada and what aspects of these changes persist to the present day. This analysis will utilize aggregated shelter access data for over 30,000 individuals from six major urban shelters dating from 2018 to the present. A graph theoretic approach will be used to examine the journeys of individuals between shelters before, during and after the COVID-19 lockdown period. This approach treats shelters as nodes in a graph and a person's transition between shelter as an arrow or edge between nodes. This perspective is used to create both timeline and network diagrams that visualize shelter use and the flow of people between shelters. Statistical results are also presented that illustrate the differences between the cohorts of people who only used shelter pre/post-lockdown, people who stayed in shelter during lockdown and people who used shelter

for the first time during lockdown. The results demonstrate not only how a complex system of care responded to the pandemic but also the characteristics of the people most likely to continue to rely on that system during an emergency.

Ethics Statement: The protocol governing the anonymization, secure storage and analysis of this secondary data set was approved by the University of Calgary Conjoint Ethics Review Board (REB-19-0095).

Conflict of Interest Statement: The author has no conflict of interest to declare associated with this submission.

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Introduction

Understanding how COVID-19 changed the movement of people through systems of care is important to gain a retrospective appreciation of the pandemic and to help plan for future similar events. Now that many of the pandemic related restrictions have been lifted, it is equally important to understand which trends established during COVID-19 endure. This latter perspective is most

urgent since it informs whether a system of care needs to adapt to more effectively address the long-term effects of the pandemic.

During the initial onset of the COVID-19 pandemic, housing and homelessness systems of care (HHSCs) across the world transformed in an effort to adopt measures to limit the spread of the virus (Corey et al., 2022; Levesque et al., 2022; Oudshoorn et al., 2021; Parsell et al., 2023). This transformation was particularly urgent in the congregate living settings of emergency housing shelters. The pandemic precipitated the opening of temporary additional spaces, an increased emphasis on housing placements to facilitate exits from shelter and a range of in-shelter measures designed to reduce disease spread.

The contribution of this paper is to illuminate how the pandemic and its associated impacts on shelter operations affected the flow of people through an HHSC in a major North American city. This analysis will focus specifically on the emergency shelter component of that HHSC. This is important since shelters typically have the lowest barrier to entry within an HHSC and often serve the people with the most complex physical and mental health challenges. Shelters are also congregate living environments which make them particularly susceptible to viral spread (Levesque et al., 2022).

The data used in this paper captures the flow of 30,117 people between six of the busiest emergency shelters in Calgary, Canada from March 1, 2018 to May 1, 2023. Critically, this data provides not just shelter access information during the height of the pandemic but also for the two years leading up to the start of the pandemic and for approximately two years after most COVID-19 restrictions were eased. This will demonstrate not only how the Calgary HHSC changed in response to the pandemic but also which of these changes continue to persist.

There have been only a limited number of studies on how people flow between shelters due to the often fragmented nature of HHSC shelter data (Culhane et al., 1994; Jadidzadeh & Kneebone, 2020). Beyond these publications, shelter access patterns have mostly been analyzed by applying clustering techniques to stay and episode data for shelter use (Aubry et al., 2013; Kneebone et al., 2015; Kuhn & Culhane, 1998) which does not shed light on movement between shelters. The work by Jadidzadeh and Kneebone (2020) is particularly relevant since it was also done for the Calgary HHSC in response to the COVID-19 pandemic. However, while COVID-19 motivated the Jadidzadeh and Kneebone (2020) study, it was conducted entirely using pre-pandemic data. It was also limited to an investigation of how often a person chose to move to a different shelter but did not provide information on which specific shelter had been chosen. This is an important omission since understanding which paths between shelters see the most traffic is a critical part of efficiently allocating resources to support shelter users during an emergency or otherwise.

This omission can be addressed by creating a picture that shows not only when someone leaves a particular shelter but also where they have chosen to go. This is not straightforward since the journey of each person through an HHSC is unique and often involves interacting with many services in different orders and for different lengths of time. However, this paper will demonstrate that this complexity can be managed by representing the HHSC as a directed graph. Graph theory and visualization is a vast field (Bollobas, 1998) that has found utility in better understanding many diverse phenomena including the transit system, the Internet and social networks (Derrible & Kennedy, 2011; Majeed & Rauf, 2020).

The following Methods section will describe the data set used

to study HHSC shelter use before, during and after the height of the COVID-19 lockdown restrictions. It also describes how this data is pre-processed to create a directed graph that represents the flow of people through the HHSC shelter system. This graph perspective is used to create timeline diagrams, cohort statistics and network diagram visualizations in the Results sections. The Discussion section will review the implications of these results and final remarks are made in the Conclusion.

Methods

1. The Data Set

This study is conducted using daily emergency housing shelter access data collected and aggregated by the Calgary Homeless Foundation (CHF) between March 1, 2018 and May 1, 2023. Records from multiple shelters for the same individual are linked and anonymized by the CHF before being released to the researchers. Each data record consists of an anonymized individual identifier, shelter access date, shelter name and duration of the shelter stay. The protocol governing the anonymization, secure storage and analysis of this secondary data set was approved by the University of Calgary Conjoint Ethics Review Board (REB-19-0095). The data set contains 30,117 people with records of accessing an HHSC consisting of three adult shelters, two family shelters and one seniors' shelter. The three adult shelters, the seniors' shelter and the first family shelter all exist in downtown Calgary within an area approximately 2.5 km in diameter. The second family shelter is approximately 5 km outside of the downtown core.

To properly illustrate the effect of the pandemic, it is necessary to divide the data timeline into three periods. The term “*lockdown*” will be used to refer to the period where shelter activity noticeably

reduced due to COVID-19 restrictions. The pre-lockdown period stretches from the start of the data on March 1, 2018 to March 17, 2020, the lockdown period is from March 18, 2020 to July 1, 2021 and the post-lockdown period is from July 2, 2021 to May 1, 2023. March 17, 2020 was the declaration of the first COVID-19 related state of emergency in Alberta (Canadian Institute for Health Information [CIHI], 2022) and corresponds approximately to the introduction of widespread COVID-19 restrictions in Canada and around the world. July 1, 2021 corresponds to reaching Stage 3 of Alberta's "Open for Summer" plan (CIHI, 2022).

Note that it is not the intent of this analysis to declare COVID-19 "over" on July 1, 2021. Clearly, the spread of COVID-19, some pandemic related restrictions and the long term medical and societal effects of the pandemic continued to persist after this date. July 1, 2021 is selected since it approximately marks a noticeable increase in shelter use activity, as will be illustrated in the Results section.

To more clearly understand the impact of COVID-19 on emergency shelter users, it is useful to divide the emergency shelter population into cohorts based on how their first and last days of shelter use coincide with the COVID-19 lockdown periods. These cohorts, the number of people in each cohort and the cohort inclusion criteria are shown in Table 1. A 30 day exclusion window relative to the start and end dates in the data set were used to calculate the dates in Table 1 in order to reduce the number of people included in the cohorts who have records of shelter access that are left or right censored by the start or end of the data set. For example, only people with a first entry in the database that occurred 30 days after March 1, 2018 were included since people with records closer to that start date are more likely to have had censored interactions with the HHSC that occur before March 1, 2018. Similarly, people who had records within 30 days of May 1,

2023 were also excluded since they are more likely to experience HHSC interactions after the data set cut-off.

Table 1. HHSC population cohorts.

Cohort Name	Size	Criteria
Before Lockdown (Before)	9447/30117 (31.4%)	Started after 31/03/2018. Ended before 17/03/2020.
Stayed after Lockdown (Stayed)	3754/30117 (12.5%)	Started between 31/03/2018 and 17/03/2020. Ended between 31/03/2020 and 01/04/2023.
Started during Lockdown (During)	3207/30117 (10.6%)	Started between 17/03/2020 and 01/06/2021. Ended before 01/04/2023.
After Lockdown (After)	7440/30117 (24.7%)	Started after 01/06/2021. Ended before 01/04/2023.

