



FINAL REPORT

Youth Homelessness: Mental Health and Substance Use During the COVID-19 Pandemic

Pandemic Proof: Synthesizing Real-World Knowledge of Promising Mental Health and Substance Use Practices Utilized During the COVID-19 Pandemic with Young People Who Are Experiencing or Have Experienced Homelessness

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Executive Summary

“When this pandemic started a lot of folks were talking about it being the great equalizer – we are all in the same situation. We very quickly realized this was not the case.”~ front-liner provider (focus group participant)

The COVID-19 pandemic is highlighting societal inequities in an unprecedented manner. Young people who are experiencing or have experienced homelessness are disproportionately impacted by the negative socioeconomic consequences of the pandemic. The pandemic has also made visible the precarious existence in which these young people live.

The aim of this knowledge synthesis was to deliver real-world evidence on promising mental health and substance use practices utilized by front-line providers working during the COVID-19 pandemic with young people who were experiencing or had experienced homelessness. However, the evidence we uncovered over the past five months has been less about downstream individual-level interventions and more about the need for upstream structural interventions.



Key Messages:



We must pay special consideration to the mental health and substance use needs of young people with current and past experiences of homelessness, who are more likely than the general population to have pre-existing mental health challenges, struggles with financial hardship, and employment uncertainty.



Providers must be careful not to inadvertently perpetuate access inequities – already common in this population – by pivoting to phone/virtual care without having a concurrent plan around addressing resource-related barriers to access.



While it intuitively makes sense to divert young people from the shelter system – especially during a pandemic – we must ensure these young people have the social and economic supports needed not just to survive, but to thrive in the mainstream.

During this pandemic, there is a pressing need to understand what individual-level practice adaptations hold promise to meet the mental health and substance use needs of young people who are experiencing or have experienced homelessness; however, it is essential that we situate this need and our response within the broader societal context in which youth exist.

The way we frame a health issue is important because it will influence our understanding of the solutions. For example, if the problem of worsening mental health and substance use is caused by/connected to structural determinants of health such as racism, insufficient housing, precarious employment, limited social connections, and poverty, and not individual “vulnerability” (a term that denotes weakness and is used all too often when referring to youth experiencing homelessness), then it is logical that the proposed solutions should encompass structural interventions.



“My greatest challenge has been not being able to access supports in person. I like things in person – just having that routine of going. Being off work and school, and not having a lot to do, I kinda declined in my mental health. I became very isolated and alone and not really going out as much.” ~ youth (focus group participant)

“There’s a lot of youth out there who have issues and anxiety and everything. I’m one of them. It’s hard to know that, in this pandemic, there’s not a lot of resources.” ~ youth (focus group participant)

This report contains survey data from 188 front-line providers across Canada and is supplemented by three focus groups – two with providers and one with young people who have experienced homelessness. We have endeavored to situate these findings

within the rapidly evolving literature on pandemic-related impacts on mental health and substance use. Below are our recommendations for practice, research, and policy:

Practice

- Increase (not decrease) outreach and do so in a proactive way (reach out to youth not seeking services)
- Increase staffing levels to facilitate enhanced engagement (consider staff burnout)
- Consider a blended model of phone/virtual support (ensure adequate staff training), in-person visits, and holistic outreach (phone/virtual supports will not be equitable for all)
- Consider implementing wellness checks (phone or in-person)
- Constantly evaluate the effectiveness of practice adaptations – there is no one size fits all approach
- Proactively alleviate the amount of system navigation work required of young people (consider active collaboration with other agencies/ organizations)



Research

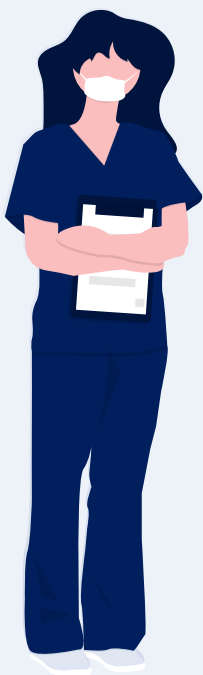
- Pilot promising phone/virtual supports (e.g., cognitive behavioral therapy interventions) that have been tested with young people who have not experienced homelessness (rigorous testing – ideally with a control group for comparison – is crucial)
- Incorporate perspectives of young people with current and past experiences of homelessness into all phases of the research process (crucial for any research involving young people who are experiencing or have experienced homelessness)
- Assess how intervention outcomes vary by subpopulations (e.g., 2SLGBTQ+, Indigenous, and racialized youth)

- Incorporate and test the integration of virtual supports into promising evidence-based complex wraparound interventions for youth exiting homelessness (e.g., Kidd et al., 2019; Kidd et al., 2020)
- Rigorously study promising interventions related to system navigation (e.g., connecting youth with an advocate/mentor), early intervention (e.g., connecting youth to family/natural supports), and housing stabilization (e.g., rent subsidies and cash transfers) – look at longitudinal outcomes beyond housing stability, such as socioeconomic inclusion



Policy

- Consider the intersecting nature of social determinants of health (e.g., race, class, gender, income, and education) when putting forward solutions to address youth homelessness
- Augment investments in agencies/organizations serving young people experiencing homelessness so they can prioritize an equity-informed approach (e.g., enhance in-person outreach to the most marginalized and free/affordable devices to access virtual/phone supports)
- Consider the potential cost-effectiveness of rent subsidies and cash transfers (collaboration with researchers would be helpful here)
- Invest in long-term outcomes beyond housing stability (e.g., equitable socioeconomic inclusion)



“One thing I’ve noticed is their source of community, that sense of belonging, it has been jeopardized. Not only because things are closed, but because they now have to adapt, or navigate, rebuilding relationships through different avenues.”~ front-line provider (focus group)

The COVID-19 pandemic has exposed and created a snowstorm of intersecting inequities that providers and young people are struggling to navigate. It also presents a unique opportunity to reimagine how we serve young people who are experiencing or have experienced homelessness. We trust this report makes a modest contribution to the emerging literature on this topic.



Section 1

Background and Overview

1. Background and Overview

An estimated 35,000-40,000 Canadian youth (aged 13 – 24 years) experience homelessness at some point during the year and at least 6,000 on any given night (Gaetz et al., 2016). The overwhelming majority have experienced some form of trauma and their challenges related to mental health and substance use have been documented for decades (Auerswald et al., 2019; Hwang, 2000; Karabanow, 2008; Kidd et al., 2017; Kulik et al., 2011; Roy et al., 2010; Wood et al., 2006). A recent pan-Canadian survey of 1,103 youth accessing homelessness services found that 42% had attempted suicide at least once and 84% reported high rates of psychological distress (Gaetz et al., 2016; Kidd et al., 2017).

Struggles with mental health and substance use are not unique to young people currently experiencing homelessness; rather, these challenges persist – and sometimes get worse – for young people who have experienced homelessness in the past. The limited longitudinal research on young people who have transitioned out of homelessness paints a disheartening picture of economic precarity and social exclusion (Kidd et al., 2016; Thulien et al., 2018). Over time, these young people can become mentally exhausted and overcome by a sense of hopelessness, placing them at high risk of returning to homelessness (Kidd et al., 2016; Thulien et al., 2018; Thulien et al., 2019). In fact, 76% of young people in the aforementioned pan-Canadian survey reported at least two failed attempts at exiting homelessness (Gaetz et al., 2016).

Intervention-focused research with this population is emerging but quite limited (Altena et al., 2010; Coren et al., 2016; Hwang & Burns, 2014; Luchenski et al., 2017; Morton, Kugley et al., 2020; Wang et al., 2019). Thus, it is against this backdrop of social and structural inequities and limited guidance in peer-reviewed literature around “what works” to improve outcomes related to mental health, substance use, and sustained exits out of homelessness, that the COVID-19 pandemic came on the scene – accelerating our need for an evidence-informed response.



The overall goal of this project was to synthesize real-world knowledge on promising mental health and substance use practices utilized during the COVID-19 pandemic by front-line providers serving young people who are experiencing or have experienced homelessness.

Objective 1

Examine how COVID-19 has impacted the mental health and substance use patterns of young people who are currently experiencing or have experienced homelessness. We did this by beginning with an electronic survey to examine our key domains of: 1) pandemic impacts on mental health and substance use patterns; 2) practice adaptations; and 3) promising and transformative approaches.

Objective 2

Identify how front-line providers have adapted their practices because of the pandemic and provide a youth-informed perspective to these adaptations. We did this by conducting three targeted focus groups with providers and young people who had experienced homelessness.

Objective 3

Highlight promising and transformative approaches to service delivery – particularly those with post-pandemic promise – that warrant further investigation. We did this by drawing on the real-world expertise of young people and providers, and by searching the literature.



2. Research Methodology

This project was informed by Community-Based Participatory Action Research (CBPAR) methodology – an approach that challenges traditional assumptions of what constitutes “good” evidence, demands researcher humility, and stresses genuine and equitable academic-community partnerships (Wallerstein et al., 2018). Conceptually, the synthesis was scaffolded by Critical Social Theory (Strega, 2005), meaning we endeavoured to appropriately contextualize our findings and recommendations, taking into account the intersecting inequities (e.g., age, race, class, gender, and sexual orientation) that contribute to the complexity of addressing the mental health and substance use needs of young people who are experiencing or have experienced homelessness.

Typically, a knowledge synthesis consists of examining peer-reviewed literature on a topic, combining these findings to create new insights, and then sharing these insights with relevant knowledge users and decision makers (Grimshaw, 2010). However, given our commitment to CBPAR methodology (e.g., challenging what constitutes good evidence), the sense of urgency from our front-line colleagues to obtain real-time knowledge of what other providers were doing, and our prior understanding that intervention-based literature on youth homelessness is quite limited, we decided to take a different approach.

We began this synthesis in June 2020, amassing on-the-ground perspectives from our front-line colleagues who serve young people who are experiencing or have experienced homelessness. We published a preliminary report on June 24, 2020, using data from an electronic survey, which was available to front-line providers across Canada from June 10, 2020 – June 17, 2020. Over the past five months, we further refined this synthesis through the generation of more qualitative data (focus groups with providers and young people) and further exploration of the peer-reviewed literature. This was an iterative process; findings from our electronic survey influenced the direction of our literature review and focus group questions, and the focus group findings influenced subsequent reviews of the literature.

Methods

This study employed a convergent mixed methods design, meaning quantitative data (electronic survey) and qualitative data (electronic survey and focus group interviews) were collected at roughly the same time and the findings combined (Creswell & Plano Clark, 2018). We believe this methodology helped facilitate a more comprehensive, nuanced understanding of the data (Creswell & Plano Clark, 2018).

The 26-item electronic survey focused on three key domains: 1) pandemic impacts on mental and substance use patterns; 2) practice adaptations; and 3) promising and transformative approaches. The June 2020 survey was distributed through e-mail and social media (e.g., Twitter) and open to all front-line providers in Canada serving youth (aged 16 – 24 years) who had experienced or were experiencing homelessness. Then, we conducted three focus groups – two with front-line providers (July 30, 2020 and August 6, 2020) and one with young people who had experienced homelessness (September 10, 2020) – via Zoom. Focus group questions were developed after analyzing the survey data, and focused on our three key domains of interest. The provider focus groups were led by Naomi Thulien and the youth focus group was led by Mardi Daley and Naomi. Each focus group lasted one hour. Ethical approval was received by the Hamilton Integrated Research Ethics Board.

Quantitative survey data was analyzed by Amanda Noble and Isaac Coplan using frequency analysis. The qualitative survey data (free text responses) were independently coded (“tagging important pieces of data”) by Naomi and Mardi. The audio recorded focus groups were transcribed and coded independently by Julia Roglich, Danielle Ali, and Mardi. During the qualitative data (from the survey and focus groups) analysis and interpretation phase, the qualitative team members met with Naomi to discuss the codes, group the codes into conceptual categories, and merge the categories into themes (Creswell & Plano Clark, 2018). Throughout this process, we endeavoured to integrate the quantitative and qualitative findings so we would expand our understanding of the emerging insights (Creswell & Plano Clark, 2018).

In keeping with the critical social theoretical scaffolding of this study, our broader study team discussed what the data illuminated about intersecting structural-level inequities faced by young people who are experiencing or have experienced homelessness. The varied experiences of our team members as front-line clinicians, researchers, public policy influencers, and having lived experience of homelessness, mental health challenges, and substance use, allowed us to provide a more contextualized, nuanced interpretation of the data. For example, our research colleagues with lived expertise were able to share whether the findings “rang true” from their own experiences with accessing mental health and substance use supports.



Section 2

Survey Data

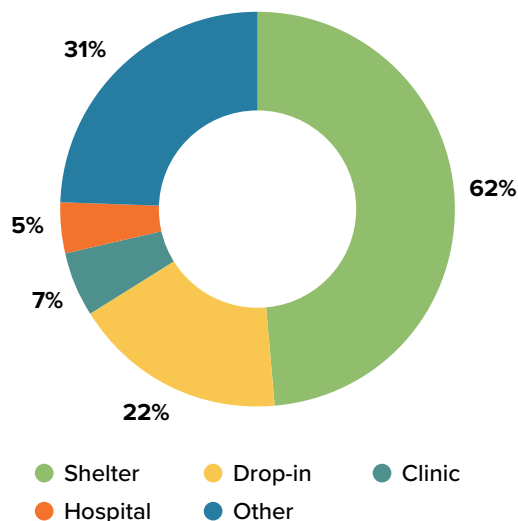
1. Demographics: Survey Respondents

Survey respondents included 188 service providers from 36 cities/towns, across nine provinces/territories in Canada. All providers worked with young people aged 16-24 years who were experiencing or had experienced homelessness. Providers represented 65 organizations, with the majority (80%) located in Ontario. The largest group of responses (62%) came from those working in emergency shelters and the second largest group of responses (31%) came from those working in a variety of settings ranging from housing programs to prisons.

