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PRELIMINARY REPORT

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

Pandemic-Proof: Synthesizing Real-World Knowledge of
Promising Mental Health and Substance Use Practices

PANDEMIC PROOF:

Synthesizing Real-World Knowledge of Promising Mental Health and Substance Use Practices for Young People Who Are Experiencing or Have Experienced Homelessness

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Most importantly, we would like to thank Canadian providers committed to working with young people who are experiencing or have experienced homelessness – especially during the COVID-19 pandemic.

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PROJECT OVERVIEW

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

Background: 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 (e.g., Auerswald et al., 2019; Hwang, 2000; Karabanow, 2008; Kidd et al., 2017; Kulik et al., 2011; Roy et al., 2010; Wood et al., 2006).

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 (Kidd et al., 2016; Thulien et al., 2018, 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 (see reviews by Altena et al., 2010; Coren et al., 2016; Hwang & Burns, 2014; Luchenski et al., 2017; Wang et al., 2019; Watters & O’Callaghan, 2016), that the COVID-19 pandemic came on scene – accelerating our need for an evidence-informed response.





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: a) pandemic impacts on mental health and substance use patterns; b) practice adaptations; and c) promising and transformative approaches.

Identify how front-line providers have adapted their practices to address these needs. We will do this by conducting targeted focus groups and individual interviews with providers that (through the survey) have identified particularly innovative and effective approaches.



Objective 2



Objective 3

Highlight promising and transformative approaches to service delivery – particularly those with post-pandemic promise – that warrant further investigation. Key mobilization activities include dissemination to multisectoral stakeholders through: plain language reports, policy briefs, social media dissemination, op-eds, academic and non-academic presentations, and publications in open-access journals.

Core Expertise: We have assembled an exceptional team of researchers, knowledge users, and collaborators – including members with lived expertise – with deep and sustained commitments to improving outcomes for young people who have experienced or are experiencing homelessness.

RESEARCH METHODOLOGY

This project is being 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 is being scaffolded by Critical Social Theory (Strega, 2005), meaning our individual-level findings and provider- and system-level recommendations will be appropriately contextualized, 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.

Key Outcomes

- Rapidly synthesize real-world, actionable knowledge on promising approaches to mental health and substance use practices being utilized during the pandemic.
- Leverage the multisectoral expertise and connections on our team to effectively engage and provide key decision makers with recommendations on promising practice adaptations.
- Build an evidence base on innovative approaches to tackling mental health and substance use practices – including what appears to be more/less effective for certain demographics (e.g., racialized and gender/sexual minority youth) – that may prove useful beyond the life of the pandemic.






Introduction

The COVID-19 pandemic is highlighting societal inequities in an unprecedented manner. For some, the social and economic consequences are an inconvenient set-back; for others, they are a matter of life and death.

Young people who are experiencing or have experienced homelessness are disproportionately impacted by the negative socioeconomic effects of the pandemic. This pandemic has made visible the precarious existence in which these young people live. In our respective professions dedicated to working with these young people, we are witnessing the fallout of pandemic-related costs such as job losses, impending evictions, outreach services operating at zero or reduced capacity, social isolation, and loneliness.



**A need for an
evidence-informed
response to this
pandemic**

The impetus for this project came from our desire to understand the rapidly changing landscape of youth homelessness in Canada and to support our colleagues on the front lines. 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 are doing, and our prior understanding that intervention-based literature on youth homelessness is quite limited, we decided to take a different approach.

We are beginning this synthesis by amassing on-the-ground perspectives from our front-line colleagues who serve young people who are experiencing or experiencing homelessness. This preliminary report consists of findings from an electronic survey, which was available from June 10, 2020 – June 17, 2020. Over the next five months, we will refine this synthesis through the contribution of more qualitative data (focus groups) and further exploration of the peer-reviewed literature. This will be an iterative process; findings from our electronic survey will influence the direction of our literature review and focus group questions, and the focus group findings will influence subsequent reviews of the literature. Our final knowledge synthesis report will be available in November 2020.

METHODOLOGY

This study is employing a convergent mixed methods design, meaning quantitative data (electronic survey) and qualitative data (electronic survey and focus group interviews) are being collected at approximately the same time and the findings combined (Creswell & Plano Clark, 2018). We believe this methodology will help facilitate a more comprehensive, nuanced understanding of the data (Creswell & Plano Clark).

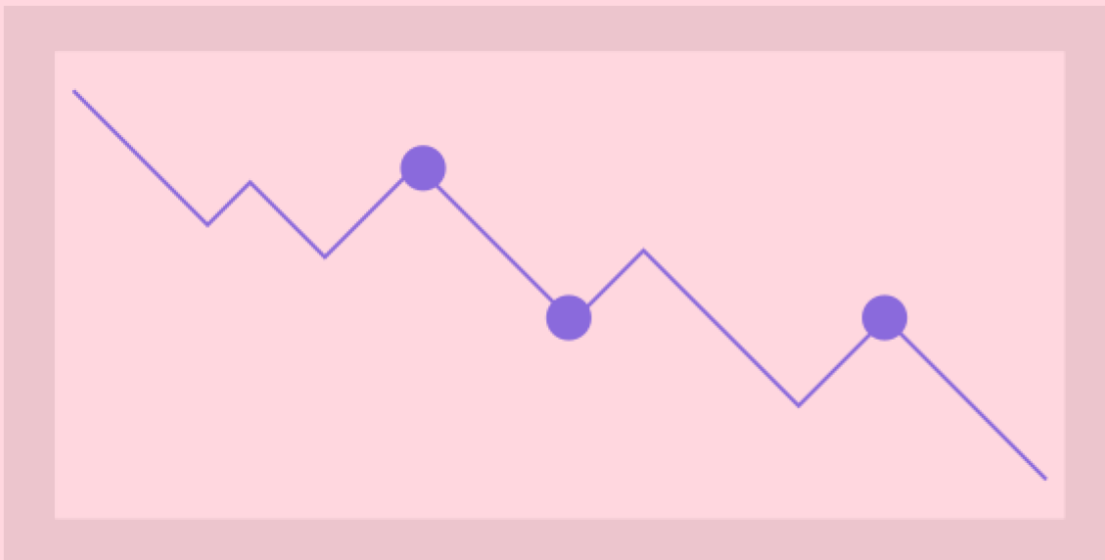
We began by distributing a 26-item electronic survey focused on three key domains: 1) pandemic impacts on mental and substance use patterns; 2) practice adaptations; and 3) promising and transformative approaches. The survey was distributed through e-mail and social media (e.g., Twitter) and open to all front-line providers in Canada serving youth (16 – 24 years) who have experienced or are experiencing homelessness. Ethical approval was received by the Hamilton Integrated Research Ethics Board.

Quantitative survey data was examined using frequency analysis. The free text qualitative responses were analyzed using reflexive thematic analysis (Braun & Clark, 2006, 2019). Briefly, reflexive thematic analysis involves six iterative phases: 1) becoming familiar with the data, 2) generating initial codes, 3) generating initial themes, 4) reviewing themes, 5) defining and naming themes, and 6) producing the report. All of the research team had access to the survey data and analysed and interpreted the responses individually before discussing and reaching consensus as a group.

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

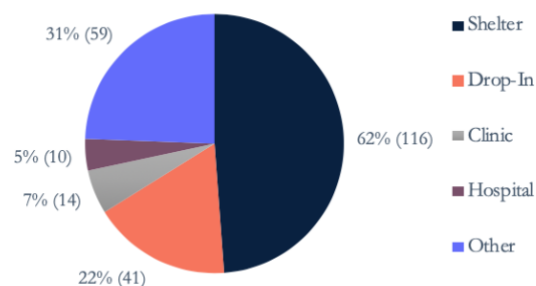


Survey Data



DEMOGRAPHICS OF PROVIDERS

Survey respondents include **188** service providers from 36 cities/towns, across 9 provinces/territories in Canada. All providers work with young people aged 16-24 years who are experiencing or have experienced homelessness. Providers represent **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.