2. Representing Shelter Access using Graphs

A graph consists of a series of nodes connected by edges (Bollobas, 1998). A directed graph associates a direction of travel from one node to the next. Edges in a directed graph are typically represented using arrows. A directed graph is created from the HHSC shelter data described in the Data Set section, where each emergency shelter is a node. A directed edge is created between two nodes if one or more shelter users use the first shelter and then make a transition to use the second shelter.

In addition to shelter nodes, the HHSC directed graph will also contain gateway nodes that represent entries to and exits from the HHSC. The Entry gateway node marks the point where a person first enters the HHSC and the Exit node marks the point where a person makes a final exit from the HHSC and no longer appears in the data set. The Gap gateway node represents when a person disappears from the data for a period of 30 days or longer but reappears at a later time to continue making use of the HHSC.

Interactions with a housing placement or other support program would also be recorded as a Gap if the person was not also actively using shelter at the same time. A Multiple gateway node is also created to capture when a person interacts with multiple shelters within a 24 hour period. Creating a single composite node to represent multiple shelter use is primarily to simplify the graph visualization since people can access multiple shelters in a large number of unique combinations. Representing each combination of same day shelter access by a unique node would cause an unacceptable amount of clutter in the graph visualization.

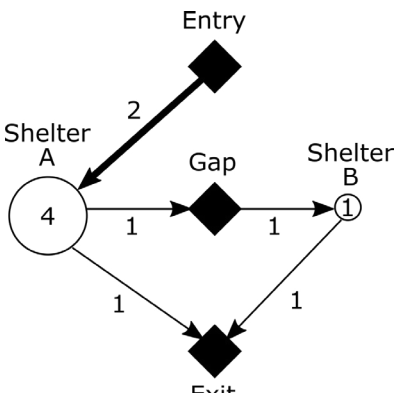
When visualizing a graph, it is useful to adjust the size of nodes and edges to convey information on relative utilization. For example, a busier shelter can be represented using a bigger dot and a commonly used transition between shelters as a thicker arrow. This utilization information can be determined simply by counting the total number of stays in a shelter and the total number of times a person makes a transition from one shelter to another.

Gaps in a person's record of shelter access are common and judging when a gap is large enough to represent a significant departure from an HHSC is subjective. However, this study will adopt a threshold of 30 days which is commonly used to define different episodes of homelessness (Aubry et al., 2013; Kneebone et al., 2015; Kuhn & Culhane, 1998). This means that if there is a gap of 30 days or less between a person accessing first Shelter A and then Shelter B, it will be recorded as a direct transition from Shelter A to Shelter B. If the gap is longer than 30 days, it would be recorded as a transition from Shelter A to the Gap node and then a second transition from the Gap node to Shelter B.

For example, consider an observation window where two people interact with an HHSC consisting of Shelter A and Shelter B. The

data shows that the first person used Shelter A for a single day. This is recorded as one transition from Entry to Shelter A, one interaction with Shelter A and one transition from Shelter A to Exit. The data shows the second person first using Shelter A for three consecutive days and then using Shelter B 31 days later for a single day. This is recorded as a transition from Entry to Shelter A, three interactions with Shelter A, a transition from Shelter A to Gap to account for the 31 day absence, a transition from Gap to Shelter B, a single interaction with Shelter B and then a transition from Shelter B to Exit. The directed graph showing HHSC utilization for these two people is shown in Figure 1.

Figure 1. Example HHSC graph visualization.



Results

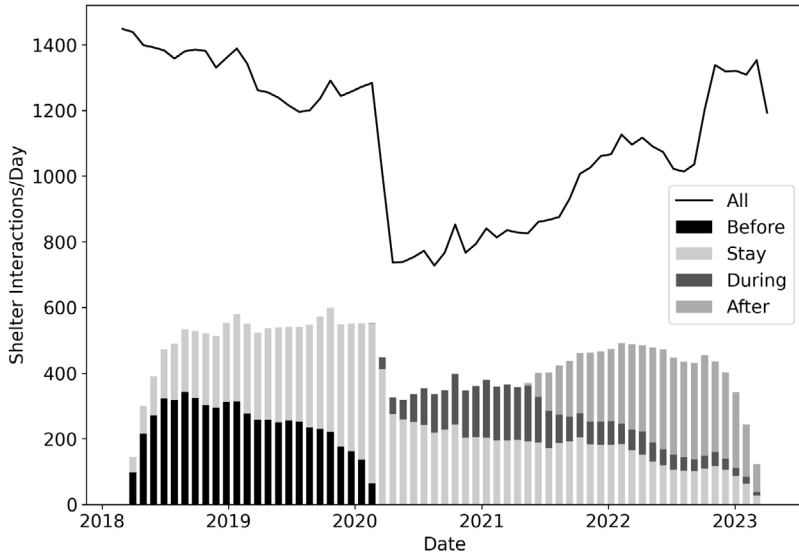
1. Shelter Stay and Transition Timelines

Figure 2 shows the number of times people interact with shelters in the Calgary HHSC from March 1, 2018 to May 1, 2023. The figure also shows the number of interactions for each of the cohorts in Table 1. The cohort bars fall short of the total number of interactions shown by the solid line since not everyone in the

dataset is included in the cohorts defined in Table 1. Note that the number of interactions per day will be higher than the more commonly reported number of unique individuals using the shelter system per day (Calgary Homeless Foundation, 2022) since Figure 2 can include the same person accessing multiple shelters and/or day and night sleep services in the same day. The figure also shows that shelter use by the Before cohort seems to taper in anticipation of lockdown. However, this is an artifact of how the cohort is created. The cohorts in Table 1 are groups of people whose entire record of shelter access fit within the indicated date ranges. Since only a minority of the Before cohort will have their records finish immediately before the start of lockdown, a tapering effect is observed. Figure 3 shows the number of shelter transitions per day where a transition is calculated as described in the 'Representing Shelter Access using Graphs' section.

Clearly, the total number of times shelter is accessed and the total number of shelter transitions reduce dramatically at the start of lockdown. Both remain low until mid-2021. However, since the purpose of this paper is to study how people move through a system of care, it is worth examining whether the reduction in transitions reflects a fundamental change in how shelters are used or if it is primarily an artifact of simply having fewer people in the system. This can be established using Figure 4 which shows the number of transitions per day divided by the number of shelter interactions per day. This figure can be interpreted as the percentage of shelter interactions that involve a change to a different shelter.

Figure 2. Shelter interaction timeline.



The total number of transitions in Figure 3 for the pre-lockdown era matches the results in (Jadidzadeh & Kneebone, 2020) almost exactly. While the shelter interaction values in Figure 2 cannot be directly compared to the census style results in (Jadidzadeh & Kneebone, 2020), the authors of that paper do demonstrate that the overall percentage of people choosing to switch shelters on any particular day is quite low. This is consistent with Figure 4.

Figure 3. Shelter transition timeline.