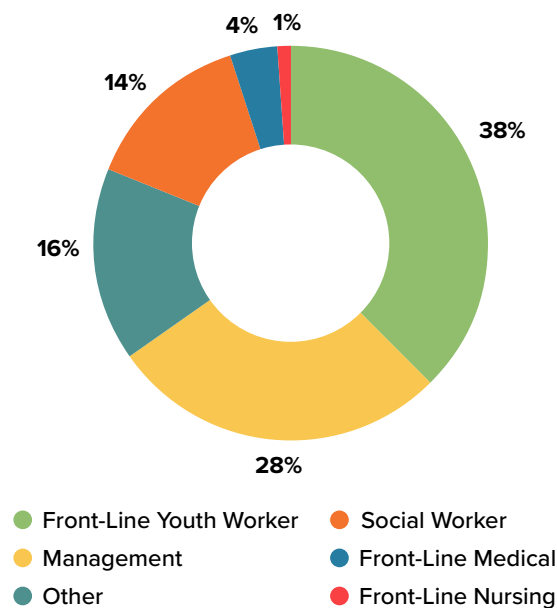
62%
of participating providers worked in a shelter setting



Provider Workplace



Respondent Roles



2. Pandemic Impacts on Mental Health and Substance Use Patterns

A. Changes in Mental Health Patterns

	Increased	Remained the Same	Decreased	Not Sure
Boredom	92% (143)	3% (5)	1% (1)	4% (7)
Feeling isolated/lonely	91% (142)	6% (9)	1% (1)	3% (4)
Anxiety	85% (133)	10% (16)	1% (1)	4% (6)
Depression	75% (117)	17% (27)	1% (1)	6% (10)
Sleep disturbances	67% (102)	18% (28)	2% (1)	14% (21)
Increase in acuity/symptoms related to pre-existing mental health conditions	67% (104)	21% (32)	1% (1)	11% (17)
Suicidal ideation	36% (55)	38% (58)	1% (2)	25% (38)
Self-harm	25% (39)	46% (70)	2% (3)	27% (41)
Suicide attempts	15% (24)	54% (83)	2% (3)	29% (44)
Positive mood	8% (13)	28% (44)	69% (107)	8% (12)

Significant increase/increase and significant decrease/decrease responses have been combined

Providers reported the pandemic has had a tremendous impact on the mental health of the young people they serve.

Over 90% reported that youth had experienced a significant increase/increase in feelings of isolation and loneliness, and boredom. Additionally, providers reported that anxiety (85%) and depression (75%) had significantly increased/increased among their clients. Just under 70% of providers noted increases in sleep disturbances and acuity/symptoms related to pre-existing mental health concerns.

91%
reported a significant
increase/increase in
isolation and loneliness

36%
 reported a significant increase/increase in suicidal ideation

Many providers reported significant increases/increases in the level of suicidal ideation (36%), incidences of self-harm (25%), and suicide attempts (15%) among young people since the pandemic began.

Youth Seeking and Accessing Mental Health Supports

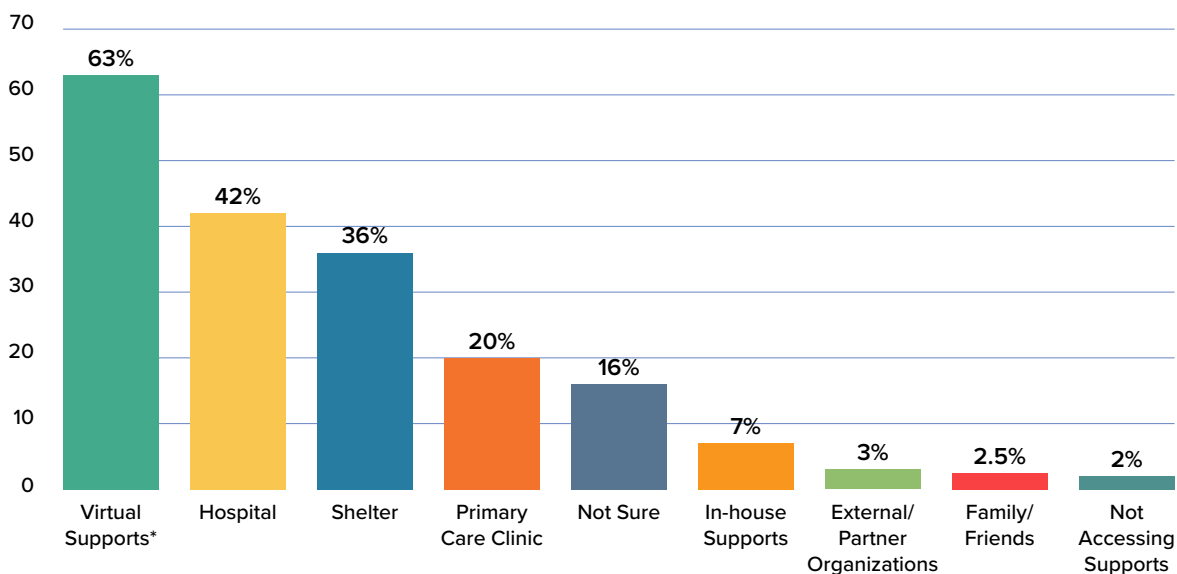
50%
 reported significantly limited/limited decrease in seeking mental health supports

80%
 reported significantly limited/limited decrease in accessing mental health supports



B. Where Are Youth Going for Mental Health Supports?

The top three most common places providers reported youth were going to access mental health services were: online supports (63%), hospitals (42%), and emergency shelters (36%). Only 20% of young people were thought to be accessing mental health supports through a primary care clinic.



Respondents were able to select multiple options
*Helplines, online chats, support groups, etc.

63%
reported youth were
accessing mental health
supports online



C. Changes in Substance Use Patterns

	Increased	Remained the Same	Decreased	Not Sure
Use of substance	69% (108)	17% (27)	4% (6)	10% (15)
Overdoses	37% (57)	23% (36)	4% (6)	35% (54)
Access to harm reduction materials/medication	12% (19)	35% (54)	28% (43)	25% (38)
Access to naloxone kits	6% (10)	45% (70)	19% (30)	29% (45)
Access to safe supply or substitution	3% (5)	29% (45)	26% (41)	42% (65)
Access to abstinence-based services, groups, or meetings	3% (5)	17% (27)	46% (71)	33% (51)
Access to supervised injection sites	1% (2)	22% (34)	26% (40)	51% (80)

Significant increase/increase and significant decrease/decrease responses have been combined

The majority of providers (69%) reported they observed a significant increase/increase in substance use since the COVID-19 pandemic began. It is especially important to note the reported increase in overdoses within this population (37%).

69%

reported a significant increase/increase in substance use

37%

reported a significant increase/increase in overdoses

While substance use was believed to have increased, providers also reported a significant decrease/decrease in access to abstinence-based services (46%), harm reduction materials (28%), and substitution therapy (26%).

It is interesting to note that a large number of respondents were unsure where youth were accessing harm reduction supports during the pandemic. For instance, 51% of providers reported being unsure of how the pandemic had impacted access to supervised injection sites.

D. Disproportionate Impacts

Some providers noted that worrisome changes in mental health and substance use patterns appeared more prevalent among youth from certain subgroups. In particular, they reported 2SLGBTQ+ (two-spirit, lesbian, gay, bisexual, transgender, and queer), Indigenous, and racialized youth seemed especially impacted. Moreover, providers noted that these additional challenges were increasing the complexity of their provider-client interactions.

“Individuals who identify within oppressed groups face increased barriers for accessing and having resources to for support when they hold another oppressive identify as a substance user. It's an added layer of stress and barriers.”

1. OPPRESSED IDENTITIES

Several providers spoke of the challenges faced by 2SLGBTQ+ youth who were having to spend more time with non-affirming family members because they had to move back home for financial reasons and/or limited access to supportive friends and spaces.

“Certainly trans and gender diverse youth have discussed the complications of navigating unsafe home environments and having to conceal their identities without reprieve of being outside/with friends/within other affirming/supportive spaces.”

“Many refugees have seen first-hand what can happen when an illness sweeps through a community. This has created greater fear than the average person, especially when the young person is in Canada without a parent.”

Refugee and Indigenous youth were also reported to be feeling especially marginalized – disconnected from familiar supports (e.g., specialized programming) and cultural experiences (e.g., sweat lodges), exacerbating feelings of loneliness.

2. TRAUMA TRIGGERS

The heightened awareness of anti-Black and anti-Indigenous racism following the deaths of individuals such as George Floyd, Regis Korchinski-Paquet, and Chantel Moore was reported to be retraumatizing for many racialized and Indigenous young people. Moreover, this trauma was thought to be exacerbated by the fact that many youth had to process their thoughts and feelings alone.

“Some Black and POC [people of colour] youth I see have been struggling due to George Floyd's death, social media images and stories of abuse, and ongoing police brutality [...]¹. With COVID-19 limiting access to safe spaces, community supports, and ability to hang out with friends, the impacts of racism during this time have amplified negative impacts on mood, anxiety and social connection/safety.”

3. UNINTENDED CONSEQUENCES OF PUBLIC HEALTH POLICY

Several providers commented on the challenges associated with following public health guidelines and how these recommendations can unintentionally exacerbate struggles related to mental health and substance use – particularly among 2SLGBTQ+, racialized, and Indigenous youth.

“Public safety measures adopted during the crisis replicated state actions taken historically which caused and still do cause significant harm.”

Providers noted the importance of young people in the aforementioned groups spending time in social circles where they feel a sense of belonging. Restrictions on movement (e.g., freedom to come and go from transitional housing) had made those sorts of connections difficult. Additionally, several providers reported young people had increased their use of substances and were using alone. Importantly, providers noted that many young people did not have equitable access to information technology, making it challenging to access the mental health and substance use supports they need.

“[...]assumptions were made that everyone has easy access to the internet and technology for virtual care[...].”

1. [...] denotes missing text

3. Pandemic Impact on Agency/ Organization

Providers reported the demand for mental health services had significantly increased/increased (65%) since the pandemic. As previously indicated, while providers reported an increase in substance use among the young people they serve, only 37% reported an increase in demand for substance use services.

31%

reported increase in
staff illness

37%

reported increase in
demand for substance
use services

65%

reported increase in
demand for mental
health services

71%

reported increase in
staffing demands

78%

reported increase in staff
burnout

69%

reported increase in
mental health distress
among providers

Significant increase/increase responses combined

In addition to youth, the pandemic is having a notable impact on service providers. An overwhelming majority of respondents (79%) reported a significant increase/increase in mental health distress and concerns among providers. Furthermore, a large number of respondents revealed significantly increased/increased rates of staff burnout (78%) and illness (31%).



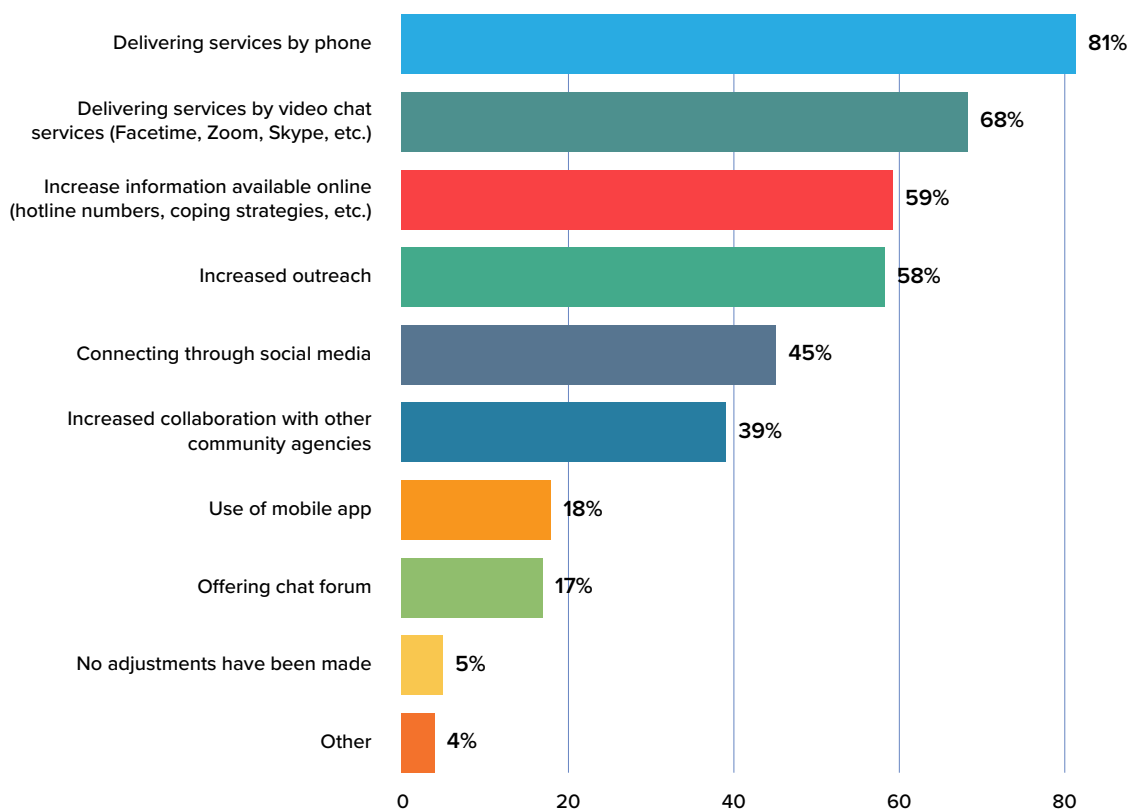
4. Practice Adaptations

A. Pandemic Impact on Organization Access to Mental Health and Substance Use Supports

The pandemic has altered the ways in which agencies and organizations can operate. In terms of access to mental health services, the majority of providers (69%) reported that buildings were either closed (18%) or their services were now delivered solely offsite (51%).