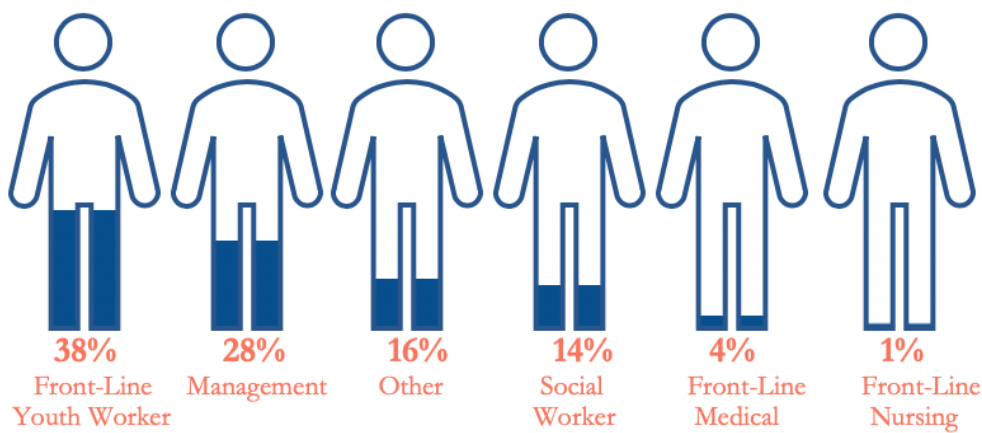


Provider Workplace

62%

*of participating providers work
in a shelter setting*

Respondent Roles





Focus One: Pandemic Impacts on Mental Health and Substance Use Patterns

1.1 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, significant decrease/decrease responses have been combined*

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

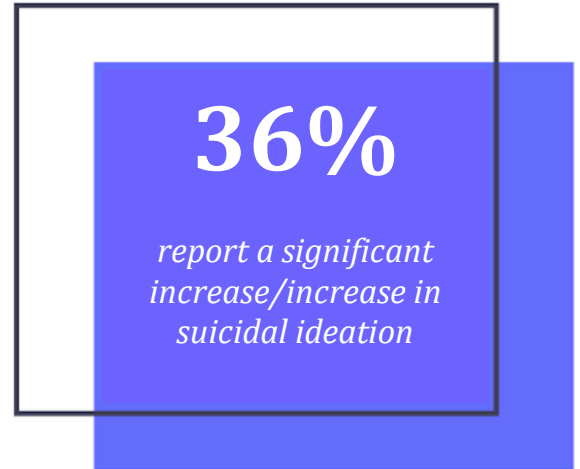
91%

report a significant increase/increase in isolation and loneliness

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



Many providers are reporting 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.



boredom
suicidal-ideation
isolated
suicide-attempts **self-harm** **anxiety**
sleep-disturbances **depression**

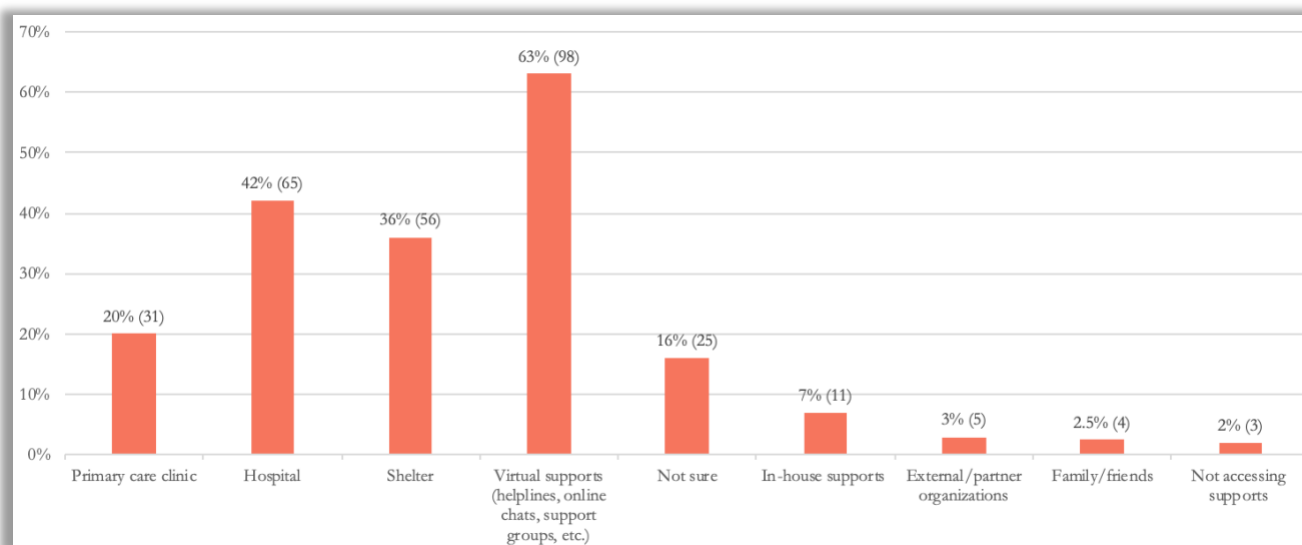
Youth Seeking and Accessing Mental Health Supports

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

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

1.2 WHERE ARE YOUTH GOING FOR MENTAL HEALTH SUPPORTS?

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



**Respondents were able to select multiple options*



63%

*report youth are accessing
mental health supports
online*

1.3 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, significant decrease/decrease responses have been combined*

The majority of providers (69%) have 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%).

While substance use is believed to have increased, providers also report 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 are unsure where youth are accessing harm reduction supports during COVID-19. For instance, 51% of providers report being unsure of how the pandemic has impacted access to supervised injection sites.

69%

report a significant increase/increase in substance use

37%

report a significant increase/increase in overdoses



1.4 DISPROPORTIONATE IMPACTS

Some providers noted that worrisome changes in mental health and substance use patterns appear more prevalent among youth from certain subgroups. In particular, they reported 2SLGBTQ (two-spirit, lesbian, gay, bisexual, transgender, and queer), Indigenous, and racialized youth seem especially impacted. Moreover, providers noted that these additional challenges are 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.”

Oppressed Identities

Several providers spoke of the challenges faced by 2SLGBTQ youth who are 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.



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 exacerbated by the fact that many 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... 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.”

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.”