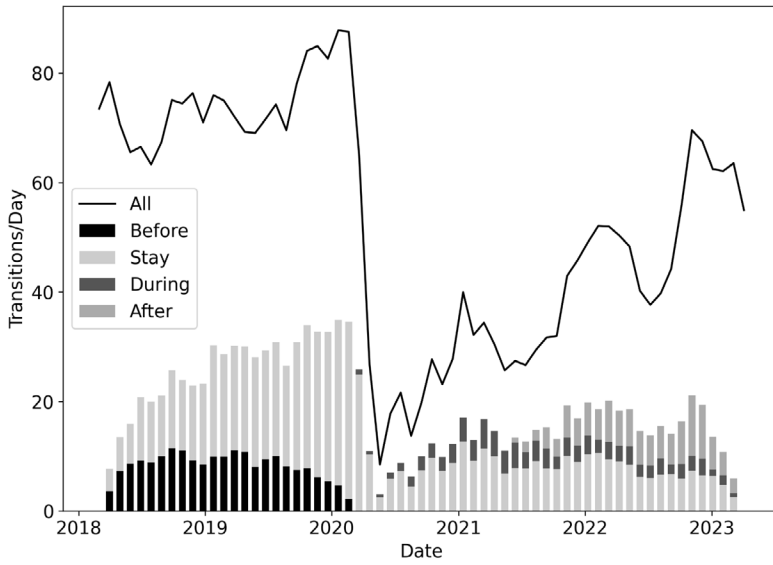
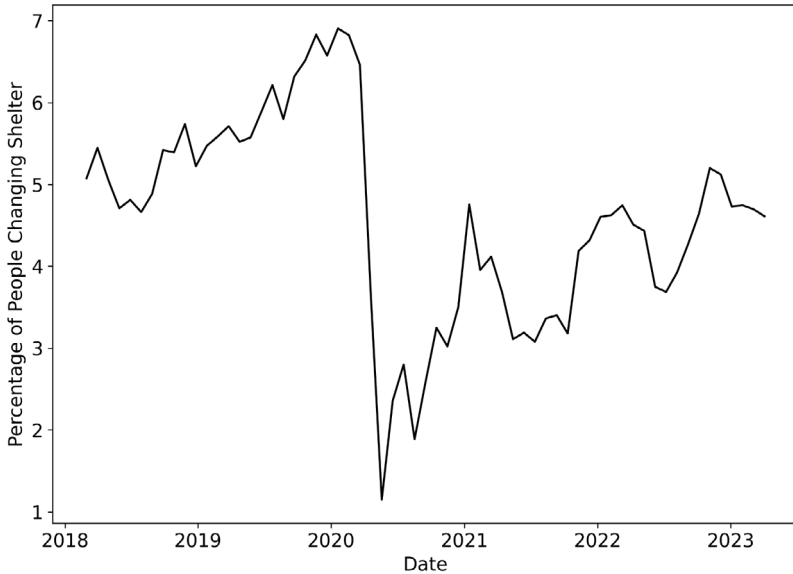


Figure 4. Proportion of shelter interactions that involve transition to a different shelter.



2. Cohort Shelter Access Statistics

Clearly, the cohorts of people shown in Figures 2 and 3 utilized the Calgary HHSC very differently before, during and after lockdown. It is important to take a closer look at the individuals in each of these groups to better understand why. Table 2 shows shelter access statistics for the cohorts in Table 1 during the pre-lockdown, lockdown and post lockdown periods. The table shows total number of stays, the number of days between a person's first and last day using the HHSC (their tenure), their shelter use percentage (number of stays divided by tenure), number of unique shelters accessed and number of shelter to shelter transitions. Shelter use percentage is included since it has been shown to be a good metric to differentiate between long term steady/chronic and long term sporadic/episodic shelter access patterns (Messier, 2023).

While some cohorts are present during multiple eras, the statistics shown for each cohort are calculated only using the portion of a person's record that falls within an era. For example, pre-lockdown statistics for the Stay cohort during lockdown were calculated using only the portion of their HHSC access patterns that fell within the date range of the pre-lockdown period.

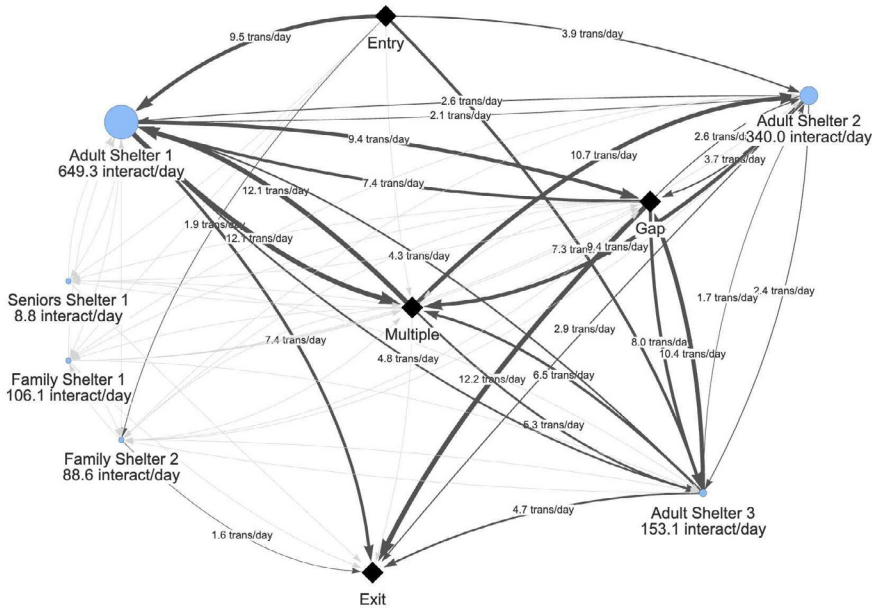
Table 2. Shelter access statistics.

	Pre-Lockdown Cohorts		Lockdown Cohorts		Post-Lockdown Cohorts		
	Before	Stay	During	Stay	During	Stay	After
Period Duration (days)	687	687	381	381	639	639	639
Median Tenure (days)	4	134	6	53	98	76	6
Mean Tenure (days)	69.4	216.9	38.6	108.8	183.4	170.7	61.9
95th Pctl Tenure (days)	394	627	193	365	580	560	336
Median Stays	2	9	3	7	8	7	3
Mean Stays	18.9	47.9	17.1	34.2	38.3	33.3	19.7
95th Pctl Stays	100	226	85	174	204	172	101
Median Use Percent	3.3%	6.7%	6.7%	10.0%	6.7%	6.7%	6.7%
Mean Use Percent	20.5%	21.5%	26.3%	24.4%	21.6%	19.6%	22.7%
95th Pctl Use Percent	100%	92%	100%	95%	97%	90%	100%
Median Unique Shelters	1	1	1	1	1	1	1
Mean Unique Shelters	1.2	1.4	1.1	1.3	1.4	1.4	1.1
95th Pctl Unique Shelters	2	3	2	2	3	3	2
Median Transitions	0	0	0	0	0	0	0
Mean Transitions	0.6	3.3	0.4	1.4	2.1	2.0	0.5
95th Pctl Transitions	3	19	2	7	10	10	2

3. Graph Visualization

Figure 5 shows a visualization of the directed graph representation of the Calgary HHSC described in the ‘Representing Shelter Access using Graphs’ section for all shelter users in the pre-lockdown period. Rather than displaying an absolute count of shelter interactions and transitions, as shown in Figure 1, the interaction and transition counts were divided by the duration of the pre-lockdown era (687 days) to arrive at an average number of stays and transitions per day. Edge thickness is proportional to the number of transitions per day except that edges representing fewer than one transition/day are unlabelled, shown in light grey and have a fixed width.

Figure 5. Calgary HHSC shelter utilization before lockdown.



Figures 6 and 7 demonstrate shelter use and shelter transition frequencies during the lockdown and post-lockdown eras

respectively. Both shelter interaction and transition frequencies are expressed as percentages relative to the pre-lockdown era. For example, in Figure 6, the average number of people using the Adult Shelter 2 shelter per day was 54.1% of the average number per day using that shelter during the pre-lockdown period.

In some cases, the figures show people exiting the system from the Gap node. This is an artifact of how the visualizations were created. Figures 5, 6 and 7 are generated for a specific range of dates. Any person in the Gap state on the last day in this date range is recorded as exiting the system from that node.