When speaking about substance use, a large proportion of providers (62%) reported they were delivering services remotely (50%) or agencies were entirely closed (12%) – completely halting the delivery of substance use services.

1. MENTAL HEALTH PRACTICE ADAPTATIONS



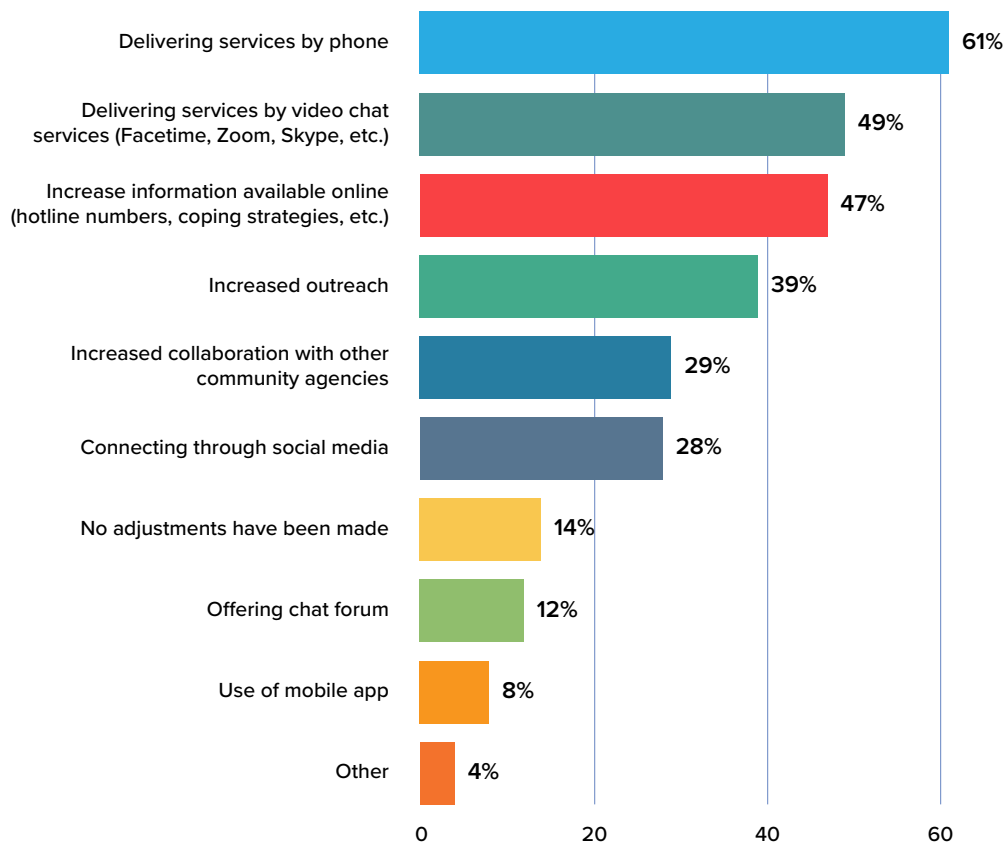
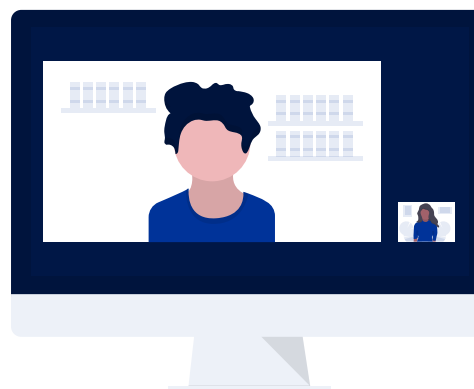
Respondents were able to select multiple options

Providers reported that mental health services had largely been shifted to delivery by phone (81%). The second most common adaptation was the move to video chat (68%), followed by connecting with youth through social media (45%). Regardless of the medium, 58% of providers reported increasing their outreach activities specific to mental health.

2. SUBSTANCE USE PRACTICE ADAPTATIONS

Similar service adaptations were reported when asked about substance use practices. Providers reported utilizing phones (61%) as a way to combat pandemic related closures. Similarly, providers reported shifting to video chat services (49%), and 28% were providing support using social media. Just under 40% indicated they had increased their outreach activities.

49%
 reported delivering
 substance use services by
 video chat



Respondents were able to select multiple options

B. Youth Satisfaction with Service Adaptations

The majority of providers sensed that young people were neutral, dissatisfied or very dissatisfied with mental health (64%) and substance use (54%) service adaptations. Notably, 24% of providers reported they were unsure how satisfied young people were with substance use service adaptations.

1. INEQUITABLE ACCESS

The move to remote care is based on the premise that young people have access to a phone or the internet. Many providers shared that this was not the case and a large barrier to accessing mental health and substance use supports.

“[...]mental health services require phone or computer to connect virtually, which not all clients have; mental health services require phone plan or internet to connect virtually, which not all clients have.”

“Many youth have not been able to access services because they have limited resources, like working cell-phones, Wi-Fi or other internet connections[...].”

Importantly, some providers noted that accessing supports online was not safe for everyone.

“Many of the youth we serve do not live in a place where they feel safe to attend online groups for several reasons including their partners or roommates don't know they were engaged in the sex trade.”



2. HUMAN CONNECTION

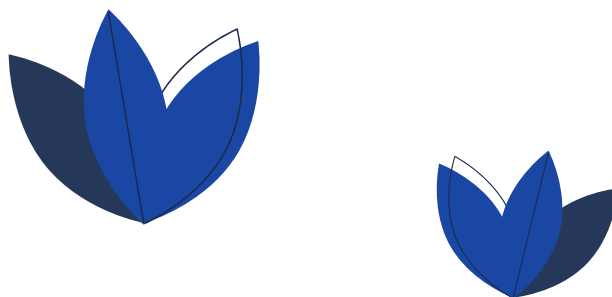
The majority of providers noted that they believed young people prefer face-to-face contact – especially if they are meeting providers for the first time. Several shared that face-to-face interactions help build trust and rapport, and that young people were missing in-person connections. Moreover, some commented on the importance of being able to “lay eyes” (in person) on youth to make appropriate assessments as to how they were “really” doing.

“Young people prefer to have in-person contact especially when seeking services for mental health and substance use. Disclosing these struggles can be a very vulnerable process and most young people prefer to meet their supports and get a sense of who they are before they can begin their journey.”

3. ENHANCING ACCESS

There were a small number of providers who sensed young people welcomed the move to phone and/or virtual supports as it enhanced access to care – especially for those living outside large urban (and more resource-intensive) settings.

“For young people outside of the Toronto-area/GTA-area we have actually seen an increase in access – these clients would normally have to travel long distances to access trans/gender diverse affirming care and have been able to connect virtually in a way that reduces the travel/cost/organization barrier that often exists.”



5. Promising and Transformative Approaches

A. Service Adaptations: Mental Health

1. PROACTIVE OUTREACH

The majority of respondents noted the importance of connecting with youth regularly and more frequently than pre-pandemic. Several shared that these proactive, consistent check-ins appeared to reassure youth during this time of social and economic uncertainty.

“Set a consistent time and day of connecting over video and phone, and provide youth interest-based projects to do with a specific goal of sharing their work with the broader community. Continue routine from pre-COVID19 as much as possible via virtual means and offer structured check ins with relevant support resources.”

Some providers also reported that they had adapted to the need for enhanced outreach by providing shorter, more frequent appointments (e.g., connecting three times/week for 20 minutes rather than once/week for 60 minutes).

2. A HOLISTIC APPROACH

Several providers shared that they had enhanced their mobile outreach, combining mental health services with delivery of food, personal care items, and art supplies. This links back to the need for a proactive approach as some providers noted that young people struggling the most with their mental health were less likely to reach out for help.

“Over-the-phone counselling seems to require more intensive listening. As a result, offering shorter session times on a more frequent basis has been welcomed by some youth and staff.”

“We have adapted from on-site drop-in with meal service to staff delivering meals daily to youth, which has allowed youth the opportunity to see familiar faces as well as having daily, face-to-face contact to share any struggles they may be experiencing.”

3. VIRTUAL CARE

Many respondents had adapted their services to offer mental health supports virtually. Those that seemed to be having the most success in terms of youth engagement appeared to be those that had pivoted to virtual care fairly rapidly (i.e., not losing youth during reorganization of care delivery) and been provided the necessary training (e.g., navigating Zoom). Still, some expressed concern about whether the move to virtual care was sustainable – especially when not everyone had made that adaptation.

“Mental health concerns are not being addressed by appropriate resources and the confusion over where to send the youth, who to call and where to access the supports is a barrier to getting timely help. We have utilized online resources and virtual meetings to help support the youth but it is not enough and not substantive. While the youth are learning to deescalate and regulate themselves, it is out of survival and necessity, not because we are providing quality supports. Often the resources are not there so there is an assumption that someone else will respond, which bottle necks the system and reduces access and capacity.”

Promising adaptations (apart from video conferencing platforms like Zoom) included:

- Free youth-focused webinars
- Drop-in video/social media chats (e.g., Instagram “live” chats to discuss strategies around creating structure and routine)
- Promoting “self-serve” applications such as Woebot (<https://woebot.io>)
- Creating social media platforms with up-to-date resources



Importantly, many providers noted that not all young people had access to online (or phone) resources, which necessitated the need to: a) provide a blended model of in-person and virtual care, and/or b) provide the means to connect (e.g., young people taking tablet computers on loan, borrowing pre-paid agency/institution phones, and free calling cards).

B. Service Adaptations: Substance Use

1. PUSHING BACK: PEOPLE FIRST

Several providers emphasized that their adaptation strategy was, in a sense, to purposely not adapt; instead, they continued to offer the same substance use/harm reduction supports they offered pre-pandemic.

“There is one place in particular that is in St. Catharines [Ontario] that has kept their doors open, with the correct protocols in place to ensure the safety of everyone. They are more or less operating the same as before. This shows consistency, and the willingness, and ability to put the people first.”

“Our organization stayed open throughout the entire pandemic to provide drop-in support and harm reduction/safe injection supplies. Considering drop-in and safe injection supplies [Safe Works Access Program] as an essential service helped us maintain a connection with folks during the pandemic. They felt they had somewhere they could go despite everything else being closed.”

2. ENHANCED OUTREACH

Similar to the comments on mental health adaptations, several providers noted that more frequent and intentional connection was needed during the pandemic. However, compared to the responses on mental health adaptations, there seemed to be more of a feeling of urgency and frustration, which is understandable given that substance use was perceived to be increasing.

“This has been difficult because we have noticed an increase in substance use and many of those we work with who were in sobriety have slipped and are using again. We have also struggled with keeping in touch with these folks so the services we are offering are not meeting their needs. The pandemic has negatively impacted those with substance use the most and virtual case management has not been as successful in supporting youth in their sobriety.”

While several providers reported utilizing virtual platforms (e.g., Zoom group therapy and Instagram “live” sessions on substance use), many spoke of the ongoing need for in-person interactions to get a better sense of what was happening at an individual and community level. Moreover, providers spoke of the importance of reaching out early (rapid identification of relapse) and remembering to do so in a trauma-informed way.

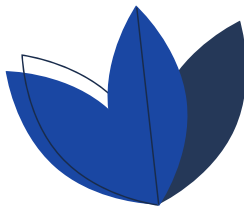
“[We have adapted by] reaching out to people and asking how they are doing. Not shaming people for using substances, especially at a time like this.”

3. EFFECTIVE COLLABORATION

Some providers reported that collaboration between the healthcare system and front-line outreach was crucial to addressing substance use during the pandemic – especially given barriers to accessing appropriate treatment due to pandemic-related closures.

“[We have adapted by] keeping communication between agencies open on supplies and supports[...] Because staff recognized that this is an issue that requires priority, collaboration, supplies, and information sharing became a priority. We are also grateful to the communication with [Alberta Health Services] hospitals to provide updates on overdose trends, and drug trends coming through the medical system.”

“[...] there was a definite dearth in resources to connect people to [...] In fact, we chose to do outreach as a counter to all of the COVID closures. A connection via telemedicine to a physician was crucial to this process.”



C. Do Adaptations Hold Post-Pandemic Promise?

The majority of providers (72%) believed the adaptations made to mental health services had the potential to be successful post-pandemic. However, when asked whether service adaptations specific to substance use hold the same promise, 40% of providers were unsure.