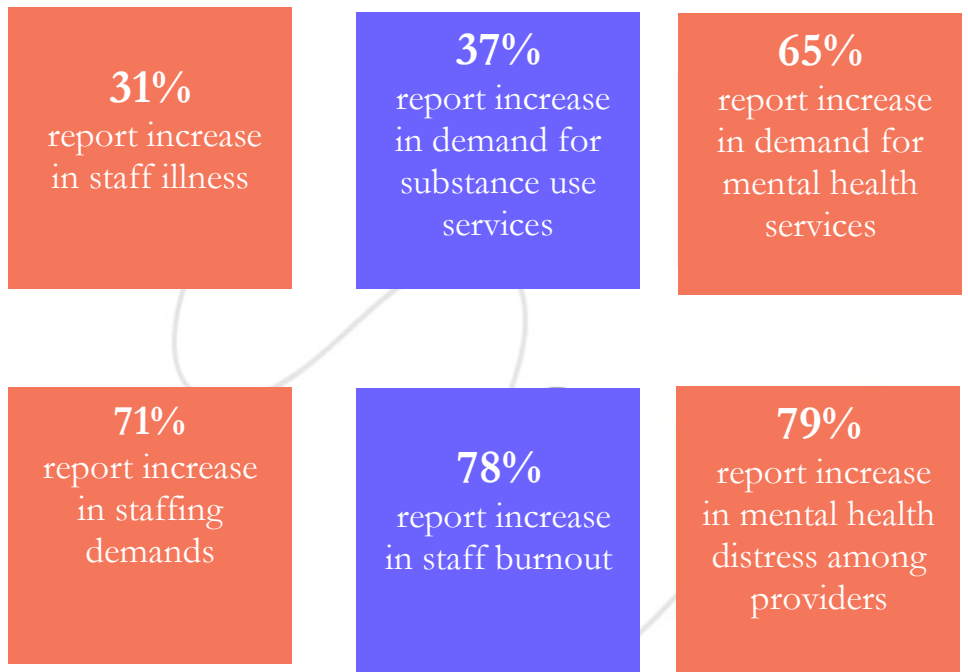
Providers noted the importance of young people in the aforementioned groups spending time in social groups where they feel a sense of belonging. Restrictions on movement (e.g., freedom to come and go from transitional housing) have made those sorts of connections difficult. Additionally, several providers reported young people have increased their use of substances and are using alone.

Importantly, providers noted that many young people do not have equitable access to information technology, making it challenging to access the mental health and substance use supports they need.

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

1.5 PANDEMIC IMPACT ON AGENCY/ORGANIZATION

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



**Combined significant increase and increase responses*

In addition to youth, the pandemic is having a notable impact on service providers. An overwhelming majority of respondents (79%) report 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%).



Focus Two: Practice Adaptions

2.1 PADEMIC IMPACT ON ORGANIZATION ACCESS TO MENTAL HEALTH AND SUBSTANCE USE SUPPORTS

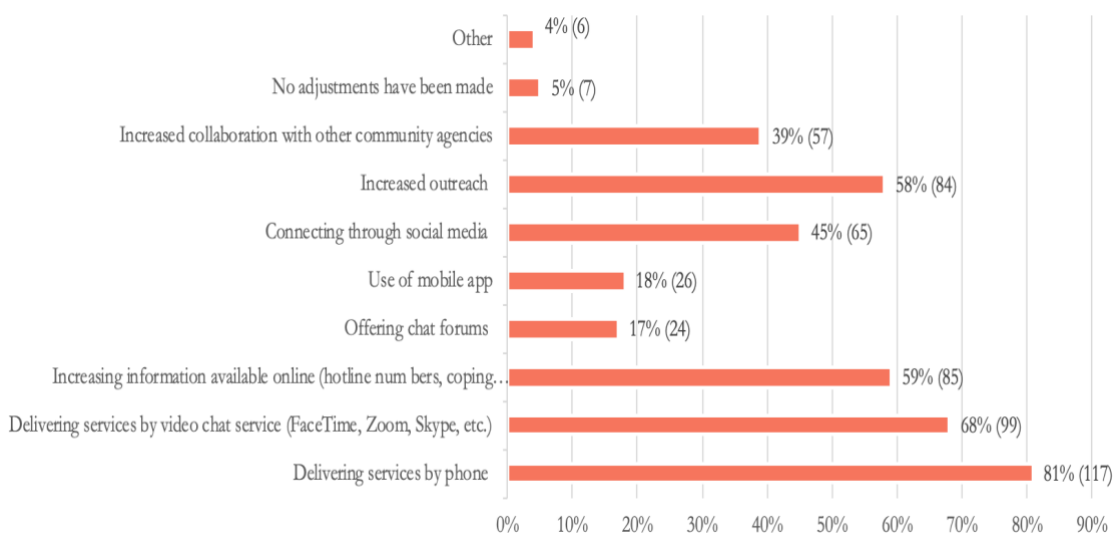


The pandemic has altered the ways in which agencies and organizations can operate. In terms of access to mental health services, the majority of providers (69%) report that buildings are either closed (18%) or their services are now delivered solely offsite (51%).

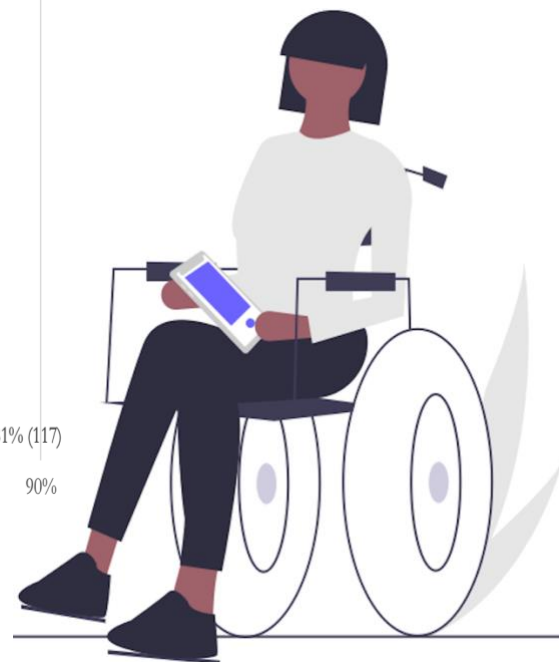
When speaking about substance use, a large proportion of providers (62%) report they are delivering services remotely (50%) or agencies are entirely closed (12%) – completely halting the delivery of substance use services.



2.2 MENTAL HEALTH PRACTICE ADAPPTIONS



*Respondents were able to select multiple options **



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



81%

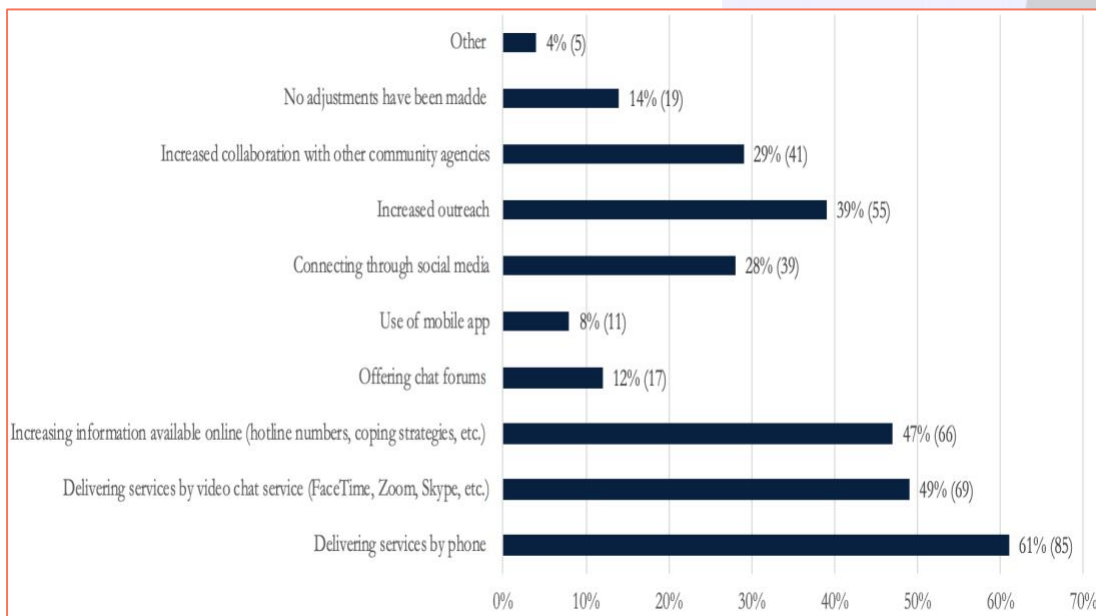
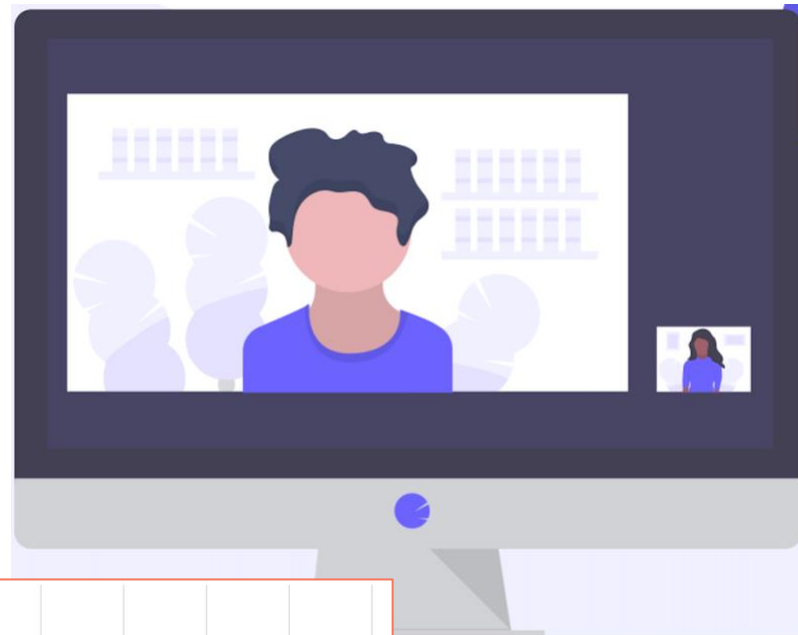
report delivering mental health services by phone