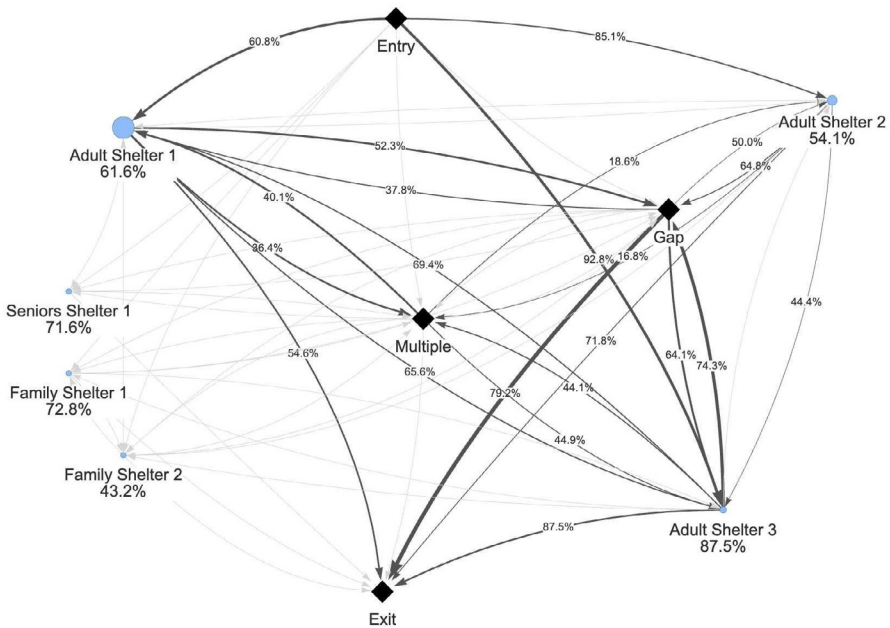
Discussion

After an initial dip at the start of lockdown, Figure 2 demonstrates that aggregate use of shelter in the Calgary HHSC begins to steadily trend upwards in late 2021. This increase is despite the arrival of the first Omicron COVID-19 wave during winter 2021 and periodic pandemic restrictions on gathering, workplaces and schools that persisted until early 2022. This return to shelter may have been encouraged by the uptake of the COVID-19 vaccine during the summer of 2021 and an increased comfort with using personal protective equipment (PPE) within shelter (Calgary Herald, 2021).

The Stay cohort makes the heaviest use of the HHSC during lockdown and chose to make the majority of transitions between shelters during that time. While the absolute number of transitions shown in Figure 3 drops sharply at the start of lockdown, the figure also shows that the total number of transitions (the solid black line) gets much closer to the number of transitions recorded for the Stay cohort. This remains true until late 2021 where the black line again starts to diverge. Figure 3 also shows

that the Stay cohort is responsible for a much higher proportion of shelter transitions than the During cohort who first accessed the HHSC during lockdown. This is despite the two cohorts being approximately the same size, as indicated in Table 1. Table 2 also shows the Stay cohort using shelter much more frequently than the Before or During cohorts. It is intuitive that a group of people making heavy use of shelter will have few options other than to continue relying on shelter even during an emergency that would make congregate living much more hazardous. Figure 3 and Table 2 are a reminder that any planning for a future pandemic response should anticipate continued shelter use by those who are currently interacting with shelter on a very consistent basis.

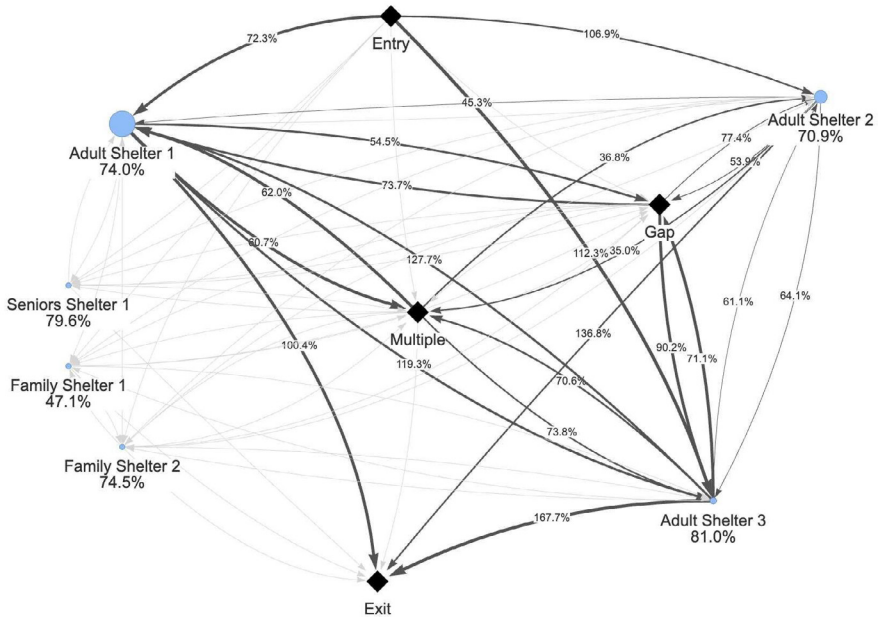
Figure 6. Calgary HHSC shelter utilization during lockdown.



Overall, transitions between shelters are rare relative to the total number of shelter interactions but remained robust to lockdown

measures. Consistent with Jadidzadeh & Kneebone, 2020, Figure 4 shows that transitions as a percentage of total shelter interactions is quite low. This is important since high traffic between shelters during a pandemic would be a mechanism to quickly spread infection from one shelter to the next. That said, transitions in Figure 4 recover very quickly in 2020 to a level comparable to the pre-lockdown era. Since Figure 3 shows that the Stay cohort is responsible for a significant portion of transitions during lockdown, this suggests that lockdown did not have a dramatic impact on the rate the Stay cohort chose to move between shelters.

Figure 7. Calgary HHSC shelter utilization after lockdown.



It is very uncommon for a person in the Calgary HHSC to interact with a large number of shelters. Even the 95th percentile of all the cohorts and periods shown in Table 2 interact with 2 or 3 unique shelters. The median number of transitions is 0 and only the cohorts with well-established records of shelter interactions

have a high number of transitions in the 95th percentile. However, statistics for the number of unique shelters suggest that even those with higher numbers of transitions are most likely switching back and forth between the same two shelters. As noted in the Data Set section, almost all shelters in the data set are located in very close proximity. This suggests that preference and not travel distance is the reason people interact with a small number of shelters.

While aggregated results are valuable, the graph visualizations presented in the Graph Visualization section provide new insight into movement through the Calgary HHSC that can guide how agencies collaborate and programs are delivered. While Figure 3 is based on counting the total number of transitions, Figures 5 through 7 show where those transitions occur. This is important. For example, Adult Shelters 1 and 3 are the most common entry points in the HHSC. This suggests that further investment in their diversion programs would have an impact on the largest number of new entrants to the system. There is also a high amount of bidirectional traffic between the Multiple node and Adult Shelters 1 and 2. Since Table 2 indicates that people tend to restrict their HHSC interactions to a small number of shelters, this suggests that many of the interactions with multiple shelters in a single day are people accessing Adult Shelters 1 and 2. Improved communication and collaboration between these two shelters would better support the people making such tightly coupled use of both agencies.

Transition patterns in a graph visualization can also provide insight into the nature of the people accessing certain parts of the HHSC. For example, Adult Shelter 3 in Figure 5 has a high amount of bi-directional traffic with the Gap node for a shelter its size. This very episodic interaction with Adult Shelter 3

suggests that it serves a higher proportion of people who may either be rough sleepers or unstably housed. Since Family Shelter 1 is the only family shelter situated in downtown Calgary, intuition would suggest very little interaction with the rest of the HHSC. While none of the transitions with other shelters is higher than 1 transition/day, Figure 5 shows users of Family Shelter 1 exiting to access adult shelter services at approximately the same rate as making a system exit. This suggests that families making use of supports may be fragmenting in some cases to also access individual adult services.