D. Challenges Utilizing Service Adaptations

Barriers to implementation of new adaptations for mental health

	Very Much	Somewhat	Neutral	Not Much	Not At All	Not Sure
Reaching everyone who needs services	45% (61)	38% (52)	7% (10)	4% (6)	1% (1)	4% (5)
Client having access to technology	45% (60)	30% (40)	10% (14)	13% (17)	1.5% (2)	1% (1)
Clients aware of new adaptations	25% (33)	51% (68)	8% (11)	7% (9)	5% (7)	4% (5)
Concerns about security/privacy	23% (31)	34% (46)	19% (26)	10% (14)	8% (11)	5% (7)
Effectiveness of service adaptation	19% (26)	49% (66)	17% (23)	7% (9)	2% (3)	6% (8)
Clients being knowledgeable about the use of required technology	16% (22)	44% (59)	18% (25)	10% (13)	8% (11)	4% (5)

Respondents were able to select multiple options

83%

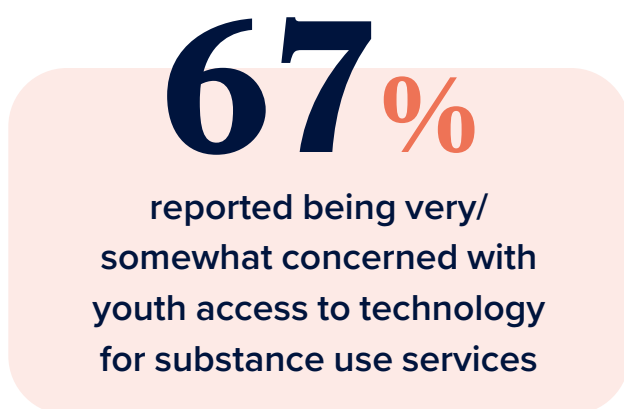
reported being very/somewhat concerned with reaching youth requiring mental health services



Barriers to implementation of new adaptations for substance use

	Very Much	Somewhat	Neutral	Not Much	Not At All	Not Sure
Client having access to technology	35% (47)	32% (42)	6% (8)	11% (15)	2% (3)	14% (18)
Reaching everyone who needs services	32% (42)	36% (48)	8% (11)	5% (7)	2% (2)	17% (23)
Concerns about security/privacy	20% (26)	30% (40)	18% (24)	9% (12)	5% (7)	17% (23)
Clients aware of new adaptations	18% (24)	44% (59)	7% (10)	8% (11)	4% (6)	18% (24)
Effectiveness of service adaptation	18% (24)	41% (55)	14% (18)	8% (11)	4% (5)	15% (20)
Clients being knowledgeable about the use of required technology	16% (21)	35% (47)	14% (19)	11% (15)	8% (11)	15% (20)

Respondents were able to select multiple options



Service providers, regardless of whether they were providing mental health or substance use supports, shared concerns over several potential barriers to service access. A large proportion of providers (83%) were very/somewhat concerned with reaching all youth requiring mental health services. Similar concerns (68%) were expressed when speaking to substance use supports.

E. Recommendations for Mental Health and Substance Use Service Adaptations

1. SYSTEM OVERHAUL

Respondents provided many articulate and emphatic calls for post-pandemic system-level reform. There were appeals to defund the police force and invest more in housing and communities, provide free access to virtual and telephone supports (including the provision of tablet computers and cell phones), amend privacy policies to allow providers to communicate using common platforms such as FaceTime and WhatsApp, and ensure appropriate infrastructure, staffing and training are in place in anticipation of a second pandemic wave.

2. HIT THE STREETS

As noted earlier, many providers – especially those interacting with young people using substances – believed there needed to be a more proactive, in-person approach to care.

“We need mental health and substance use street outreach workers. Hit the streets. Get to the people who are not being seen. Get to the people who need the help the most. Waiting behind a desk for a referral does nothing for the person on the street in agony.”

3. ENSURE ADEQUATE STAFFING

Given the increased demands on staffing during the pandemic – especially those offering enhanced access – there were calls to augment staffing levels accordingly.

“The other onsite mental health services provided by a frontline staff have been less consistent because the staff has gotten pulled into other roles needed to keep the shelter operating (serving meals, cleaning, etc.). Ideally, service roles would be preserved and other staff hired to support shelter operations during a future pandemic.”

4. EQUITY-INFORMED RESPONSE

There were also calls for an equity-informed response – especially given young people who are experiencing or have experienced homelessness face disproportionate challenges related to race, class, gender, and sexual orientation. Additionally, there was an awareness that the move to virtual supports was less likely to be effective for the most marginalized.

“[...] as a system whole, especially what is happening in the world right now, [we] need to re-construct, re-work and re-structure how we deliver service. Client identities are missing entirely. Health equity needs to be at the forefront of the change, especially when Black and Indigenous individuals are disproportionately affected by this pandemic. My specific recommendation is a complete flip of how we deliver care.”

“We have had to recognize that our most resilient youth are the ones who participate in virtual supports. The most entrenched have become more vulnerable and have disengaged from service. We have had to create safety plans for staff to conduct outreach during the pandemic and enhance street-based outreach services compared to service levels pre-pandemic.”





Section 3

Provider Focus Groups

We had eight front-line providers from three different provinces and five different organizations attend our two provider focus groups. All the providers worked in clinical roles, providing mental health and/or substance use counselling to young people who were currently experiencing or had experienced homelessness.

As mentioned previously, the primary aim of the provider focus groups was to learn how providers had adapted their practices because of the pandemic and to explore practice adaptations with post-pandemic promise. However, we quickly realized that providers also wanted to voice their concerns over how young people were fairing during the pandemic.

We begin this section by examining provider perceptions of pandemic impacts on young people who are experiencing or have experienced homelessness. Then, we look at how providers have adapted to these impacts. We finish by exploring what practice adaptations might hold post-pandemic promise.



1. Pandemic Impacts on Mental Health and Substance Use Patterns: A “snowstorm” of inequities

Providers spoke about the intersectional nature of inequities – which one provider described as a “snowstorm” – associated with homelessness and the COVID-19 pandemic. The parallel with a snowstorm is powerful because it portrays a sense of disorientation – losing control of your bearings – disrupting the ability to clearly see and plan for what lies ahead.

Provider comments related to inequities were similar to those from the survey highlighted earlier in this report in terms of concerns for youth who face an added layer of stigma and discrimination related to gender, sexual orientation, disability, and race. Furthermore, providers highlighted that friends and family of the young people they serve were more likely to live/work in high-risk transmission areas, placing youth at higher risk of contracting COVID-19.

“When this pandemic started a lot of folks were talking about it being the great equalizer – we are all in the same situation. We very quickly realized this was not the case. Our communities of colour and our most marginalized communities were feeling the impacts much greater and had higher rates of infection. They are much more likely to be working front-line jobs, much more likely to be working minimum wage jobs. So, we’re actually seeing that it’s the family members and natural supports of the youth that are directly getting the impacted by the pandemic in terms of exposure to infection. Perhaps more so than the youth that are sitting in shelter.”

This excerpt illuminates the inextricable link between homelessness, low socioeconomic position, and health. Moreover, as this provider noted, the inequities experienced outside the shelter system are just as – if not more – important to address than the needs inside the shelter system.

A. Powerlessness: “A kind of mirroring”

Many providers perceived the lack of control over pandemic-related closures reinforced a sense of powerlessness, which one provider – a mental health and substance use counsellor – described as “a kind of mirroring” of past trauma and the ensuing sense of isolation and disconnection. The provider noted that the pandemic “mirror” reflected the young people’s place in life and exposed their lack of social supports – especially for those with past experiences of homelessness and residing outside the shelter system.

“They [the youth] are very much on their own. I keep hearing this over and over and over again. It really brings up a lot of memories and a lot of flashbacks about feeling the most alone in their life [...] it is also especially true for the young people I see [living] in the community.”

B. Disrupted connections: Healing through relationships

Another key theme was the importance of relationships – in addition to routine and structure – to help alleviate the overwhelming feelings of boredom and loneliness all providers sensed the young people were experiencing. Several providers discussed the notion of healing through “natural supports” such as friends and chosen family – the latter perceived to be especially important among the 2SLGBTQ+ community – and how pandemic-related restrictions had disrupted their ability to help facilitate these important connections.

“One thing that I’ve noticed is their source of community, that sense of belonging, it has been jeopardized. Not only because things are closed, but because they now have to adapt, or navigate, rebuilding relationships through different avenues.”

Providers also noted that “expendable programming” such as recreation programs were one of the few “pro-social” options available to young people, leaving them on their own to figure out how to connect with others. However, as another mental health and addiction counsellor noted, connecting virtually is not an option available to all young people and choosing to meet in-person sometimes means facing additional stigma.

“Our homeless folks don’t always have the privilege of having internet access or having the sources to meet virtually. So, they meet in person, and then there’s that additional stigma of, ‘Are you taking COVID seriously?’

by people who are now looking at them, maybe wandering downtown or finding community in parks, meeting up with friends, maybe not wearing masks, maybe not participating in the social distance initiatives that are going on.”

Providers also discussed that, for young people using substances, breaking pandemic-related public health restrictions by using with friends not only provided them with the human connection they were missing, but was actually a safer option in terms of mitigating the risks of an overdose than using alone. When viewed from this perspective, we see the agency exerted by young people as they seek to heal and navigate their way through this pandemic snowstorm.



2. Practice Adaptations: Reaching out

During our discussions with providers, we got the sense that young people were not the only ones feeling a bit disoriented by the pandemic – providers were struggling to find their way too.

“Living in a context where we are powerless against this pandemic and the decisions being made is undermining the sense of self-control and self-efficacy that we all work really hard to empower the youth to have.”

Providers shared that, given the previously mentioned concerns – particularly around isolation and disconnection – they have adapted by adopting a more proactive approach to reaching out to youth and, sometimes, the broader community. However, as also noted in our survey data, this has meant most providers have modified their practices by primarily (or as a preferred option) reaching out through virtual/phone supports, inadvertently creating a two-tier system – one for those with means and one for those without. We also got the sense that, for the most part, providers have not had a chance to further adapt their practices based on demographics such as race, gender, and sexual orientation.

Proactively reaching out to target mental health and substance use was discussed at a downstream individual level and at an upstream family/community/systems level. Several providers shared experiences of trying to address the immediate needs of young people, their families, and the larger community, while others shared their experiences with shelter diversion and reaching outside the homelessness sector.

A. Individual/family/community practice adaptations:

- **Hosting an outdoor drag show** – perceived as being especially appreciated by the 2SLGBTQ+ community of young people.
- **Setting up tents outdoors for bi-weekly drop-in mental health and substance use counselling** – included the incorporation of a drug usage tracking form to facilitate further discussion (e.g., types of substances, triggers for using, and whether using alone).

- **“Walking therapy”** – as the name implies, the mental health and substance use counsellor conducted physically distanced counselling sessions while walking with clients.
- **Instituting weekly community meals and staffing at night** (the residential program was not typically staffed during the night) – the latter led to a deeper appreciation of “the silence and the loneliness that was in the building.”
- **Enhanced street outreach**, including providing printed information on what services were open/closed, assisting with system navigation (e.g., pregnant client with complex health needs experiencing homelessness and using a wheelchair), and meeting basic/harm reduction needs (food, clothing, clean needles, etc.) – seen as vital for underserved young people.
- **Connecting with the guardians of youth living** in residential transitional housing programs to, “Come parent your kid in the house. We’ll make room. We’ll get out of your way.”
- **Utilizing chefs already employed by the organization** to make large casseroles on a weekly basis for families in the community to pick up.

B. Broader adaptations:

- **Successfully advocating for donor funding be used to supply free iPads for youth** – helped facilitate connection to virtual supports.
- **Reaching out to the provincial representative for Children and Youth on behalf of young people at risk of losing their housing to collaborate on a plan for housing stabilization** – “Normally, we have a call maybe once a month, maybe once every two months, but we called them about everybody.”
- **Proactively connecting with funders** to outline which programs were being amended and the impact on pre-pandemic outcomes.
- **Enhanced effort to divert youth from shelter and reconnect them with natural supports** – “There was much more consideration around what role family can play.”

C. Two-tier supports: “Technology is a luxury”

Glancing through the list of practice adaptations, one quickly realizes that, for the most part, these adaptations require young people to have an established relationship with the provider/organization. Moreover, the rapid pivot to virtual/phone supports exposes a new kind of inequity – digital poverty – meaning these technological substitutions for in-person interventions are luxuries not available to all, further exposing the class divide among youth who have experienced or are experiencing homelessness.

Two-tier supports were especially evident when discussing young people struggling with substance use and residing outside the shelter system. As one substance use counsellor noted:

“[...] there’s been a sudden stop of support because they [front-line colleagues] can’t actually go out and physically meet with youth even though they know where they are. Everything just got shut down. Technology is a luxury to have, and that’s been a massive barrier to youth who are experiencing homelessness to be able to access substance use and mental health counseling because our program is only being offered online or over the telephone.”