2.3 SUBSTANCE USE PRACTICE ADAPPTIONS

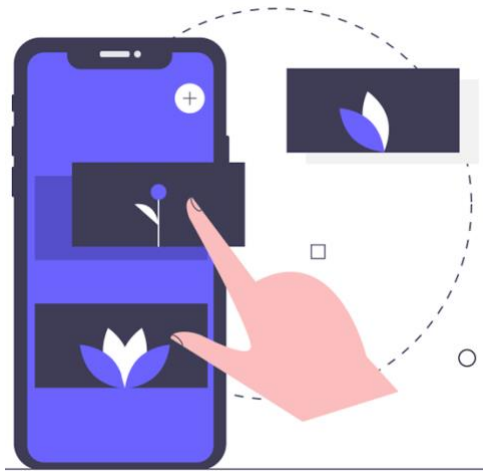
Similar service adaptations were reported when asked about substance use practices. Providers report utilizing phones (61%) as a way to combat pandemic related closures. Similarly, providers have reported shifting to video chat services (49%), and 28% are providing support using social media. Just under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

49%

report delivering substance use services by video chat



2.4 YOUTH SATISFACTION WITH SERVICE ADAPTIONS



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

Inequitable Access

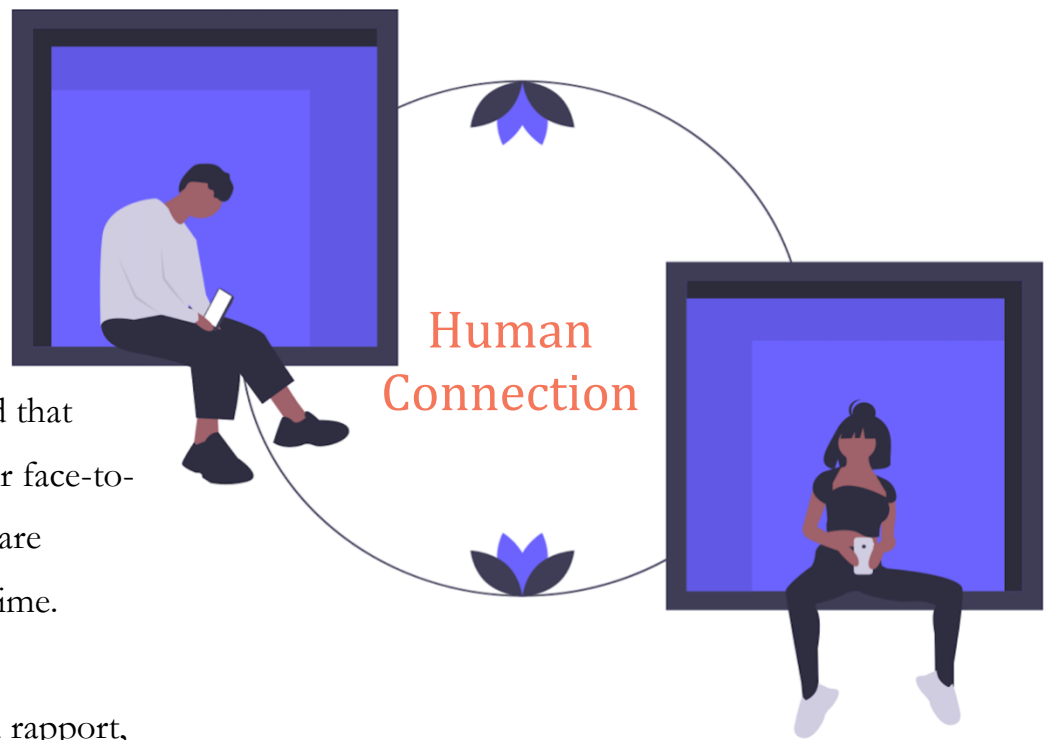
The move to remote care is based on the premise that young people have access to a phone or the internet. Many providers shared that this is not the case and a large barrier to accessing mental health and substance use supports.

“...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 is 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.”



The majority of providers noted that they believe 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 are 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.