Graph visualization reveals that reductions in movement between the different elements of the Calgary HHSC were not uniform. Figure 6 shows the overall expected decrease in shelter interactions and transitions for the lockdown period. In many cases, a shelter's transition traffic and the number of interactions with that shelter decrease by approximately the same amount. For example, Adult Shelter 1 shelter interactions drop to 61.6% pre-lockdown levels and the traffic from Entry to Adult Shelter 1 and Adult Shelter 1 to Exit decrease to 60.8% and 54.6%, respectively. However, movement between shelters and to/from the Multiple node drops to smaller levels. This reflects a tendency to "*shelter-in-place*" during lockdown. Adult Shelter 3 is also an exception to the reduction. It continued to operate at 87.5% capacity during lockdown with entry traffic equal to 92.8% of pre-lockdown levels.

The recovery of movement within the Calgary HHSC is also not uniform and contains some encouraging signs. Overall, the shelter capacities in Figure 7 have not yet reached pre-lockdown levels. This is mainly because the post-lockdown era, as defined in this paper, includes approximately one year of shelter operations where COVID-19 restrictions would have had at least some effect on shelter and program capacity. A positive trend in Figure 7 is the

higher rate of direct transition to system exit from the top three busiest shelters: 100.4%, 136.8% and 167.7% for Adult Shelter 1, Adult Shelter 2 and Adult Shelter 3, respectively. While there are many reasons for leaving an HHSC, this increase in system exits does coincide with shelters continuing to make transitioning people from shelter to housing a priority in the post-pandemic era. This system level picture can be combined with program level information from each of these shelters to demonstrate the positive impact of housing-focused programming to government and funding agencies.

Conclusion

The pandemic had a profound impact on the operation of HHSCs and the people they serve. Understanding this impact in retrospect provides valuable information on how an HHSC can be better prepared to support people during future pandemics or other emergencies.

The visualizations presented in the Graph Visualization section reveal an HHSC consisting of agencies that are richly connected by the journeys of the people they serve. Almost every possible transition between agencies was observed. Figure 4 also indicates that the proportion of people choosing to move between shelters remains surprisingly robust over the pandemic timeline. At the same time, this same figure shows that the overall percentage of shelter interactions that involve a transition to a different shelter is quite small. This means that monitoring or attempting to discourage transitions between shelter in future pandemics may not be the best use of resources.

A higher impact activity would be to better understand the people who continue to rely on emergency shelters during future

pandemics or other emergencies. Not surprisingly, Table 2 shows that these people tend to be the longer term or chronic shelter users. These people require different supports than short term or episodic shelter users and their voices should be included in any future HHSC pandemic response plans.

Finally, characterizing an HHSC as a directed graph is a powerful tool for understanding the complex and highly connected way people access the agencies making up that HHSC. Pandemic or not, system flow visualizations like those presented in the Graph Visualization section reveal how agencies are connected by the people they serve. This perspective should be a powerful motivator for the operators of those agencies to continue to collaborate and communicate along the lines of how people flow into and out of their programs. It also encourages us to look at an HHSC as single system of care since that is how many people choose to engage with it.

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CHAPTER EIGHTEEN

***A Profile of COVID-19 and Homelessness in
Canada's Rural and Remote Communities***

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Abstract: The COVID pandemic impacted people experiencing homelessness in communities across Canada. In this chapter we construct a profile of COVID and homelessness in rural and remote regions. The data was collected through an online survey conducted with 175 key stakeholders between February 12, 2021, and April 15, 2021. Respondents were diversely located across 8 provinces and 2 territories, with 36% in northern regions.

The results indicated that while some commonalities existed with urban centres, there were unique experiences of COVID and homelessness in rural and remote communities. Three key themes were found. First, there was a general increase in the rates of homelessness in these regions, accompanied by large migration out of the communities by people in search of housing and other supports. Second, service challenges arose within rural and remote communities; the most pressing challenges were related to client concerns, transportation, and staffing. Additionally, less than half of the service providers' organizations had a pandemic plan in place to provide guidance on these challenges prior to the COVID outbreak. Finally, the data indicated trends in funding and program changes. Findings indicated that over three-quarters of organizations received additional funds from their usual funding sources. These were largely allocated towards purchasing supplies and creating new programs and services, including isolation and assessment facilities, shelters, and housing supports. This research demonstrates the unique challenges and needs, but also the resourcefulness, of rural and remote communities in the face of the COVID outbreak.

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Introduction

Prior to the COVID outbreak, there was limited research on the intersections of pandemic planning and homelessness. The literature that did exist focused primarily on homelessness and H1N1 (Buccieri & Schiff, 2016), tuberculosis (TB), and Severe Acute Respiratory Syndrome (SARS) (Babando et al., 2022). Findings of a recent systematic literature review indicate that there has been continuous improvement in the disaster preparedness literature pertaining to homelessness compared to past pandemics (Karabanow et al., 2021). Since the COVID outbreak began, researchers have been documenting the impact of pandemic restrictions and disease transmission on people experiencing homelessness (PEH) at the individual, interpersonal, community, and policy levels (Rodriguez et al., 2022). What emerges in the body of literature are thematic gaps and opportunities related to service provision and homelessness.

A primary gap has been the impact of the high risk of viral transmission for PEH living in communal settings, such as shelters, their precarious health status (Hwang & Burns, 2014), and the need for early identification protocols (O'Shea et al., 2020). Researchers in Brussels assessed 1,994 PEH in shelters and found that being under the age of 40, having access to urgent medical care, and sharing a room with someone who has tested positive, were all risk factors for testing positive for COVID (Roland et al., 2021). Close proximity is one critical factor in the spread of

COVID and an additional factor is the increased mobility of people residing in shelters. Daily movement tracking of 36,855 unique individuals in Calgary in 2019 showed that the use of emergency shelters is characterized by large flows into the broader community and smaller flows between individual shelters. This provides a measure of the extent to which people reliant on homeless shelters are exposed to transmission of COVID (Jadidzadeh & Kneebone, 2020). Migratory patterns also indicate a flow between cities and rural areas, making both urban and rural sites high-risk for transmission (Schiff et al., 2020).

Given the need for social distancing and the high risk of viral transmission for PEH in congregate shelter settings, many cities responded by adapting hotels to serve as quarantine facilities and temporary housing during COVID (Parsell et al., 2022). The benefits of being housed in a hotel included stability of movement, protection from COVID and other hazards, and freeing mental space to allow for future planning (Padgett et al., 2022). These facilities have also been found to create health-affirming relationships as well as opportunities for the continuity of care and connection to services (Johnson et al., 2023). However, some residents have reported being dissatisfied with the living conditions and lack of social integration, meaningful activity, and sense of belonging in the community (Pilla & Park-Taylor, 2022), and other residents complained about forcible confinement and continual surveillance reminiscent of incarceration.

The COVID pandemic had a negative impact on the mental and physical health of numerous PEH in many areas globally. In Germany, researchers found that the reduced operating hours and capacity of service agencies contributed to increased rates of aggression, anxiety, and desperation amongst clients (Gräske et al., 2022). Similar findings were reported in the UK, where a

lack of resources and constrained services reduced the ability to provide face-to-face services, which was found to exacerbate the mental health concerns of already vulnerable clients (Kaur et al., 2022). Likewise, in Toronto researchers found approximately 40% of Housing First clients were minimally impacted by COVID, while the majority experienced the onset of new mental health problems such as anxiety, stress, and/or paranoia; or the exacerbation of pre-existing disorders such as depression, PTSD, and OCD (Mejia-Lancheros et al., 2022). Amongst PEH, there were also certain populations that were disproportionately impacted by COVID. Youth in Toronto experienced psychosocial outcomes that included isolation, decreased mental health, and increased substance use, particularly amongst Black, 2SLGBTQ+, and/or new Canadian youth (Noble et al., 2022). In the US, veterans reported increased mental health problems after the onset of the pandemic as well (Wynn et al., 2021), and living in rural areas was reported to particularly exacerbate health disparities for veterans in unstable housing (Cusack et al., 2022).