D. One size fits all: “Funnelled through like everyone else”

While all providers agreed that mental health and substance use patterns were disproportionately impacting some groups of young people (e.g., racialized and 2SLGBTQ+ youth) more than others, there seemed to be a one size fits all approach to service delivery. For example, one mental health and substance use counsellor was particularly troubled by the challenge of providing culturally-informed care to Indigenous young people:

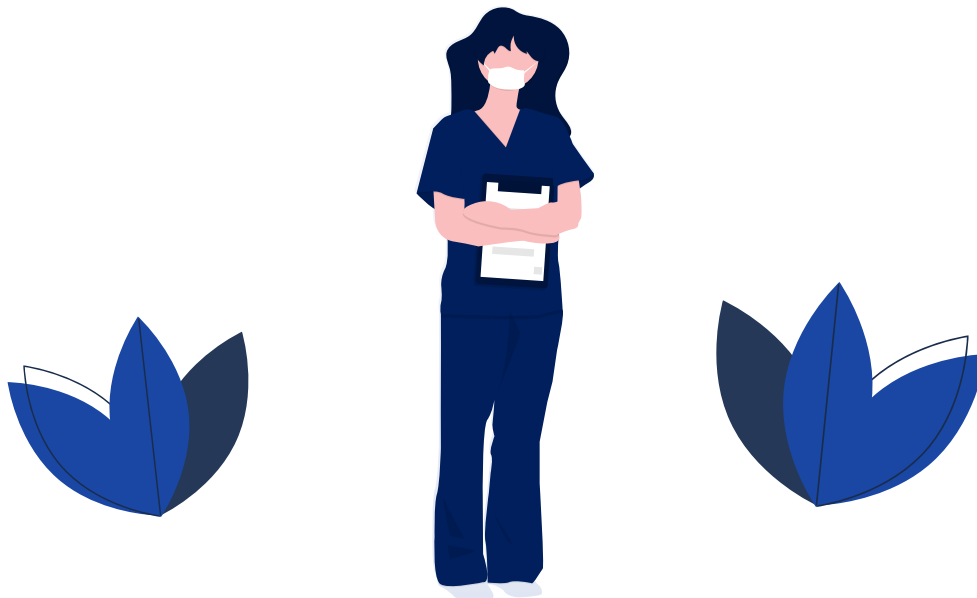
“I want to mention our Indigenous youth. They’ve been forgotten in this pandemic. We’re talking about government municipalities putting out initiatives to protect us, but those initiatives don’t incorporate Indigenous ways of learning. They don’t incorporate Indigenous ways of culture or language. So, a lot of our Indigenous youth again are being put into this lens and kind of funnelled through just like everyone else.”

One thing we do know about Indigenous youth and recovery is that it has to come from a place of healing, and that starts with the community. But when we've taken away that community, we've taken away their process of healing. [...] we haven't really created a platform for Indigenous youth to connect to their culture."

Paradoxically, another provider – a physician specializing in street medicine – noted how health and social supports were so specific, they were having trouble providing holistic care to their pregnant client in a wheelchair:

“[...] there was just nowhere she could go for the support that she needed because supports were so siloed. There were supports for homeless young people. There were supports for disabled people. There were supports for pregnant people. But there wasn't anything that actually met her needs as a person.”

Evident from these excerpts is that, like the young people they serve, providers are also caught in a system created around dominant ways (i.e., non-Indigenous and non-intersectional) of understanding how to address health inequities.



3. Promising and Transformative Approaches: The magic wand question

While many of the aforementioned downstream and upstream practice adaptations shared by our focus group participants were creative, we understood that these adaptations were born out of necessity – a way of weathering the pandemic storm. However, as the title of this report (and our study) implies, our aim was to get at promising approaches – a better way of meeting mental health and substance use needs – that may hold post-pandemic potential for young people who are experiencing or have experienced homelessness.

To explore practice adaptations with post-pandemic potential, we asked providers to imagine they had a magic wand and could make any changes they liked to the way they delivered mental health and substance use services to the young people they serve. Notably, just like in our survey responses, providers mostly commented on the way these services should be delivered rather than expanding on the practice adaptations themselves. In other words, the medium (e.g., phone/virtual supports) seemed to be less important than the message (ensuring youth felt supported/connected). They also spent more time talking about system-level reform rather than individual-level interventions.



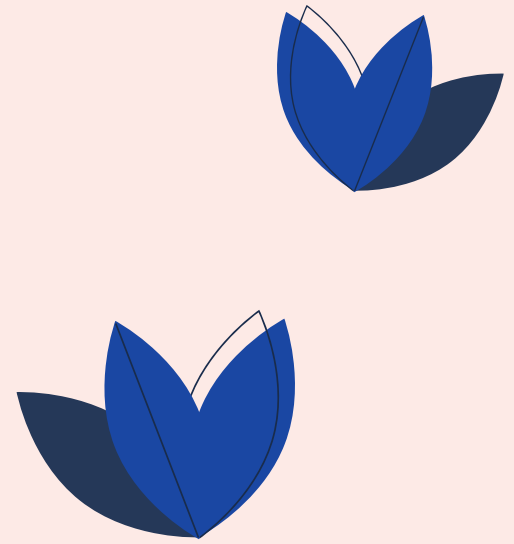


We have included all of their “wishes” here:

- Free phones/phone plans/internet
- Enhance funding for program staff
- Continue offering a hybrid of virtual/phone and in-person access to mental health and substance use supports – provide youth options and demonstrate flexibility
- Private/safe spaces for youth to engage in virtual counseling
- More funding for shelter diversion – emphasize connections to family and natural supports instead and engage family in care planning
- Enhance funding to the social service sector – especially to those disproportionately impacted by the pandemic
- Enhance collaboration with providers from other organizations – more external consultations – be open to seeing/doing things differently
- Triage intakes – start with a “lighter touch” – not everyone needs intensive case management
- Constantly assess and adapt practice based on youth outcomes (and let youth know providers can/will adapt)
- Reduce the long wait list for mental health services

Shelter diversion was spoken about most often – not just in the magic wand question but throughout our focus group discussions – which is remarkable given all of the focus group participants worked in the homelessness sector. In other words, their idea of promising and transformative approaches would be for young people not to need them at all.





Section 4

Youth Focus Group

Six young people – all from Ontario – participated in our youth focus group. All of them were living independently but had experienced homelessness within the past two years. All had been receiving care for mental health and/or substance use immediately prior to or during the pandemic. The average age of the participants was 23 years. Three young people identified as Black, one as Indigenous, and two as white. Two identified as transgender, two as non-binary, three as female, and two as male (participants could select multiple gender identities).

We intentionally asked our youth focus group participants relatively the same questions we asked the provider group participants so we could compare/contrast the responses. A unique aspect of this focus group was that all of the participants had past (not current) experiences of homelessness. Therefore, while providers shared their view from the inside (of the shelter system) out, the young people shared their perspective from the outside in. Just like the provider focus groups, our aim was to uncover practice adaptations with promise – adaptations that especially resonated with the youth. However, similar to the provider focus groups, the young people had much more to say about the context in which these adaptations were occurring rather than the practice adaptations themselves.

We begin this section by exploring youth perceptions of how the pandemic has impacted young people who are experiencing or have experienced homelessness and struggling with issues related to mental health and/or substance use. Then, we examine what young people had to say about how providers have adapted to these impacts. We conclude by exploring what practice adaptations youth felt might hold post-pandemic promise.



1. Impacts on Mental Health and Substance Use Patterns: “I like things in person”

All of the young people shared that the pandemic had put a strain on their mental health. One acknowledged an increase in substance use as a way to cope. Youth described feelings of isolation, loneliness, lack of routine, and boredom as contributing factors to their struggles with mental health. Moreover, the importance of in-person connection came up throughout our discussion.

“My greatest challenge has been not being able to access supports in person. I like things in person – just having that routine of going. I was off work from March until June. [...] being off work and school, and not having a lot to do, I kinda declined in my mental health. I just became very isolated and alone and not really going out as much.”

This excerpt highlights the lack of routine and limited social connections in key domains of life such as employment and education – areas that have the potential to foster a sense of socioeconomic inclusion and prevent homelessness from reoccurring. When viewed from this perspective, we can appreciate the unintended negative consequences to mental health when these domains, along with in-person supports to help sustain transitions away from homelessness, are suddenly disrupted.



2. Practice Adaptations: “There’s not a lot of resources”

Unlike our discussion with providers about practice adaptations, youth did not share many examples of the adaptations themselves. In fact, there was an overall sense that resources specific to mental health and substance use were limited. Instead, the conversation centered around their experiences of accessing these adaptations, which they characterized as primarily consisting of phone/virtual supports. We also had an unanticipated and insightful conversation around system navigation.

“It’s really hard for me to be able to wait very long or to be put on a waiting list. I understand they have a waiting list. But there’s a lot of youth out there who have issues and anxiety and everything. I’m one of them. It’s hard to know that in this pandemic, there’s not a lot of resources.”

A. Drop-in appointments: “It’s hard to plan needing support”

Several young people discussed their regular use of drop-in spaces prior to the pandemic. Many of these spaces were now closed or operating on an appointment-only basis. As the name implies, drop-in means that the youth were able to use these spaces at a day and time that worked best with their schedules – especially important for youth engaged in activities like employment and education. As one youth noted, young people cannot always anticipate when they might need support:

“Sometimes it’s hard to plan needing support. Sometimes things come up and you unexpectedly need support but you can’t just drop in and get it.”

B. Phone/virtual supports: A double-edged sword

Youth shared mixed responses regarding their sense of the useability and effectiveness of mental health and substance use supports being adapted from in-person to phone/virtual, which aligns with providers’ perceptions from our survey data. Some young people appreciated the flexibility that phone/virtual supports provided in terms of not needing to leave their homes (especially important for those really struggling with their mental health) and enjoyed the opportunity to connect with young people from more distant locations

during on-line group therapy. Others expressed frustration over adaptations like on-line group therapy (most often describing cognitive behavioral therapy or dialectical behavior therapy), citing challenges around staying engaged/focused and developing relationships with fellow group members, problems with technology, and questioned the effectiveness of on-line group therapy. Some shared frustrations over long wait times for on-line group therapy, while others sensed that providers who had not adapted to phone/virtual supports were waiting until the pandemic was over to offer the “more beneficial” in-person therapy:

“What ended up happening was the service I was trying to access felt it was more beneficial for them to meet their clients in person so it became a longer wait because they had to wait until it was safe to start meeting people in person again. So what should have taken a couple of months to get processed has now been seven or eight.”

“[agreeing with youth cited above] I don’t think that the services are leaning towards online. I think they’re all – or most of them – are moving towards waiting until after COVID. If they’re waiting until the end of it then we’re all gonna be waiting for ever and ever and ever to access these resources. Why can’t we access these resources now over the phone or aka a Zoom meeting? [...] I can’t wait that long for somebody to say ‘WOO WOO’ you got something.”

Here, we see the conundrum providers find themselves in: adapt to the demand for mental health and substance use supports by offering phone/on-line supports which may not be accessible or effective for all, or try to find a safe way to continue offering in-person mental health and substance use supports. Arguably, a hybrid of approaches may make the most sense moving forward and aligns with what providers shared in response to the aforementioned “magic wand” question posed during their focus groups.



C. Reaching out: “It’s better than being an octopus”

During our focus group discussion with young people, we noticed how often they normalized the work of navigating access to the supports they needed. These conversations were in contrast to our conversations with providers, who showcased the multiple acts of reaching out from their own standpoint. In other words, young people needed to be just as – if not more – proactive than providers and, it was so commonplace for them, they did not think to highlight that as being problematic:

“[...] I’ve set up meetings with my workers. And like, ‘Here’s what I need help with and here’s what you can help me with.’ Just break down each task as I go. It’s better than – it’s better than being an octopus with 10 arms.”

Notable from this excerpt is reference to the siloed nature of supports that require youth to navigate many “arms” of support. In addition, this youth perceived they needed to break down their requests into manageable tasks – a skill that may be challenging for those with particularly comprehensive mental health and substance use needs. In fact, when we asked youth what advice they would give to other youth trying to access supports for mental health and substance use during the pandemic, they used phrases like “don’t give up”, “advocate for yourself”, “make a list of what kinds of support you need”, “know exactly what you want”, and “research different things.” Again, this is telling of the invisible work required by young people who are experiencing or have experienced homelessness.



3. Promising and Transformative Approaches: “It gets a little sad and a little exhausting”

To understand what practice adaptations especially resonated with participants and to learn how providers might adapt their practices to better meet the needs of young people going forward, we asked participants to share their “ideal” way of receiving care. All of the participants spoke about the importance of in-person communication – especially when establishing a new relationship with their provider. One participant expressed fatigue with alternate forms of communication:

“I think the online stuff is, is good too. But I also think that in order to have healthy relationships, healthy friendships, and healthy work relationships, I think it’s also good to be in-person as well. I seem to be cooped up, always on the internet, or always doing things by Zoom or phone call. It gets a little sad and a little exhausting sometimes.”

The notion of fatigue resonated with other participants too, and they shared how much easier they found it to communicate in person and articulate their needs – especially if English was not their first language:

“I don’t know how to put it, but when I see a person face-to-face, like their expression and how they are moving, I understand what that person is feeling. And also with my school, to do it online, it’s not really that easy because there’s a lot of English and I’m still learning English. If I’m seeing the teacher in person, while the teacher is explaining everything, I understand, this is what he is saying. Also, you can meet friends and be like, ‘What is the teacher saying?’, then they can explain better. But online, but you have to figure everything else yourself.”

This excerpt highlights the disproportionate impacts of the pandemic, even among youth who have experienced homelessness. In this example, a racialized woman whose first language is not English, is sharing her added challenges with on-line learning. Additionally, as evident in the beginning of the excerpt, the inability to observe facial expressions and body language in-person, exacerbates a sense of disconnection.

Breaking down barriers: The magic wand question

Just like in the provider focus groups, we ended the youth focus group with our “magic wand” question. We told young people to imagine they could change anything about mental health and substance use supports for young people experiencing homelessness. Notably, similar to the provider responses, the young people spoke more about the context in which these services were delivered rather than the services themselves. However, unlike the provider responses, no one spoke specifically about phone/virtual supports. Instead, they spoke broadly about breaking down barriers to access. We were again struck by the work required to access support and also by the perceived stigma for reaching out. In other words, young people felt they must be the ones to initiate requests for help; however, at the same time, they felt judged for seeking that help.