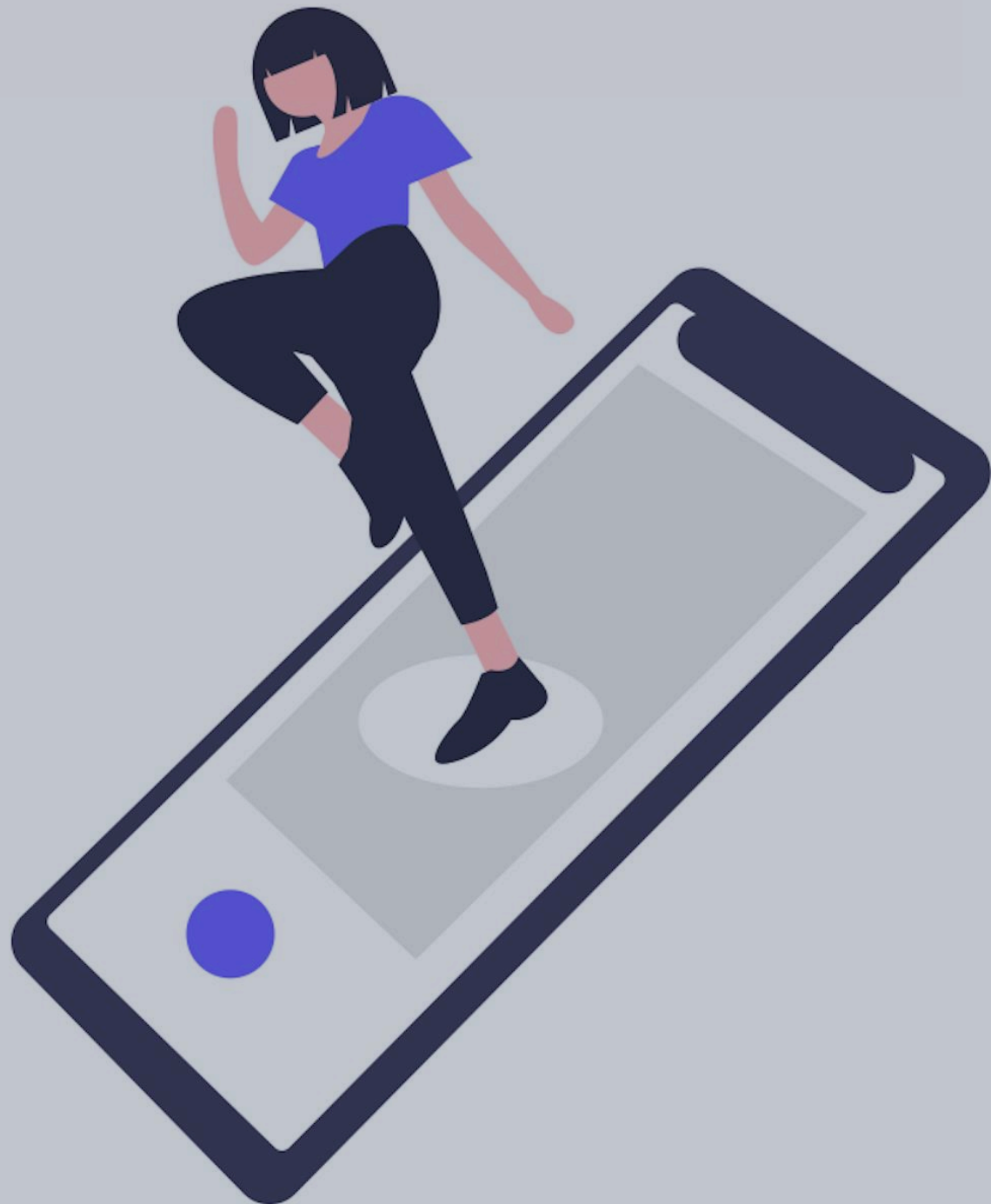
“Young people prefer to have in-person contact especially when seeking services for mental health and substance use. Disclosing these struggles can be a very vulnerable process and most young people prefer to meet their supports and get a sense of who they are before they can begin their journey.”

“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.”

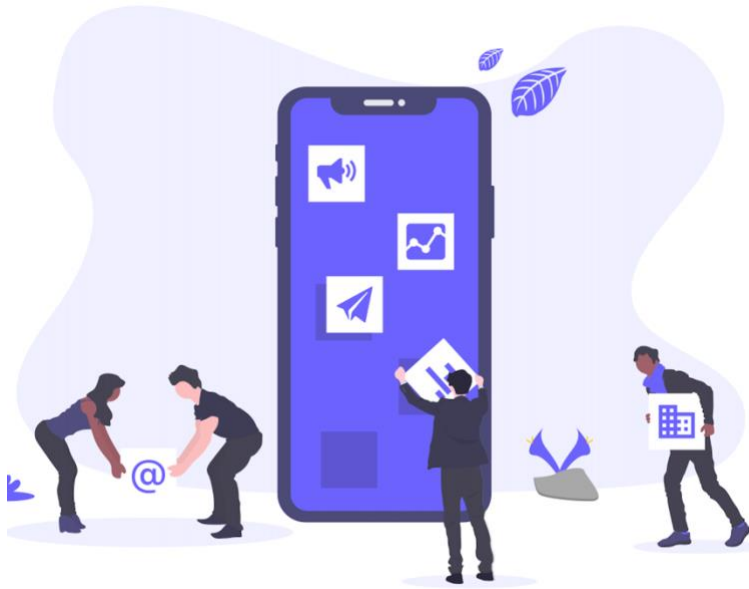
Enhancing Access

There were a small numbers 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.

Focus Three: Promising and Transformative Approaches



3.1 SERVICE ADAPTIONS: MENTAL HEALTH



Proactive Outreach

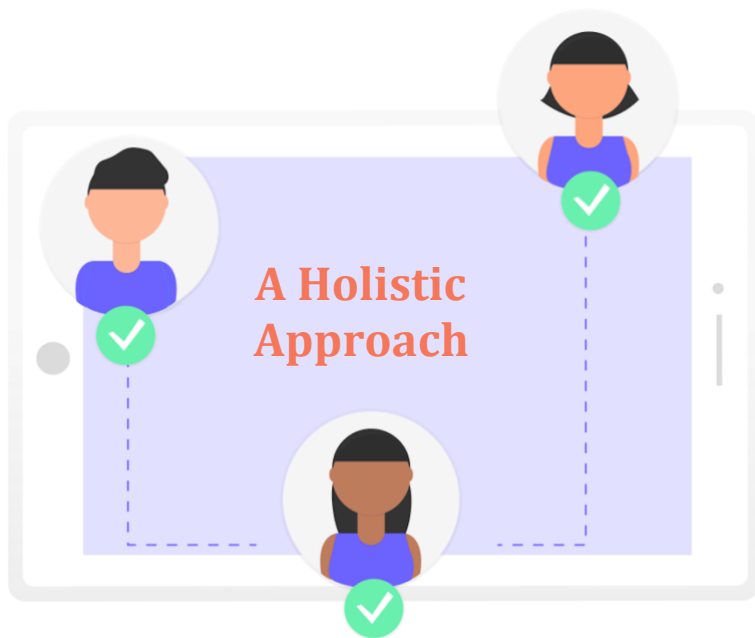
The majority of respondents noted the importance of connecting with youth regularly and more frequently than pre-pandemic. Several shared that these proactive, consistent check-ins appear to reassure youth during this time of social and economic uncertainty.

“Set a consistent time and day of connecting over video and phone...provide youth interest-based projects to do with a specific goal of sharing their work with the broader community...continue routine from pre-COVID 19 as much as possible via virtual means...[offer] structured check ins with relevant support resources.”

Some providers also reported that they have 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).

“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.”

Several providers shared that they have 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 are less likely to reach out for help.



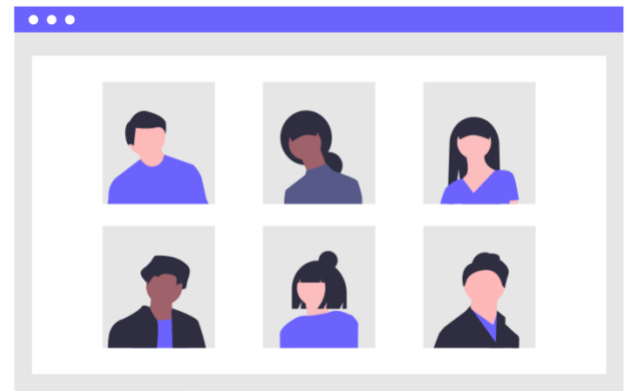
Many respondents have adapted their services to offer mental health supports virtually. Those that seem to be having the most success in terms of youth engagement appear to be those that have pivoted to virtual care fairly rapidly (i.e., not losing youth during reorganization of care delivery) and been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

- 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 have access to online (or phone) resources, which necessitates 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).

3.2 SERVICE ADAPTIONS: SUBSTANCE USE

Pushing Back: People First

Several providers emphasized that their adaptation strategy was, in a sense, to purposely not adapt; instead, they continue to offer the same substance use/harm reduction support 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

“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.”

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 is perceived to be increasing.

Enhanced Outreach



“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.”