A review of the literature showed the urgent need to address systemic inequality and the social determinants of health, as well as provided evidence in favour of permanent supportive housing, income assistance, and mental health measures as interventions (Moledina et al., 2021). During COVID some novel programs emerged to help address the increased mental and physical health needs of PEH. In California for instance, the Backpack Medicine Program was implemented as a multi-disciplinary public health intervention to increase access to testing, health care, and housing amongst PEH with underlying comorbidities such as lung disease and immunocompromised states (Alarcón & Khan, 2021). In Toronto, the PHONE-CONNECT program was launched to address digital health inequity by providing phones as a health care intervention, through an emergency department,

to improve patients' access to health care, information, and social services (Kazevman et al., 2021).

The COVID pandemic highlighted many of the existing gaps within homelessness service sectors (Skjefte et al., 2022). For instance, researchers have identified challenges related to narrowly directed funding and short-term solutions to homelessness (Roebuck et al., 2022). In Germany, a review of 135 services showed that over 70% reported not only having increased costs during the pandemic, but also that they had to cover the increase themselves (Gräske et al., 2022). Additionally, COVID highlighted a lack of personal protective equipment (PPE), staff shortages, and communication problems within homelessness organizations and sectors (Campbell et al. 2022; Karabanow et al., 2021). The impact on staff was significant (Goodwin et al., 2022). Notably, homelessness service providers had to deal with the shift to remote work and virtual service provision, reduced levels of client engagement, and persistent service disruptions (Aykanian, 2022a). Results of a survey with 132 frontline workers in Texas showed that perceiving a decline in job satisfaction related to the COVID-19 pandemic was associated with higher stress, higher burnout, and lower compassion satisfaction (Aykanian, 2022b). As such, in both urban and rural settings, there was an urgent need for emotional support for staff and volunteers during the pandemic (Pixley et al., 2022).

However, while there are organizational challenges within homelessness services, senior leaders also perceive opportunities (Campbell et al., 2022). As an example, Lashley and Stoltzfus (2022) report on how leaders at a shelter adopted a coordinated organization response to implement new protocols and procedures for intake, testing, managing staff, and onsite vaccination, that were based on the CDC's 'whole community' framework.

Goodwin et al., (2022) note that as pre-existing problems within the homelessness sector were exacerbated by the pandemic, recovery efforts need to be implemented in ways that address these issues while also being aligned with service providers' values, such as being collaborative and grounded in human relationships.

There were many gaps and opportunities that emerged during COVID. It is evident from the literature review that researchers have studied the impacts of COVID on homelessness sectors and PEH around the world. However, with a few notable rural and remote based exceptions (Cusack et al., 2022; Pixley et al., 2022; Schiff et al., 2020), most of the research has been conducted in urban centres. Given the challenges of rural homelessness generally – such as the limited access to services, resources, and transportation – it is important to consider how COVID might have impacted these communities in ways that are unique from what is documented in the largely urban-based literature.

This raises three questions that guide the analysis in this chapter:

- 1.** *What impact, if any, did the COVID pandemic have on rates of homelessness in rural and remote communities within Canada?*
- 2.** *What challenges emerged related to homelessness service provision in these communities?*
- 3.** *What funding and services were created to address the challenges?*

To answer these questions, we draw upon data collected through a national survey of rural and remote service providers during the COVID pandemic.

Methods

Our team conducted a national survey of rural and remote-based homelessness service providers in Canada during the COVID pandemic. The survey, created and distributed online using Qualtrics software, was designed in English and subsequently translated into French, however it should be noted that none of the participants chose to complete the French version. The research team developed the survey tool through two methods. First, a subcommittee of the research team reviewed a survey instrument that team members had previously used during the H1N1 pandemic (Bucciari & Schiff, 2016). Relevant questions were identified and incorporated into a survey draft, along with COVID-specific questions. Second, the draft survey was then circulated to all members of the research team and discussed at a virtual meeting. Questions were edited until the team felt confident the questions reflected the research literature, addressed the research questions, and were methodologically sound.

Prior to its distribution the Research Ethics Boards of Lakehead University and Trent University independently reviewed and approved the research study and survey instrument. All participants provided informed consent at the beginning of the survey and were advised their participation was voluntary, anonymous, and could be withdrawn up until the time they submitted their responses. Electronic distribution of the survey link occurred through professional networks, such as the National Alliance to End Rural and Remote Homelessness. Potential participants received a notice about the survey that detailed its purpose and provided a direct anonymized link. The survey was voluntary, self-selected, and open for participants to complete between February 12, 2021 and April 15, 2021. Data analysis for this chapter was conducted using SPSS 27. This chapter does not present findings

on significant statistical relationships, but rather a holistic representation of the participant responses. An overview of the participants' and their organizations' demographics is provided in Table 1.¹ Additional demographic and survey information can be found in the project report (Schiff et al., 2022).

Three guiding questions were used to structure the data analysis. First, we examined the impact of COVID on the rates of homelessness in rural and remote communities of Canada. Second, we looked at the challenges that emerged in service provision for PEH. Finally, we discussed the funding and services that emerged to address these challenges.

There are limitations worth noting. This survey was distributed online and may not have been accessible to service providers in very rural and remote communities with internet limitations. Additionally, although there may be a self-selection bias as participants are primarily women, this could reflect the gender split that has been reported as a norm in homelessness services (Toor, 2019). The respondents' length of time working in homelessness services also fits national norms (Waegemakers Schiff et al., 2023). The over-representation of participants from Ontario may come from the effect of snowball methods of propagation of the survey. Tests for differences between groups, such as those in northern or non-northern communities, or communities grouped by population size, found no significant differences. Thus, this chapter groups all respondents together to provide an overview of COVID and homelessness service provision in rural and remote communities.

1. Participants were given the option "prefer not to answer" for each question, so not all counts and percentages represent the full sample.

Table 1. Demographics

n = 175	%
Sex	
Female	72%
Male	25%
Province or Territory Location	
Ontario	66%
Newfoundland & Labrador	12%
Northwest Territories	8%
Alberta	5%
British Columbia	4%
Nova Scotia	2%
Yukon	1%
Saskatchewan	1%
Manitoba	1%
Prince Edward Island	1%
Nunavut	0%
Quebec	0%
New Brunswick	0%
Number of years working in current agency	
0 to 5	56%
6 to 10	17%
11 to 15	13%
16 or more	13%
Current type of position	
Upper management	28%
Middle management	18%
Front line work	30%
Coordinator / Admin	5%
Other (Volunteer / Board / Research / Elected)	7%

n = 175	%
Number of paid staff (full and part time)	
0 to 5	17%
6 to 10	9%
11 to 15	13%
16 or more	60%
Average number of clients supported yearly	
Less than 50	5%
51 to 100	13%
101 to 200	5%
201 to 300	7%
More than 300	57%
Organization in a northern region	
No	60%
Yes	36%
Population size of the community	
Less than 1000	1%
1000 - 5000	8%
5001- 9999	15%
10,000 - 50,000	41%
50,001 - 99,999	10%
More than 100,000	24%

Results

1. COVID and Homelessness Rates in Rural and Remote Communities

The first research question asks what impact, if any, COVID had on the rates of homelessness in rural and remote communities. The majority of respondents (68%) indicated that their community has a way of identifying the number of PEH. Of those

whose communities did identify PEH, information was collected in descending order through point-in-time counts, municipal by-name lists, other enumeration methods, federal HIFIS database, organizational intake processes, additional informal and/or shared databases, and coordinated access programs. In addition to tracking rates of homelessness in the community, 64% of respondents also reported having a way of identifying service users within their respective organization. This tracking was done primarily through the federal HIFIS database, municipal databases, and agency-specific tools such as spreadsheets and case management trackers. Based on this information, nearly 73% reported that homelessness increased in their community during COVID, 16% indicated the rates remained the same, and 3% believed homelessness decreased.