We have compiled their “wishes” here:

- **Stop the stigma** – “I would change the stigma for reaching out for help and [discussing] the taboo topics. Like sometimes you feel judged, and also you feel like sometimes there’s a little bit of favouritism.”
- **Reduce barriers to accessing supports** – “I would reduce the barriers in accessing services. If you are just getting into accessing support it’s really hard to navigate. Generally make it easier because if you don’t know what you’re looking for, you don’t know what supports you need, and it can be really intimidating to try to access any support.”
- **Help us understand what supports are available** – “It is sometimes hard for homeless people or people who are just getting out of homelessness to access supports that are not offered to them. I’ve seen a lot of homeless people say, ‘I’ve never been offered mental health support, I’ve never been offered this, I’ve never been offered that.’ It’s really hard because people living on the streets don’t know about these connections. It would be good to have more workers out walking the street to find these homeless youth, to be able to give them access, to be able to give them more resources, because I don’t see that a lot in the community.”
- **Relax access criteria** – “They [youth] have to hit all the specific criteria between a certain time frame for a lot of programs and services. And that can be really difficult. If we know we have to be homeless within a month to access this service and okay, well it’s been 32 days, and I was couch surfing, so it’s not officially homelessness. All of these things.”
- **Mentors as friends** – “I’d prefer mentors to be more friendly if they’re meeting us [this youth was in a mentorship program]. And I’d also wish for the mentors to know exactly what the youth want. Because it’s really hard for the youth to just say what they really want.”

At several points during this time of sharing their wishes, youth were enthusiastically nodding, giving a “double thumbs up”, or verbally agreeing with each other. Clearly, their wishes around breaking barriers resonated with everyone. A common thread through all of these excerpts is the desire for someone to help these young people navigate the complexities of accessing support. This becomes especially poignant when we consider the pandemic snowstorm of inequities in which youth must traverse.



Section 5

Discussion

The aim of this knowledge synthesis was to deliver real-world evidence on promising mental health and substance use practices utilized during the COVID-19 pandemic by front-line providers working with young people who were experiencing or had experienced homelessness. However, the evidence we uncovered over the past five months has been less about downstream individual-level interventions and more about the need for upstream structural interventions. In fact, the providers and young people we heard from were almost silent on the promise of individual-level practice adaptations; that too is data (Eakin & Gladstone, 2020).

As it turns out, our survey and focus group participants' responses were in line with the recently released report from the Chief Public Health Officer of Canada: *From Risk to Resilience: An Equity Approach to COVID-19* (Public Health Agency of Canada, 2020). Dr. Theresa Tam notes that, during the process of developing the report, the evolving evidence around the relationship between COVID-19 and the social determinants of health dictated “a focus on broader approaches and principles, rather than on specific interventions” (p. 63).

Over the past five months, we have collectively witnessed that COVID-19 is not impacting all Canadians equally. For example, in Toronto, people from racialized communities, newcomers to Canada, people with lower education levels, people who are unemployed or have low incomes, and people who live in crowded households have notably higher COVID-19 case and hospitalization rates compared to the group with the lowest percent of each (City of Toronto, 2020). Arguably, young people with current or past experiences of homelessness fall into many/most of these high-risk groups (Gaetz et al., 2016; Kulik et al., 2011).

While there is a pressing need to understand what individual-level practice adaptations utilized during this pandemic hold promise to meet the mental health and substance use needs of young people who are experiencing or have experienced homelessness, it is essential that we situate this need and our response within the broader societal context in which youth find themselves. The way we frame a health issue is important because it will influence our understanding of the solutions (Raphael & Curry-Stevens, 2016). For example, if the problem of worsening mental health and substance use is caused by/connected to structural determinants of health such as racism, insufficient housing, precarious employment, and poverty, and not individual “vulnerability” (a term that denotes weakness and is used all too often when referring to youth experiencing homelessness), then it is logical that the proposed solutions should encompass structural interventions.

We have provided insights into promising individual-level practice adaptations in our discussion; however, we have also endeavoured to critically examine the evolving societal landscape in which these adaptations are occurring, and suggest some transformative structural-level changes as well. For ease of reference, we present our findings within the three study domains:

- 1. pandemic impacts on mental health and substance use patterns;**
- 2. practice adaptations; and**
- 3. promising and transformative approaches to mental health and substance use care.**



1. Pandemic Impacts on Mental Health and Substance Use Patterns

The survey data on provider perceptions of pandemic impacts on mental health and substance use patterns is concerning but aligns with emerging peer-reviewed evidence on this population (e.g., Tucker et al., 2020) and with what young people shared during our focus group discussion – particularly in the area of mental health. Indeed, international mental health experts, including academics and clinicians, are warning of a mental health pandemic, emphasizing the urgent need for prevention and early intervention – especially among marginalized/underserved populations (Galea et al., 2020; Moreno et al., 2020).

Our focus group discussions with providers and youth highlighted the snowstorm of intersecting inequities young people (and providers) are trying to navigate during this pandemic. In addition to dealing with struggles related to mental health/substance use and pandemic-related closures (job, school, drop-in centres, etc.), most young people have friends/family at high-risk for getting COVID-19 or belong to a high-risk group themselves. Furthermore, current public health restrictions and ensuing service limitations operate on the assumption that young people: have a place to isolate; can isolate safely and with others; can afford phones/computers; and have access to the internet.

An additional layer of complexity is the impact of highly publicized anti-Black and anti-Indigenous racist acts during the pandemic, which providers noted have been (re)traumatizing for many youth, exacerbating the sense of decreased social connection and belonging common among many young people who are experiencing or have experienced homelessness (Kidd et al., 2016; Thulien et al., 2018; Thulien et al., 2019). Finally, reports of 2SLGBTQ+ youth having to move back home to non-affirming families and/or having limited access to supportive friends/spaces is especially concerning given the high rates of suicidality in this group of young people (Gaetz et al., 2016; Green et al., 2020).

A. Mental Health Patterns

Provider perceptions that almost all the young people they served were struggling with boredom and loneliness resonated with our youth focus group participants. While the notion of boredom might, at first glance, seem anticipated and relatively unimportant, this concept is emerging in homelessness literature – especially in the occupational science domain – as anything but benign. A recent scoping review of boredom and homelessness

highlighted the link between boredom and a host of negative outcomes, including struggles with mental health and substance use (Marshall et al., 2019). Additionally, perceptions of loneliness are an important consideration given the sense of isolation and “outsiderness” that can persist even after young people have left the shelter system (Thulien et al., 2018, p. 94). Finally, provider beliefs that the overwhelming majority of their clients/patients were experiencing increases in anxiety, depression, sleep disturbances, and acuity/symptoms related to pre-existing mental health is alarming but consistent with emerging evidence.

Ninety young people (average age 22 years) with current or past experiences of homelessness enrolled in an ongoing clinical trial in the United States (U.S.) were asked about their mental health symptoms in the past week (questions were asked between April and July 2020) (Tucker et al., 2020). The young people reported experiencing hopelessness (48%), anxiety (44%), loneliness (38%), sleep problems (34%), and depression (36%). In addition, they noted that, since the pandemic began, it had been a little or a lot harder to access mental health (44%) and case management (42%) supports. While the pre-COVID-19 baseline scores related to emotional distress are not provided for comparison, these symptoms, along with the reported decrease in ability to access mental health and case management supports, are concerning and very much resonate with our survey and focus group findings.

Similar findings of pandemic-related mental health struggles are being reported in the general population. A survey conducted in April 2020 by the Centre for Addiction and Mental Health (CAMH) with 622 young people (aged 14-27) across Ontario found that 68% of youth who had previously sought mental health support reported significantly increased problems with mood and anxiety since the pandemic began (CAMH, 2020a; Cribb, 2020). More recently, a national survey conducted by CAMH in September 2020 with 1,003 Canadian participants revealed that, among respondents 18-39 years of age, many were struggling with moderate to severe anxiety (30%), loneliness (29%), and depression (27%). Overall, these symptoms were notably more prevalent among those with additional challenges such as financial strain (e.g., 46% of respondents struggling with anxiety reported feeling very worried about personal finances) and job loss (e.g., 44% of those struggling with depression reported they lost their job or were no longer working due to the pandemic) (CAMH, 2020b).

Taken together, this evidence highlights the disproportionate emotional toll of the pandemic, and reinforces the need to pay special consideration to the mental health of young people with current and past experiences of homelessness, who are more likely

than the general population to have pre-existing mental health challenges, struggles with financial hardship, and employment uncertainty (Gaetz et al., 2016; Thulien et al., 2018). Moreover, given the demand for mental health services is likely to increase (Galea et al., 2020; Moreno et al., 2020), there is an urgent need for front-line providers working with young people who are experiencing or have experienced homelessness to meet this demand in a way that is responsive to the social and emotional needs of the young people they serve.

B. Substance Use Patterns

The survey responses regarding substance use patterns among youth depict a concerning picture of a perceived marked increase in use combined with some providers noting a decrease in access to supports such as harm reduction materials, safe supply or substitution, and support groups. A qualitative study conducted by the Canadian Centre on Substance Use and Addiction (CCSA) in April 2020 with 17 key informants (12 people with lived experience of substance use and five people who provided harm reduction services) revealed themes similar to our own – particularly in the area of increased social isolation and reduction in substance use supports (CCSA, 2020). The study authors also noted that participants spoke about fear over health vulnerabilities (e.g., compromised immunity), which was felt to be exacerbated by inequitable living conditions such as marginal/overcrowded housing (CCSA, 2020).

Prior to the pandemic, young people in Canada aged 20 - 29 years represented 20% of all opioid-related deaths (Government of Canada, 2020), and youth aged 15 - 24 years were the fastest growing population hospitalized for opioid overdose (Government of Canada, 2019). Thus, we now have two public health crises on our hands: the COVID-19 pandemic and the opioid epidemic. In addition, recent data from the U.S. highlights that individuals with a recent (within the past year) substance use disorder (SUD) – especially those with an opioid use disorder (OUD) – are at significantly increased risk of contracting COVID-19 and having worse clinical outcomes (Wang et al., 2020). And, among patients with recent diagnosis of SUD, African Americans had significantly higher risk of COVID-19 than whites, with strongest effect for OUD (Wang et al., 2020). Here again, we see the inextricable link between COVID-19 and other determinants of health like race and substance use.

The perceptions by our survey respondents regarding an increase in substance use and decrease in corresponding supports align with emerging evidence on how the pandemic is impacting young people with current or past experiences of homelessness who engage in substance use. In the aforementioned Tucker et al. (2020) study, young people who

had used substances before the pandemic reported an increase in use of alcohol (16%), tobacco (20%), and marijuana (28%) compared to pre-pandemic. Similar to the reported challenges around access to mental health supports, almost one third (32%) noted it was a little or a lot harder to access substance use services.

More than one third of survey respondents noted that they believed drug overdoses had increased since the pandemic began. Data coming from provinces like Ontario, Alberta, and British Columbia is confirming these beliefs (PHAC, 2020). For example, in September 2020, Toronto Public Health reported a 113% increase in drug-related deaths (from all drugs) compared to the median number of weekly drug-related deaths that occurred in 2019 (Toronto Public Health, 2020). In British Columbia – the province most severely impacted by the surge in overdose deaths (PHAC, 2020) – there was a 112% increase in the number of drug-related deaths in September 2020 compared to the number of drug-related deaths in September 2019 (Ministry of Public Safety & Solicitor General, 2020). To put this in perspective, this amounts to more than four people dying every day in British Columbia (Ministry of Public Safety & Solicitor General, 2020). In addition, recent data from British Columbia highlights that Indigenous Peoples are disproportionately dying from drug overdoses (PHAC, 2020).

Notable from our survey data was that providers seemed to be losing sense of what was happening with their clients given approximately half reported they were unsure if the young people they served had access to supervised injection sites. Admittedly, this survey was done in June 2020, and providers may have more clarity now. However, to state the obvious: A marked increase in substance use and overdoses combined with ongoing lack of clarity around whether young people have access to appropriate harm reduction provisions is a recipe for disaster.



C. Providers

The COVID-19 pandemic is placing tremendous strain on agencies/organizations and providers. Demand for mental health and substance use supports is high and likely to rise (Moreno et al., 2020). At the same time, the vast majority of our survey respondents reported that they were feeling burned out and struggling with their own mental health. As we have heard so many times during this pandemic: The pandemic is a marathon, not a sprint. In other words, agency/organizational leaders will need to move past an immediate/emergency response – a common critique of the homelessness sector (Gaetz et al., 2018) – to more sustainable, long-term planning. This will mean getting creative and re-imagining how to effectively address the mental health and substance use needs of young people, and situating those needs within the broader social and economic context of their lives. Doing this successfully will require concerted and sustained effort on behalf of providers, who require strong and visionary agency/organizational and political (federal, provincial, and municipal) support.



2. Practice Adaptations

Despite the pressing need for enhanced mental health and substance use supports, survey respondents noted that most agencies/organizations had either shut down their services entirely or (more commonly) moved them all off-site (e.g., phone/virtual vs. in-person supports). While this has likely improved somewhat since June 2020 (when the survey responses were solicited), those of us practicing clinically are still doing so with restrictions (e.g., youth with COVID-19 symptoms – which can range from a sore throat to diarrhea – are not typically seen in-person), and providers participating in our July 30th and August 6th groups were continuing to primarily deliver their services off-site. Additionally, youth participating in our September 10th focus group noted ongoing disruption with access to mental health and substance use supports.