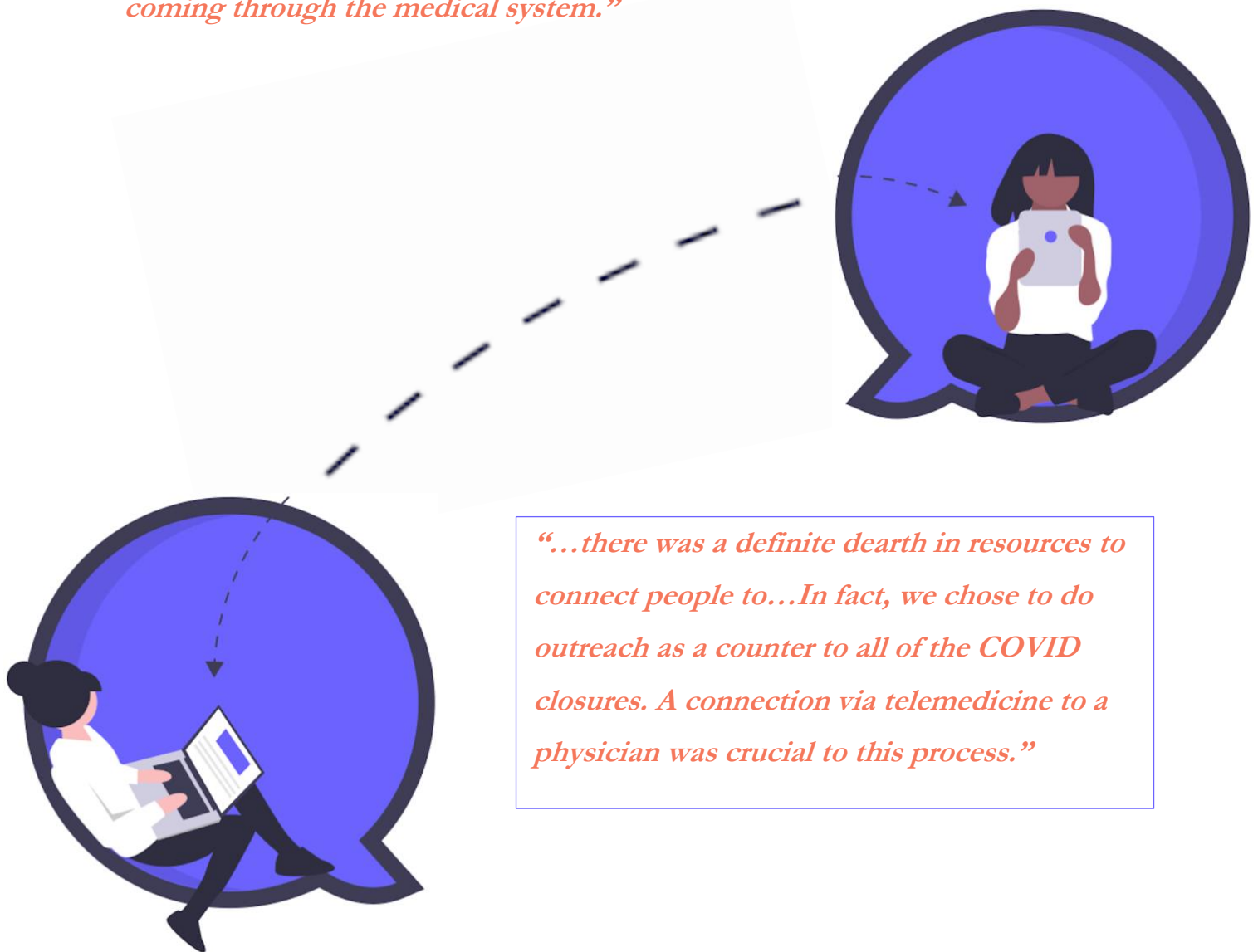
While several providers reported utilizing virtual platforms (e.g., Zoom group therapy and Instagram “live” sessions on substance use), many spoke of the ongoing need for in-person interactions to get a better sense of what was happening at an individual and community level. Moreover, providers spoke 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.”

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.”

3.3 DO ADAPTIONS HOLD POST-PANDEMIC PROMISE?

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



3.4 CHALLENGES UTILIZING SERVICE ADAPTIONS

	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)

83%

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

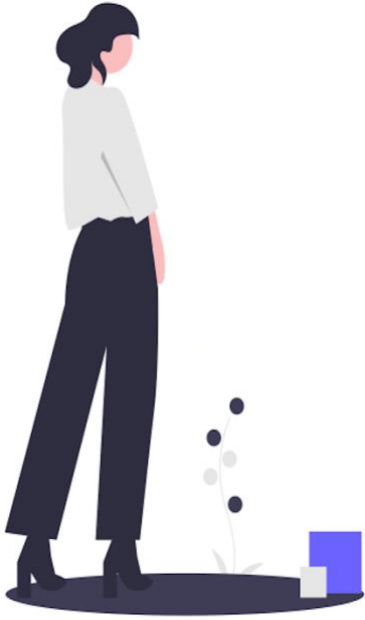
Barriers to implementation of new adaptations for mental health

67%

report being very/somewhat concerned with youth access to technology for substance use services

	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)

Barriers to implementation of new adaptations for substance use



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%) are very/somewhat concerned with reaching all youth requiring mental health services. Similar concerns (68%) were expressed when speaking to substance use supports.

In addition to concerns reaching young people, providers reported being very/somewhat concerned that youth are not aware of new mental health (76%) and substance use (62%) service adaptations.

The majority of respondents are very/somewhat concerned regarding youth access to technology for mental health (75%) and substance use services (67%).

3.5 RECOMMENDATIONS FOR MENTAL HEALTH AND SUBSTANCE USE SERVICE ADAPTIONS

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 – including the provision of tablet computers and cell phones – to virtual and telephone supports, 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.





Hit the Streets

As noted earlier in the report, many providers – especially those interacting with young people using substances – believe there needs 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.”

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 (e.g., serving meals, cleaning, etc.). Ideally, service roles would be preserved and other staff hired to support shelter operations during a future pandemic.”



Equity-Informed Response

There were 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 is 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.”





Discussion

DISCUSSION

As we noted at the outset of this report, the motivation for this knowledge synthesis came from our desire to understand the rapidly changing landscape of youth homelessness in Canada during the COVID-19 pandemic and to support our colleagues on the front lines. This preliminary report represents our “first pass” at the survey data collected from June 10, 2020 – June 17, 2020. While our findings are preliminary and require deeper analysis and further data collection, there are some important discoveries that warrant close attention.

1. Pandemic Impacts on Mental Health and Substance Use Patterns

Provider perspectives regarding pandemic impacts on mental health and substance use patterns are insightful and alarming. Overall, these insights paint a picture of young people and providers struggling to adapt to pandemic-related closures. Moreover, current public health restrictions and ensuing service limitations operate on the premise that young people: have a place to isolate; can isolate safely and with others; can afford phones/computers; and have access to the internet.

Young people are expected to be “good citizens” by complying with state regulations that could literally cost them their lives; this is especially true for youth with identities further marginalized by gender, race, and sexual orientation. For example, the Canadian federal government is reporting a 20 – 30% increase in gender-based and domestic violence since the pandemic began, with one shelter in the greater Toronto area reporting a 400% increase in calls for help (Patel, 2020).



Furthermore, racialized and Indigenous young people are overrepresented in the youth homelessness sector (Gaetz et al., 2016) and providers are noting that recent events involving anti-Black and anti-Indigenous racism 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., 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).