When asked how frequently PEH migrate out of the community 50% said sometimes, 26% said often, 18% were unsure, and 5% said never. According to these participants, the reasons for leaving included a lack of local affordable housing (39%), lack of emergency shelters (31%), seeking services in another community (29%), choosing to be closer to family / friends (19%), and/or a lack of medical services (13%). Many participants reported that when PEH migrate out they are likely to go to a nearby larger metropolitan city (66%), with some saying a nearby small community (17%), another nearby rural or northern community (14%), or another province or territory altogether (4%). Over half of the participants believed that when PEH left they often returned (54%), while others believed they only returned sometimes (30%), were unsure (12%), or reported they never come back (5%). According to written survey responses, *“lack of adequate housing and services in remote communities push people into larger communities.”* While lacking access to shelter and housing is an issue that predates COVID, in rural and remote communities the

pressure to increase social distancing and reduce contact during the outbreak strained capacity and forced people to migrate to larger cities. One participant wrote, *“We have one emergency shelter that can only take 3-4 people at a time. When people identify that they are at risk, they are often sent into (a larger town). This is 9 hours away from our region.”* During COVID homelessness increased and PEH were forced to migrate out of rural and remote communities to seek supports in more urban areas.

2. Homelessness Service Provision Challenges During COVID

The second research question considered what challenges arose for service providers in these communities during the pandemic. Survey results indicated that prior to COVID over half of the participants' organizations did not have a pre-existing pandemic plan (52%). Comparatively, 34% had a pandemic plan and 15% were unsure whether one existed for their organization. The majority reported their organization had adequate facilities to allow for social distancing (66%), while 28% said they did not, and 5% were unsure. When asked whether their organization provided quarantine for symptomatic individuals 46% said no, 43% said yes, and 8% were unsure. According to 63% of participants, other organizations in their community provided quarantine services for symptomatic PEH, 19% were unsure whether other organizations did, and 18% reported there were no others with this service.

To better understand the challenges these rural and remote communities faced, we provided survey respondents with a list of potential issues noted in the literature and asked them to select the top 5 that impacted their organization. The most pressing challenges during COVID, as reported by respondents, included addressing client concerns (45%), lacking access to transportation

(35%), staffing instability (31%), the need for isolation and quarantine facilities (24%), and lacking access to health care services. When asked how many other homelessness organizations in their community were facing the same COVID challenges, participants reported all were (51%), some were (25%), or that there were no other homelessness organizations in the community (18%). Written responses from survey participants indicated, *“Real rural homelessness that takes place in farmland or other rural communities that are NOT towns is ignored. County and regional municipalities don’t seem to understand how prevalent it is to have youth and adults and families couch surfing, using the nearby town pool for showers, living in a shack on someone’s back quarter. This type of homelessness is 100% neglected.”* According to another participant, *“Stigma, lack of resources, migration, and lack of federal policies and funding, and national media attention all contribute to the ‘hidden’ nature of rural homelessness. Research like this is so important to changing the narrative.”*

3. Funding and Services that Emerged During COVID

Through the third research question we examined what new funding and services emerged to support rural and remote communities with homelessness service provision during COVID. Results indicated that over three-quarters (76%) received additional funding to support their organization, while 11% indicated they did not, and 12% were unsure. The sources of COVID funding were consistent with regular funding bodies, with half the respondents receiving additional funding from those same sources during the COVID outbreak. An overview of the regular and COVID funding sources can be found in Table 2. Additionally, 74% believed other homelessness organizations also received additional funding during COVID. Respondents indicated the additional funding was provided in descending order for personal

protective equipment (PPE), disinfecting supplies, staff, food, new programs, new infrastructure, and other miscellaneous supplies.

Table 2. Funding Sources

Regular	Funding Source	COVID
46%	Provincial / territorial funding	23%
32%	Donations / fundraising	13%
30%	Municipal funding	12%
21%	Other federal funding	12%
16%	Reaching Home (Rural and Remote Stream)	11%
13%	Reaching Home (Designated)	9%
11%	Non-profit or foundation	5%
8%	Health region	5%
5%	Reaching Home (Indigenous Stream)	3%
3%	Indigenous government	3%
2%	Reaching Home (Territorial Stream)	2%

Discussion

There has been limited research conducted on rural and remote homelessness during the COVID pandemic (Cusack et al., 2022; Pixley et al., 2022; Schiff et al., 2020). This chapter aims to address that gap by reporting on a national survey of service providers' experiences in these communities. First we examined whether COVID had an impact on the rates of homelessness in rural and remote areas. Based on data collected within homelessness sectors and individual agencies, nearly three-quarters of participants reported that homelessness increased in their community during COVID. In addition to the rise in homelessness rates participants

also reported increased migration patterns, with three-quarters of respondents indicating PEH sometimes or often leave the community in search of affordable housing, emergency shelter, and social services in nearby metropolitan centres. This observation supports the literature, which shows large flows of PEH into communities and smaller flows between individual shelters (Jadidzadeh & Kneebone, 2020). Migratory patterns, such as between rural and urban areas, serve to increase the transmission of COVID within congregate shelter settings (O'Shea et al., 2020; Roland et al., 2021) as well as in the general population (Schiff et al., 2020).

Secondly, the survey results shed light on service provision challenges that arose related to homelessness in rural and remote communities. Findings indicated that over half of the participants' organizations did not have a pandemic plan in place prior to the COVID outbreak. This is perhaps not surprising, as there was limited research about the intersections of homelessness and pandemics prior to COVID, and what did exist related to SARS, TB (Babando et al., 2022), and H1N1 (Buccieri & Schiff, 2016). In the time since COVID first emerged, the knowledge base about homelessness and pandemics has grown (Karabanow et al., 2021) with a focus on the individual, interpersonal, community, and policy impacts (Rodriguez et al., 2022). Within rural and remote communities, the most pressing challenges were related to client concerns, transportation, and staffing. While transportation was a unique finding, client and staffing concerns are well documented (Campbell et al., 2022). During the COVID pandemic, the overall mental health of PEH has declined, particularly amongst Housing First clients (Mejia-Lancheros et al., 2022), marginalized youth (Noble et al., 2022), and US Veterans (Cusack et al., 2022; Wynn et al., 2021). Researchers have found that reduced service operating hours in part led to the increase in mental health problems

amongst clients (Gräske et al., 2022). Reduced service hours were also found to have inhibited service providers' abilities to provide face-to-face support for vulnerable individuals (Kaur et al., 2022). Staffing concerns, the third most pressing issue in rural and remote communities, was a common theme in urban centres as well. Research shows the impact of COVID on staff was significant (Goodwin et al., 2022), as they had to balance the shift to working at home with providing care and client engagement (Aykanian, 2022a), which led to decreased job satisfaction (Aykanian, 2022b), and increased traumatic stress (Waegemakers Schiff et al., 2023).

One additional concern is the number of respondents who were unaware of the availability of services locally, or of the funding sources available. This lack of awareness may reflect the need for increased transparency of operation in agencies in smaller communities. It may also reflect the need for additional staff training on local resources and their gaps, which would assist in program delivery.

Finally, the survey results were used to explore what new funding and services emerged in rural and remote communities to support PEH during COVID. Findings indicated that over three-quarters received additional funds to support their organization, and that the funding was from their regular sources. This additional funding was important given that researchers have identified narrowly directed funding as a pressing problem for community organizations (Roebuck et al., 2022), and that many organizations had increased costs that they were required to pay out of their existing budgets (Gräske et al., 2022). The funding provided in rural and remote communities was largely used for PPE, disinfecting supplies, staff, and food. Additionally, over half of the communities used the additional funding to create new programs and services, including isolation and assessment facilities, shelters, and

housing supports. Some communities also used the additional funding to create health promotion programs which were also found in the literature, such as the Backpack Medicine Program in California (Alarcón & Khan, 2021) and the PHONE-CONNECT program in Toronto (Kazevman et al., 2021).