Before we expand on provider practice adaptations and youth perceptions of those adaptations, it is important to emphasize that we are living in unprecedented times and providers serving youth who are experiencing or have experienced homelessness are doing their best to keep up. Moreover, providers are working in a field with limited rigorous evidence on how best to address youth homelessness (Morton, Kugley, et al., 2020). For example, a recent review of interventions designed to address and prevent youth homelessness – a review that included quasi-experimental evaluations (often not included in systematic reviews) – found that, of the 54 interventions reviewed, the majority were of low quality (e.g., poor design and small number of participants) and lacked long-term follow-up (Morton, Kugley, et al., 2020). Additionally, there was very limited evidence on how the effects of interventions varied by subpopulations disproportionately impacted by homelessness (e.g., 2SLGBTQ+, Indigenous, and racialized youth) (Morton, Kugley, et al., 2020). The authors caution that many of the program models communities and governments rely on to address youth homelessness (e.g., rapid rehousing, host homes, transitional living programs, and shelters) are not substantiated by rigorous studies. When viewed from this perspective, we can appreciate the monumental challenge providers face trying to navigate mental health and substance use needs during a pandemic without adequate evidence to guide the way.

The majority of survey respondents stated they had adapted their practice by delivering services pertaining to mental health and substance use over the phone (most common) or virtually; however, most providers also reported that youth seemed either neutral (i.e., “take it or leave it”) or dissatisfied with these adaptations. Moreover, when commenting on adaptations specific to substance use, approximately one quarter of providers

were unsure what youth using substances thought of the practice adaptations, which is understandable given the aforementioned uncertainty around what is happening with this population in general.

Survey respondents were right to question the acceptability of their practice adaptations. During our focus group with young people, they spoke frequently about the importance of in-person relationships. It was not that they did not appreciate the benefits of phone/virtual supports; however, most felt that these supports were better suited for one-on-one (vs. group) counselling and for pre-established (in-person) relationships. Many expressed frustration around the long wait times for mental health supports, which they felt had worsened since the pandemic began. Some felt the wait times had become worse because some providers were reluctant to pivot to phone/virtual supports, holding out for a time when it would be safer for in-person visits to resume. Also, the notion of fatigue with on-line communication resonated with many participants and is an important consideration.

A recent paper by a group of Canadian experts in child and youth mental health highlights many of the concerns brought up by our survey respondents and focus group participants (Madigan et al., 2020). The authors note that phone/virtual mental health supports have the potential to enhance access to mental health care during the pandemic; however, there are important limitations relevant to young people with current or past experiences of homelessness. In particular, Madigan et al. caution that some clients may not be able to afford these forms of support, may not have a safe place to speak privately, and may not be able to sustain the focus required to participate in on-line counselling. They suggest a hybrid approach to phone/virtual supports may prove beneficial, where building rapport is done in-person and then clients are transitioned to phone/virtual supports.

It is important to point out that none of the young people in our focus group would be considered “homeless” anymore; yet, they still depended on in-person drop-in supports, citing the value of having as-needed care, even after exiting homelessness. In fact, as mentioned in our focus groups findings, we were struck by the amount of system navigation (“octopus”) work required of and normalized by the young people. The reliance on post-homelessness supports and the unpredictable nature of these needs aligns with longitudinal research on youth exiting homelessness (Kidd et al., 2016; Thulien et al., 2018; Thulien et al., 2019). Careful consideration must be made before providers and the agencies/organizations they work for pivot to “drop-in by appointment only” services as this may exacerbate the challenges – including system navigation – faced by young people exiting homelessness.

Our focus group discussions with providers enabled us to further explore practice adaptations. Overall, providers discussed adaptations that were admirable and creative (e.g., outdoor drop-in counselling tents, walking counselling sessions, and shelter diversion through proactive outreach to government agencies and natural supports); however, two issues came to the forefront as we integrated our focus group and survey data: 1) inequitable access, and 2) the need for human connection.

For the most part, practice adaptations described by providers – in the focus groups and through the survey – were directed at young people with whom they had pre-existing relationships. It was less clear how providers might connect with young people who had never heard of them or their agency/organization. Although marketing mental health and substance use services through social media might help reach underserved youth during the pandemic (Cohen & Bosk, 2020), it is important to keep in mind not all of these young people will have reliable (or any) access to social media, especially if their financial situation is made worse by pandemic-related job closures. As the move to virtual/phone technology accelerates, providers must be attuned to and address the growing concern over digital poverty and digital literacy (PHAC, 2020; Seah, 2020), ensuring they do not inadvertently create a two-tier system of access.

The importance of human connection was underscored by providers (in the survey and focus groups) and youth, and a core theme throughout our three study domains. Providers emphasized that healthy relationships and strong community supports were important sources of strength and healing for young people with current and past experiences of homelessness – especially for 2SLGBTQ+ and Indigenous young people. A 2020 National U.S. survey of over 40,000 2SLGBTQ+ youth found that 40% of respondents (aged 13-24 years) reported seriously considering attempting suicide in the past 12 months; however, attempting suicide was less likely among those who had at least one in-person affirming space (12% at least one space vs. 20% no space) and those who had high levels of support from family, friends, or a special person (13% high support vs. 22% low support) (The Trevor Project, 2020). In addition, a recent rapid review of factors that may help protect Indigenous Peoples and communities in Canada and internationally from the COVID-19 pandemic and its impacts, identified the community (e.g., wisdom of elders and traditional ways of caring/expression) as a key source of strength (National Collaborating Centre for Methods and Tools & National Collaborating Centre for Indigenous Health, 2020).

In summary, the emphasis on phone/virtual practice adaptations is understandable given the requirement to align with pandemic-related public health measures; however, the implications for young people who prefer/depend on in-person supports – especially the most marginalized (e.g., transgender, refugee, and street-entrenched young people) – are worrisome. Providers must be careful not to inadvertently perpetuate access inequities – already common in this population (Kulik et al., 2011) – by pivoting to phone/virtual care without having a concurrent plan around addressing resource-related barriers to access. Crucially, the importance of community and personal relationships should not be underestimated.



3. Promising and Transformative Approaches

To get at our final objective of uncovering promising practice adaptations with potential to transform how mental health and substance use care is delivered, we asked everyone participating in the survey and focus groups to expand on the potential of current adaptations, and to imagine how ideal mental health and substance use services might look. Overall, we got the sense that provider practice adaptations were made out of necessity and not necessarily because the adaptations represented a better way of serving young people. In other words, responses pertaining to this domain were not what we envisioned at the outset of this research. That said, the ambivalence on behalf of providers and youth makes sense given providers had to rapidly adapt their practices, and do so in a sector plagued by insufficient evidence on how interventions impact long-term outcomes – including socioeconomic inclusion and housing stability (Luchenski et al., 2017; Morton, Kugley, et al., 2020) – to guide the way.

Admittedly, at first glance, some of the adaptations suggested by providers and youth might not seem particularly promising or transformative. However, on closer examination, we believe that, with adequate resources (e.g., staffing and financial support), more rigorous evaluation, and attention to the social determinants of health (e.g., equitable social and economic inclusion), several of these adaptations might signal a better, more youth-centred way of approaching the mental health and substance use needs of young people who are experiencing or have experienced homelessness.

A. Proactive Outreach

The majority of providers commented on the need to adopt a proactive approach to outreach through more consistent and frequent check-ins. This appears important for two reasons: 1) clients who struggle the most with their mental health may not reach out on their own; and 2) the consistency of regular check-ins helps to combat boredom and the ensuing emotional distress, reinforcement of low socioeconomic position (i.e., need finances to keep occupied), and existential crisis (i.e., questioning why one exists) that can accompany a persistent lack of structure and routine (Marshall et al., 2019). Additionally, given the sense of social and economic exclusion experienced by many young people who have transitioned out of homelessness (Thulien et al., 2018; Thulien et al., 2019), it makes sense – especially given our current economic downturn – for providers to make

a concerted effort to connect with clients who have moved on to independent housing. Indeed, young people participating in our focus group certainly expressed the need for enhanced relational connection.

The link between social disconnection and mental health challenges has been studied for more than 100 years. In 1897, French sociologist Emile Durkheim wrote about how the act of suicide was lowest in societies that had the greatest degree of social cohesion (Berkman & Krishna, 2014). Since then, our understanding of the concept of social cohesion (connection between individuals/groups) has grown, and social cohesion is considered to be an important determinant of health (Solar & Irwin, 2010). A review of the potential impact of COVID-19 on suicide rates highlights that the mental health consequences of the pandemic may continue to rise even after the pandemic is over (Sher, 2020). The author emphasizes that social connection through proactive outreach is needed to help mitigate the risk of suicide – especially to those disproportionately impacted (e.g., underlying mental health and substance use challenges; living in a high prevalence area) by the pandemic (Sher, 2020).

One inspiring example of proactive outreach is from St. Michael's hospital in Toronto, ON. Early in the COVID-19 pandemic, the Social Determinants of Health Committee struck a working group to focus on patients/clients likely to be disproportionately impacted by the pandemic (St. Michael's Unity Health Toronto, 2020a). One of the initiatives of this interdisciplinary team of healthcare professionals is to conduct wellness check-ins. These proactive phone calls help providers assess issues related to income, personal safety, and food security, and connect people to the appropriate supports. Between March and June 2020, the team of 17 healthcare professionals had made more than 1,800 calls (St. Michael's Unity Health Toronto, 2020a). Investment in this sort of proactive outreach by providers working with young people who have experienced homelessness offers the possibility of intervening on challenges related to mental health and substance use before they lead to devastating consequences such as a return to homelessness or loss of life. Moreover, this approach would demonstrate an enhanced understanding of the inextricable links between mental health, socioeconomic context, and the COVID-19 pandemic.



The pivot to a mobile, holistic approach to care by some providers as a way to counteract pandemic-related closures is encouraging and links back to the need to adopt a proactive process to engage youth – especially those struggling the most with mental health and substance use. Active engagement through combining mental health services with things like meals, personal care items, and art supplies makes sense and aligns with an approach to health that aims to facilitate a sense of social inclusion and address social inequities among people who are experiencing or have experienced homelessness (Luchenski et al., 2017). A review of interventions targeting marginalized and excluded populations identified mobile outreach as a promising intervention for youth experiencing homelessness (Luchenski et al.); however, reviews of interventions specific to this population (e.g., Altena et al., 2010; Coren et al., 2016; Wang et al., 2019) have not identified this form of outreach in the peer-reviewed literature.

B. Phone and Virtual Care

The move to telemental health – psychological services delivered via text, telephone, or video conferencing (Madigan et al., 2020) – by the majority of providers could represent a promising adaptation. For example, in our experience working with young people who are transitioning out of homelessness in Toronto, we have seen many young people find more affordable housing outside of the downtown core, which often means a 30 – 45 minute transit ride downtown to access mental health and substance use supports. Telemental health could be more cost-effective for young people (e.g., no need to pay for transit or take time off work/school) and help facilitate a broader reach (Madigan et al., 2020). It could also help address the lengthy wait times for mental health services noted by youth and providers during our focus groups. However, as previously mentioned, primary reliance on this form of healthcare delivery also has the potential to exacerbate access inequities.

The feasibility, acceptability, and effectiveness of turning in-person mental health and substance use supports into telemental health during a pandemic is uncertain – especially for young people with current and past experiences of homelessness (Madigan et al., 2020; Moreno et al., 2020). While recent reviews of interventions specific to mental health and substance use in this population have highlighted promising approaches such as cognitive behavioural therapy (CBT) for depression and family-based therapy for substance use (Noh, 2018; Wang et al., 2019), all of those interventions were conducted in-person. Moreover, when looking at interventions for these young people in general, most are done with young people still experiencing homelessness (Morton, Kugley, et al.,

2020). Therefore, it is unclear whether these approaches might produce similar positive outcomes when conducted using telemental health techniques, and whether they would be effective with young people who are no longer experiencing homelessness.

There have been some recent systematic reviews of telemental health interventions in the general population that signal this form of intervention may hold promise for young people with current or past histories of homelessness. A meta-analysis of 17 therapist-supported electronic CBT (eCBT) interventions (most using video conferencing; four studies exclusive to children/youth), found that eCBT was at least as good as in-person CBT at reducing symptoms of depression (Luo et al., 2020). Lin et al. (2019) focused their review on telemental health (mostly video conferencing; none specific to youth) and SUD (nicotine, alcohol, and opioids). Their analysis of 13 studies found this form of care an effective alternative with high patient satisfaction; however, they noted there were some substantial methodological limitations with the studies and suggest more research is needed, including a deeper understanding of who might be most appropriate for this sort of intervention (Lin et al., 2019). Nesvåg and McKay (2018) analyzed 28 unique digital interventions (telemental health and virtual platforms; six specific to youth) targeting SUD (most commonly alcohol and polysubstance use) and found these interventions were generally feasible, and just over half (55%) of the studies with control groups generated some positive findings; however, the interventions were not consistently effective in helping people in recovery from SUD reduce their substance use or achieve other recovery goals.