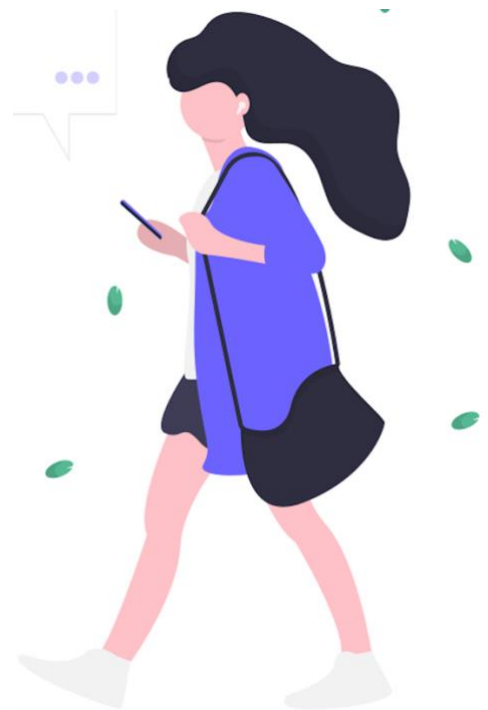
Mental Health Patterns

While provider reports that almost all young people are experiencing boredom and loneliness might be expected, the perception that the overwhelming majority of young people are experiencing increases in anxiety, depression, sleep disturbances, and acuity/symptoms related pre-existing mental health is alarming but consistent with emerging evidence on this topic.

For example, a survey conducted in April by the Centre for Addiction and Mental Health (currently under peer review) with 622 young people (ages 14 – 27) across Ontario found that 68% of youth who had previously sought mental health support reported significant problems with mood and anxiety since the pandemic began (Centre for Addiction and Mental Health, 2020; Cribb, 2020).

Moreover, the concept of boredom is emerging in the homelessness literature – especially in the occupational science domain – as anything but benign. For example, a recent scoping review of boredom and homelessness highlights the link between boredom and a host of negative outcomes, including struggles with mental health and substance use (Marshall et al., 2019). In addition, provider perceptions of increase in suicidal ideation, self-harm, and suicide attempts in our survey is especially concerning given the reported 80% decrease in ability to access mental health supports.

More than half of young people are reported to be turning to online supports; however, the effectiveness of these supports is unclear given rigorous studies on mental health interventions for youth experiencing homelessness are almost exclusively in-person interventions (see recent review by Wang et al., 2019). There are some promising intervention studies targeting mental health for youth experiencing homelessness using mobile devices (e.g., Bender et al., 2015; Glover et al., 2019); however, the evidence in this area is still nascent.

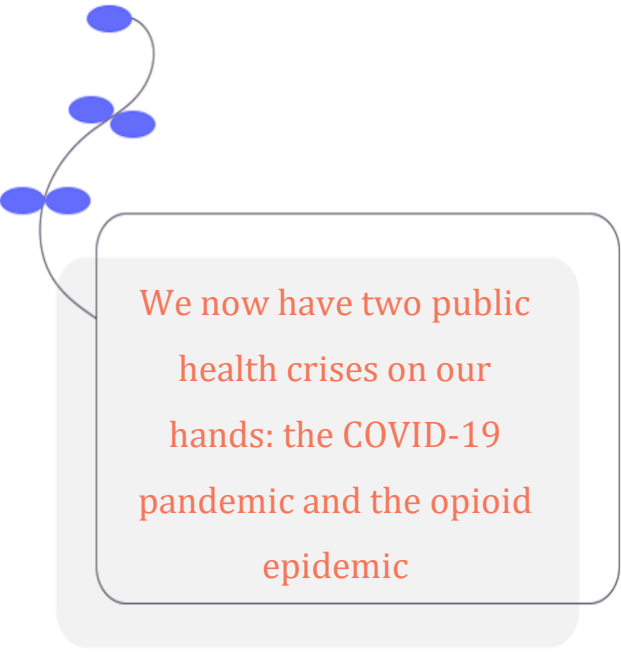


Finally, a notable 42% of providers believe young people are turning to the hospital for mental health supports with only 20% believed to be seeking help at a primary care clinic. While hospitalization rates in Canada are known to be higher among homeless adults than the general population (Hwang et al., 2013), it is unclear whether young people are turning to hospitals for mental health support more than they did pre-pandemic. Regardless, it is clear there are improvements to be made in helping

young people access mental health supports outside a hospital setting – especially given the reported increase in need and decrease in ability to access these supports during the pandemic. Furthermore, given the economic stressors brought on by the pandemic are likely to continue post-pandemic (e.g., loss of minimum wage jobs young people often depend on to make ends meet), there is an urgent need to improve access to mental health supports.

Substance Use Patterns

Reports regarding substance use depict a concerning picture of a 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. Prior to the pandemic, young people in Canada aged 20 to 29 years represented 19% of all opioid-related deaths, and youth aged 15 to 24 years were the fastest growing population hospitalized for opioid overdose (Government of Canada 2019a; 2019b).



We now have two public health crises on our hands: the COVID-19 pandemic and the opioid epidemic

More than one third of respondents noted that overdoses have increased since the pandemic began. This is similar to what is being reported in provinces like British Columbia, where they recently recorded the highest number of illicit drug overdose deaths in a single month (The Canadian Press, 2020). Notably, providers seem to be losing sense of what is happening with their clients given approximately half reported they were unsure if the young people they serve have access to supervised injection sites. To state the obvious: a reportedly marked increase in substance use and overdoses combined with a lack of clarity around whether young people have access to appropriate harm reduction provisions is a recipe for disaster.

Providers

The COVID-19 pandemic is placing a tremendous strain on agencies/organizations and providers. Demand for mental health and substance use supports is high. At the same time, the vast majority of providers are reporting that they are feeling burned out and struggling with their own mental health. The pandemic is a marathon, not a sprint. In other words, agency/organizational leaders will need to move past an immediate/emergency response – common in the homelessness sector – to more sustainable, long-term planning. This will likely mean getting creative and re-imagining how to effectively address the mental health and substance use needs of the young people they serve.



2. Practice Adaptations

Despite the need for enhanced mental health and substance use supports, most agencies/organizations have either shut down their services entirely or (more commonly) moved them all off-site. This is understandable given the requirement to align with pandemic-related public health measures; however, the implications for young people who depend on these services – especially the most marginalized (e.g., transgender, refugee, and street-entrenched young people) – are worrisome. Additionally, as we head toward the winter season and the weather becomes colder, the demand for on-site services will likely rise.

The majority of providers have had to pivot to delivering services pertaining to mental health and substance use to over the phone (most common) or virtually; however, most providers are also reporting that youth seem 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 are

unsure what youth using substances think of these practice adaptations, which is understandable given the aforementioned uncertainty around what is happening with this population in general. As noted previously, there is a paucity of evidence regarding phone/virtual mental health and substance use interventions specific to young people who are experiencing or have experienced homelessness. Thus, there is an urgent need to understand the effectiveness of these interventions and importantly, whether they are sustainable given various agency/organizational financial and staffing constraints in the current economic climate. Indeed, pandemic aside, it is quite conceivable that these adaptations make sense from a health outcome and economic perspective, but we need more evidence – particularly from young people being impacted by these adaptations.