Conclusion

The COVID pandemic had an impact on PEH and service providers. This research showed that while there were many commonalities with urban centres, there were also some unique factors in rural and remote communities within Canada. Notably, homelessness increased during the pandemic and people frequently migrated out in search of housing, shelter, and services. This increased the risk of transmission within communities and within service agencies. While many ultimately returned back to their smaller (rural) regions, more funding is needed to minimize relocation and enhance the housing and services available locally. This research indicated that during COVID community agencies received some additional funding, which was mostly used to create more supports locally. To be impactful long-term, this funding should be increased and regularized to have a sustainable impact. Further, over half of the agencies did not have a pandemic plan at the beginning of the COVID outbreak, but there has been considerable knowledge acquired since that time. Organizations must continue to integrate these learnings into plans for ongoing public health measures and future pandemic responses. Finally, it is noteworthy that while medical issues such as isolation and quarantine were noted, the most pressing concerns in rural and remote communities pertained to the psycho-social well-being of people. The mental health of clients and service providers was deeply challenged by the lack of interaction, and lack of

transportation meant people could not get to services, even during the limited times they were open. As rural communities build back in the wake of COVID we must capitalize on the opportunities that exist for change and growth, while also recognizing the strength and resilience that exist within these regions.

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Conclusion

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The COVID 19 pandemic highlighted significant weaknesses not just in healthcare systems, but dramatic faults in our systems of social care and support as well. This was particularly evident in our housing systems which grew to an unprecedented and alarming level of crisis both during, and following, the pandemic. In addition to this and as our first book on pandemic and homelessness highlighted:

Large-scale emergencies, such as global pandemics, have become a reality of daily life, but while everyone is affected, not everyone is affected equally (Blickstead & Shapcott, 2009). Vulnerability is increased with inadequate structural and systemic protections, and is also grounded in the greater human, social, economic, physical and environmental capital accorded to some people over others (Canadian Red Cross, 2007) (Buccieri K in Buccieri and Schiff, 2016).

This most recent pandemic certainly amplified the evidence for the inequitable ways in which such emergencies disproportionately

impact the most marginalised citizens. In this book we set out to understand what we have learned from past pandemics and whether those lessons and new lessons were evident in the COVID-19 response in the context of housing and homelessness. While our first book focused exclusively on Canadian experiences, with this volume we hoped to identify the common themes, experiences, and lessons that might inform international understanding and global cooperation as it relates to housing, homelessness, and health. With this in mind, this book brought together chapters from a range of different locations, including Canada, the United States, Australia, Ireland, and Switzerland to examine pandemic preparedness, homelessness, and the international lessons we have collectively learned from COVID-19.

This book was structured around four sections, designed to move readers through different lenses and perspectives on housing and homelessness with each section. We began with a focus on special populations – highlighting intersectional experiences of those who are particularly affected by homelessness, such as women, seniors, people who use drugs, youth, and Indigenous youth. The first three chapters of this section (by Atlogabe, Cloutier et al., and Milliken et al.) focused specifically on women, trans, and non-binary people's experiences of homelessness during the pandemic. These chapters each integrate different intersectional approaches all of which highlighted the need for gender-specific consideration. More importantly these chapters all highlighted the need for holistic and comprehensive strategies for ending homelessness which take into account diverse needs. Findings of these three chapters suggest a need for a structural and system redesign – to create social services systems which are adequately resourced and flexible to innovation in service delivery approaches. This includes the need to emphasise collaborative and harm reduction approaches in homelessness services. The

next chapter in this book by Naidoo et al., contributes important perspectives from Indigenous programs with specific attention to the needs of Indigenous youth. Their findings highlighted the strengths of culturally-based programming while also pointing to specific considerations for public health planners to remove barriers for Indigenous programs in pandemic contexts. A final chapter in this section by Stewart and Townley also focused on youth experiences of homelessness. They conclude with important considerations for pandemic planning which responds to the unique barriers and challenges experienced by youth during the COVID-19 pandemic.

The second section of this book examined lessons from the pandemic for housing and social services provision models. A first chapter in this section by Waegemakers Schiff et al., also explored an often-overlooked aspect of homelessness service provision – the experiences of frontline workers. In addition to everyday challenges, in the context of pandemics there are particular concerns for health and safety of frontline workers in the homelessness sector. This chapter points to significant considerations for pandemic planners and service providers in supporting safety for frontline homelessness workers. A second chapter in this section by Jones et al., also examines the experiences of frontline workers, with particular attention to those workers who have lived experience of homelessness. They conclude with recommendations for lived experience workers in homelessness planning, indicating that *“frontline staff with lived experience play a critical role in pandemic planning and eradicating homelessness based on their unique experiences.”* The chapter that follows, by Panaite et al., similarly focused on lived experience workers – also highlighting the incredible value of peer support workers particularly in pandemic situations.

This section then turned attention to the critical question of vaccination and consideration of the complex challenges associated with delivering vaccinations to persons experiencing homelessness. McCosker provides critical evidence-based recommendations for pandemic planners to consider for vaccination in this context. Parulkar et al., also provide critical insight for pandemic planners in relation to vaccination programs for persons experiencing homelessness. In line with the recommendations of Panaite et al., in Section 2 this chapter also demonstrates the significant value and impact of peer-support programs in homelessness service provision.

In the third section we applied a geo-political lens – examining the ways in which homeless individuals and service providers experienced the pandemic at different city, regional, and state levels. The first chapter in this section by Wilkinson and Schiff looks at the often-underexplored rural experiences of homelessness service providers. In this chapter, we identified recommendations for increased funding and attention to rural communities in the context of pandemic planning and homelessness services. In the chapter that follows, O Carroll et al., provide an international perspective on homelessness response, by discussing a successful collaborative strategy that not only had significant impact during the pandemic, but also led to a national commitment to collaborative responses for ending homelessness. The next chapter in this section by Distasio et al., provides a critical systems-level perspective on the value of collaboration across the homelessness sector, to effectively respond to needs in pandemic contexts. Their description of the experience in a Canadian city highlights important considerations for homelessness service providers in terms of ongoing systems-level planning to end homelessness. The final chapter in this section, by Rodriguez et al., similarly identifies the value of collaboration among homelessness service

providers and policy makers. In addition to this key recommendation, their research also contributes key lessons from interviews with persons experiencing homelessness and service providers to, “*meet PEH where they are*”; “*tailor communication and education for PEH and train shelter staff accordingly*”; “*improve data collection*”; and “*center the voices of the most vulnerable.*”

The final section of the book focuses on macro-level analyses, examining federal and global responses to housing and homelessness within the context of this most recent pandemic. The first chapter by Bonakdar highlights the intersecting social and geographic inequities in homelessness response. Importantly, Bonakdar concludes with a call for “*a radical shift in mainstream practices and policies to better equip the system(s) with tools that can address the long-standing social and geographic equity issues that were heightened during the COVID-19 pandemic.*” The next chapter in this section by Drilling et al., highlights a unique and important broadscale perspective on pandemic experiences in the context of homelessness. In alignment with several other chapters, the authors also highlight the critical importance of collaboration amongst policymakers and service providers to address homelessness in the context of pandemic planning. The chapter that follows, by Messier, explores the impact of the pandemic on shelter pattern use. This study provided valuable information about pandemic and emergency planning in terms of patterns of shelter use during emergency events. Finally, Buccieri et al., return to the subject of rural homelessness, pointing to the significance of rural homelessness and the need for more funding, support, and resources to support rural service providers on a larger scale.

Overall, the chapters in this volume contribute a diversity of perspectives from a range of international locations, at varying socio-geographic scales, and with attention to diverse aspects of

intersecting identities for persons experiencing and responding to homelessness. The chapters in this book call for some key considerations, two of which focus on the critical importance of collaboration and inclusion for PEH in homelessness response. Authors of these chapters also come together in calls for improved data collection, attention to the needs of diverse populations, consideration for underserved communities such as rural regions, and the value of innovative and flexible models for homelessness service provision. We hope that this extensive collection highlights key lessons going forward: pandemics are a feature of contemporary society that will persist – the lessons of COVID-19 and its impacts on those most structurally vulnerable must be taken into account for ongoing and future pandemic planning.

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