Virtual adaptations outside of telemental health mentioned most often by providers and young people included utilizing self-serve applications (e.g., Woebot [CBT] and Calm [mindfulness]) and social media platforms (e.g., Instagram for live chats on mental health/substance use and providing mental health/substance use resources). We were able to find two studies of a self-serve mental health application specific to young people with current or past experiences of homelessness, although one study (Glover et al., 2019) was a modified and scaled-up version of the first (Scheuller et al., 2019). The application in both studies consisted of features such as questions about daily coping skills and a focus on behaviour change through CBT principles. The Scheuller et al. study also offered participants three telephone counselling sessions, while the Glover et al. study was fully automated. The Scheuller et al. study consisted of 35 young people and the intervention lasted for one month. While the intervention was deemed feasible, there was minimal change in clinical outcomes such as depression and emotional regulation at the one-month follow up period compared to baseline (Scheuller et al., 2019). The Glover et al. study consisted of 100 young people and the intervention lasted for three months. This intervention was deemed acceptable; however, no clinical outcomes were reported (Glover et al., 2019).

There are recent studies of virtual interventions outside of telemental health and not specific to this demographic that might hold potential for young people who are experiencing or have experienced homelessness. A systematic review of six internet-based CBT interventions (included two youth-focused interventions; four were self-guided) targeting suicidal ideation and behaviour, found internet-based CBT interventions for suicide prevention were associated with significantly reduced suicidal ideation compared with controls (Büscher et al., 2020). A pilot randomized controlled trial of a self-serve conversational text-based agent (Woebot), developed using CBT principles, demonstrated that young adults (average age 22 years) using Woebot had significant improvements in depression compared to the control group who were provided with an electronic book on depression (Fitzpatrick et al., 2017). Wang et al. (2018) conducted a systematic review of studies using mental health applications to target a range of mental health challenges (e.g., anxiety, depression, post-traumatic stress disorder, suicidal behaviour, SUD, and alcohol use disorder). After analyzing 17 studies (four targeted children/young adults), the authors concluded that mental health applications have the potential to improve the monitoring and management of mental health symptoms and disorders; however, they caution that the majority of applications on the market lack clinically validated evidence of their efficacy. Finally, a systematic review on the use of social networking sites in mental health interventions for young people (mean age range for the majority of studies 18 – 21 years) found high acceptability, significant improvements in mental health knowledge and number of depressive symptoms, but no improvement in anxiety or psychosis symptoms in the nine analyzed studies (Ridout & Campbell, 2018). Importantly, the authors identified moderation by clinical experts a key component of the more successful interventions. They suggest future studies are needed to address the lack of high-quality evidence for the efficacy of social networking sites in reducing mental health symptoms.

A noteworthy project that incorporates features of telemental health and social networking, and specifically targets 2SLGBTQ+ youth, is The Trevor Project. This California-based organization offers crisis intervention and suicide prevention services via phone, text, or on-line chat (Green et al., 2020). In addition, the organization offers “the world’s largest safe space social networking site for LGBTQ youth” where youth under the age of 25 years can connect with other young people for support (Green et al., 2020, p.2). While this telemental health project is not specific to youth experiencing homelessness, given the overlap between homelessness and 2SLGBTQ+ youth (Gaetz et al., 2016; Green et al., 2020), there may be some transferrable practices that warrant further investigation. In addition, analysis of 31 synchronous text-based chats (March – April 2020) from a U.S. national on-line chat-based support program for 2SLGBTQ+ youth (Q Chat Space) high-

lights that this form of support is crucial during the pandemic as it offers young people “stuck at home with unsupportive parents” a safe space to communicate without fear of being overheard (Fish et al., 2020, p. 452). In addition to helping young people cope with the interpersonal challenges of living with non-affirming parents, the authors found that on-line chats helped with intrapersonal challenges such as boredom and mental health deterioration, and structural challenges such as limited access to in-person community spaces (Fish et al., 2020).

C. System Navigation

As noted previously, after our focus group discussion with young people, we had a better appreciation of the amount of system navigation worked required of them. Additionally, when we asked young people to imagine what they would like to change about mental health and substance use supports, they described breaking down barriers to access and reducing the stigma of reaching out for help.

While there have been promising mobile applications to assist with system navigation for youth who engage with homelessness sector supports (e.g., Buccieri & Molleson, 2015; Greeson et al., 2020; Sheoran et al., 2016), an important consideration is whether the application will still be feasible once it is no longer being paid for and updated by the research team. One promising in-person navigation strategy utilized a strengths-based approach (youth met regularly with an advocate for six months), targeting a sense of personal control to link hard-to-reach young people (chronic homelessness, limited service use, and regular use of substances) to appropriate services, and demonstrated improvements in mental health outcomes (e.g., depression and self-efficacy) during the nine-month follow-up period (Slesnick et al., 2017).

Another navigation-focused approach (The Navigator Project) is being piloted by one of the authors of this report (Dr. Stephen Hwang) using a homelessness outreach counsellor embedded in the general internal medicine department of St. Michael’s hospital in Toronto, ON. After patients are discharged from the hospital, the outreach counsellor assists with system navigation in an effort to reduce hospital re-admission rates (St. Michael’s Unity Health Toronto, 2020b). Clearly, there is no one-size-fits-all approach to system navigation; however, it is important to reinforce that navigating the complexities and reducing the stigma of accessing mental health and substance use supports was a key feature youth wished for in an ideal system.

D. Early Intervention and Housing Stabilization

The notion of preventing homelessness from reoccurring through early intervention (e.g., enhancing family/chosen family and natural supports) and housing stabilization (e.g., facilitating appropriate mental well-being and economic supports) was a concept implicitly and explicitly woven throughout the qualitative data. Indeed, from a “promising and transformative” perspective, the idea of preventing homelessness from reoccurring warrants careful consideration as an effective way to tackle the mental health and substance use needs – predicted to worsen and last some time, even in the general population (Galea et al., 2020; Moreno et al., 2020) – of young people trying to navigate their way through the snowstorm of health inequities exposed and exacerbated by the COVID-19 pandemic.

Studies evaluating the effectiveness of family strengthening are promising in terms of mental well-being and health behaviours (e.g., substance use); however, little is known about whether these interventions prevent or reduce youth homelessness (Morton, Kugley, et al., 2020). Moreover, it is crucial that these sorts of interventions be accompanied by financial support as youth experiencing homelessness often come from families with inadequate incomes (Auserwald et al., 2020). Finally, as mentioned earlier in this report, young people with current or past experiences of homelessness likely have families that reside and/or work in areas disproportionately impacted by pandemic-related health and economic impacts. Thus, it is imperative that these contextual factors are considered – including how socioeconomic inequities might impact family dynamics – and addressed prior to proposing this type of intervention.

Interventions targeting housing stabilization for youth (e.g., rent subsidies, case management, economic and employment programs, and service connection) are limited and the evidence regarding effectiveness inconclusive (Morton, Kugley, et al., 2020). For example, the only randomized controlled trial published in a peer-reviewed journal on the effectiveness of Housing First (rent subsidies and case management) for youth demonstrated housing stability, but no change in other study outcomes such as quality of life, community integration, or employment relative to treatment as usual over the two-year follow-up (Kozloff et al., 2016) (note: this was a subgroup analysis of a larger Canadian study – At Home/Chez Soi – comprised primarily of adults; average age 40 years). A recently published master’s thesis on six-month outcomes from a Canadian Housing First for Youth randomized controlled trial showed similar findings in terms of housing stability, but no change in community integration relative to treatment as usual (Amiri, 2019). Qualitative data from this mixed methods study highlighted struggles with meaningful socioeconomic inclusion, and the author suggested enhanced social supports – including building on

existing natural supports – may be helpful (Amiri, 2019). In that regard, Morton’s review of effectiveness studies highlights the importance of interventions involving case management being “adequately resourced for individualized relationships” (p. 10) – linking back to the importance of connection noted from providers and youth participating in this study.

We have more to learn about how to facilitate outcomes beyond housing stability, including how to facilitate meaningful socioeconomic inclusion (Quilgars & Pleace, 2016). Aubry et al. (2020) conducted a systematic review on the effectiveness of permanent supportive housing and income assistance interventions for individuals experiencing homelessness in high-income countries. After analyzing 72 articles, they found these interventions were effective in demonstrating housing stability and improving food security; however, outcomes related to physical and mental health, substance use, income and employment, and quality-of-life showed either inconsistent outcomes or no significant difference relative to treatment as usual (Aubry et al., 2020). Additionally, recently published six-year At Home/Chez Soi outcome data of adults from the Toronto, ON site – believed to be the first study to assess the outcomes of Housing First over six years – continued to demonstrate housing stability, but no changes in other outcomes such as quality of life, substance use severity, or community functioning relative to treatment as usual (Stergiopoulos et al., 2019). Finally, direct cash transfers to young people is being explored as an equitable, low-barrier, scalable intervention that has the potential to promote housing stability and youth choice and control (Morton, Chávez, et al., 2020); however, more research is needed to understand the short- and long-term impacts on outcomes such as social and economic inclusion. That said, given the estimated monthly cost of a shelter bed and services in a city like Toronto is \$2,250 (City of Toronto, 2017), direct cash transfers could potentially be a cost-effective option.

In sum, while it intuitively makes sense to divert young people from the shelter system – especially during a pandemic – we need to ensure these young people have the social and economic supports needed to not just survive, but also thrive in the mainstream. Again, fostering supportive relationships could be key to moving outcomes beyond housing stability. Emerging evidence would seem to suggest that multi-component, critical time interventions that include aspects of case management, mental health and peer support, need to attend transitions into stable housing to see benefit in broader community outcomes. One of our colleagues on this report led a pilot randomized controlled trial of a complex housing stabilization program consisting of case management, peer support,

and mental health counselling for youth exiting homelessness, that demonstrated promising results in terms of mental health, employment, education, and housing stability relative to treatment as usual (Kidd et al., 2020). Two other authors of this report are also focused on youth transitioning out of homelessness, leading a pilot randomized controlled trial where all young people are provided portable rent subsidies for two years and half are also provided mentorship (Thulien et al., 2019).



4. Limitations

The data presented in this report has some important limitations. First, the majority of responses came from Ontario and may not represent what is happening elsewhere in Canada. Second, response bias must be considered for any findings gleaned from self-reports. For example, participants' responses may have been influenced by factors such as wanting to advocate for change, respondent fatigue, or providing answers that seemed more socially acceptable. Third, given our small sample size, our qualitative findings are not meant to be generalizable; however, some of the concepts that were generated during our focus group discussions may be transferable to similar contexts. Finally, the literature we reviewed to supplement our findings is unlikely to have captured all relevant literature given the rapid pace of research and publication during these unprecedented and evolving times.





Section 6

Recommendations and Conclusion

To reiterate: there is a pressing need to understand what individual-level practice adaptations utilized during this pandemic hold promise to meet the mental health and substance use needs of young people who are experiencing or have experienced homelessness; however, it is essential that we situate this need and our response within the broader societal context in which youth exist.

With this in mind, and drawing from our study data and the literature, we provide recommendations for practice, research, and public policy. We see important alignments with two documents in particular: *From Risk to Resilience: An Equity Approach to COVID-19* (Public Health Agency of Canada, 2020) and *The Roadmap for the Prevention of Youth Homelessness* (Gaetz et al., 2018).

Practice

- Increase (not decrease) outreach and do so in a proactive way (reach out to youth not seeking services)
- Increase staffing levels to facilitate enhanced engagement (consider staff burnout)
- Consider a blended model of phone/virtual support (ensure adequate staff training), in-person visits, and holistic outreach (phone/virtual supports will not be equitable for all)
- Consider implementing wellness checks (phone or in-person)
- Constantly evaluate the effectiveness of practice adaptations – there is no one-size-fits-all approach
- Proactively alleviate the amount of system navigation work required of young people (consider active collaboration with other agencies/organizations)

Research

- Pilot promising phone/virtual supports (e.g., CBT interventions) that have been tested with young people who have not experienced homelessness (rigorous testing – ideally with a control group for comparison – is crucial)
- Incorporate perspectives of young people with current and past experiences of homelessness into all phases of the research process (crucial for any research involving young people who are experiencing or have experienced homelessness)
- Assess how intervention outcomes vary by subpopulations (e.g., 2SLGBTQ+, Indigenous, and racialized youth)
- Incorporate and test the integration of virtual supports into promising evidence-based complex wraparound interventions (e.g., Kidd et al., 2019; Kidd et al., 2020) for youth exiting homelessness
- Rigorously study promising interventions related to system navigation (e.g., connecting youth with an advocate/mentor), early intervention (e.g., connecting youth to family/natural supports), and housing stabilization (e.g., rent subsidies and cash transfers) – look at longitudinal outcomes beyond housing stability, such as socioeconomic inclusion

Policy

- Consider the intersecting nature of social determinants of health (e.g., race, class, gender, income, and education) when putting forward solutions to address youth homelessness
- Augment investments in agencies/organizations serving young people experiencing homelessness so they can prioritize an equity-informed approach (e.g., enhance in-person outreach to the most marginalized and free/affordable devices to access virtual/phone supports)
- Consider the potential cost-effectiveness of rent subsidies and cash transfers (collaboration with researchers would be beneficial here)
- Invest in long-term outcomes beyond housing stability (e.g., equitable socioeconomic inclusion)

Conclusion

This report represents insights from survey data of 188 front-line providers across Canada and is supplemented by three focus groups – two with providers and one with young people who have experienced homelessness. We have endeavoured to situate these findings within the rapidly evolving literature on pandemic-related impacts on mental health and substance use. The COVID-19 pandemic has exposed and created a snow-storm of intersecting inequities that providers and young people are struggling to navigate. It also presents a unique opportunity to reimagine how we serve young people who are experiencing or have experienced homelessness. We trust this report makes a modest contribution to the emerging literature on this topic.



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