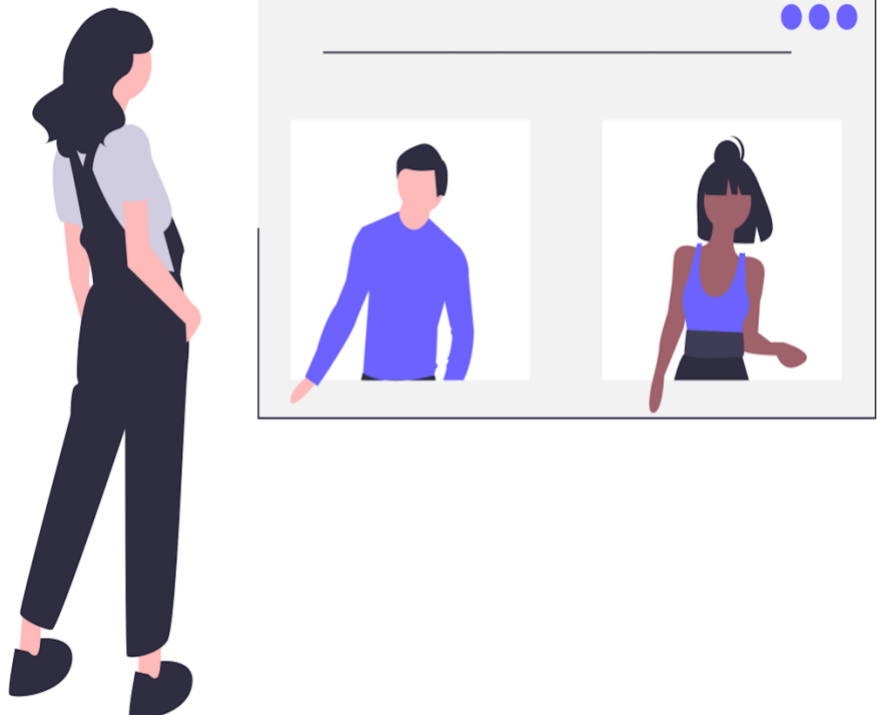
Most providers report that they have enhanced their mental health and substance use outreach endeavours during the pandemic and become more intentional about connecting with youth. While these are positive adaptations, it is important to remember that providers are also reporting their own struggles with mental well-being. Additionally, some providers are noting that these visits are becoming more complex – a trend that may continue/worsen as the pandemic drags on – so agency/organizational leaders need to be cognisant of the additional burden enhanced outreach places on providers.

When considering these practice adaptations, it is crucial to restate the necessity of adopting an equity-focused approach: practice adaptations that require the use of a phone and/or the internet mean young people must have access to these resources. These adaptations also assume young people have access to safe spaces to communicate.



Agencies/organizations 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.

Finally, it is important to note that recommendations by provincial public health authorities regarding the preference for phone/virtual visits in community/primary care settings (e.g., Ontario Ministry of Health, 2020) are targeted to the general population. Again, many young people who have experienced or are experiencing homelessness lack the resources to access these types of appointments. Moreover, given provider reports of the overwhelming sense of loneliness experienced by this population during COVID-19 – especially among 2SLGBTQ, racialized, and Indigenous young people – it seems likely that many will prefer and benefit from the human connection experienced during in-person visits. That being said, young people living in less resource-intensive communities (e.g., rural/remote settings) may find the move to phone/virtual care a welcome change; one that should continue post-pandemic. Going forward, it is highly plausible that a blended model of phone/virtual and in-person visits may be the best way to serve young people who are experiencing or have experienced homelessness.



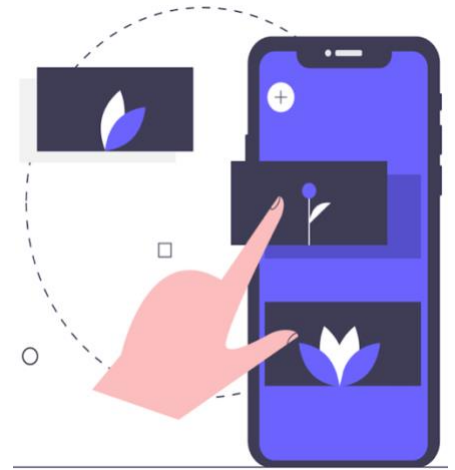
3. Promising and Transformative Approaches

Despite the unprecedented challenges brought about by the COVID-19 pandemic, front-line providers have adapted remarkably. While there is still a great deal to learn about the effectiveness and sustainability of these adaptations, we believe some may hold promise as a better way of addressing the mental health and substance use needs of young people who are experiencing or have experienced homelessness. Notably, almost three quarters of providers believe their mental health adaptations hold post-pandemic promise. However, when asked about adaptations related to substance use, only about half of providers believe their adaptations hold post-pandemic promise and 40% are unsure – the latter notion of uncertainty a narrative that kept emerging during our data analysis specific to substance use. For ease of reference, we begin by discussing promising mental health and substance use adaptations separately; however, we appreciate that there is overlap and transferrable learnings between these adaptations.

Mental Health Adaptations

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, 2018, 2019), it makes sense – especially given our current economic downturn – for providers to touch base with clients who have moved on to independent housing.

The pivot to a mobile, holistic approach to care is especially inspiring and links back to the need to adopt a proactive process to engage clients – especially for those struggling the most with their mental health. 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). Indeed, 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.



The move to virtual care by the majority of respondents is a promising adaptation; however, as previously mentioned, this is still an emerging area of research. Notable adaptations such as youth-focused webinars, drop-in social media chats, and social media platforms with regularly updated mental health resources warrant further investigation. Additionally, self-serve applications targeting mental health such as Woebot (<https://woebot.io>) – developed by researchers from Stanford University using principles of cognitive-behavioral therapy – has shown promise in a randomized controlled trial with youth recruited from a university campus (Fitzpatrick et al., 2017) and may hold potential for use with young adults who are experiencing or have experienced homelessness.



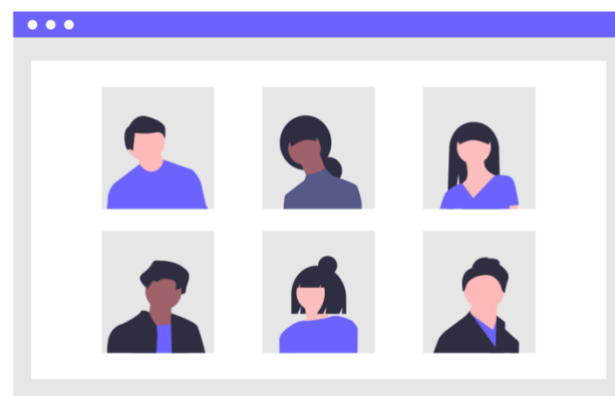
Substance Use Adaptations

As noted throughout this report, there seems to be less clarity around how best to adapt to substance use patterns that have emerged during the COVID-19 pandemic. This is perhaps unsurprising given the dearth of guidance in the peer-reviewed literature on youth-focused addiction services (Roglich et al., 2020). Nevertheless, our analysis of the quantitative and qualitative responses to questions pertaining to substance use gave us the sense that pandemic-related closures are likely disproportionately impacting this group of young people. Indeed, this aligns with our own experience working and interacting with youth engaged in substance use.

As noted previously, providers have adapted to addressing needs related to substance use by utilizing telephone and virtual supports, albeit to a lesser extent than these same supports are used to address needs related to mental health. Additionally, when reading through the comments related to substance use adaptations, themes related to the importance of in-person engagement begin to emerge. Thus, it is especially worrisome that the majority of services for these young people are either closed or been relocated off-site. Moreover, one gets the sense that effective engagement with young people using substances involves getting a “feel” for what is going on in the community – something challenging to do through telephone and virtual supports. Again, this resonates with our own familiarity with this group of youth.

Some providers serving young people using substances have adapted by finding safe ways to keep their agencies/organizations open while operating in a manner consistent with public health guidelines. Additionally, similar to mental health adaptations, providers report needing to enhance their outreach endeavors with more

frequent and intentional connections. Virtual supports such as Zoom group therapy and Instagram “live” sessions on substance use may indeed be an effective way to engage at least a subset of young people who use substances but again, more research is needed. Reviews of interventions specific to substance use with this population continue to show mixed results with most studies demonstrating either findings that are not statistically significant or improvements over time in both the intervention and control groups (Wang et al., 2019).



One promising pandemic-related service adaptation noted by providers is more intentional collaboration between outreach workers and the healthcare system. Connection to telemedicine during street outreach and updates from hospitals on trends related to substance use are great examples of collaboration and likely crucial given the vast majority of providers believe substance use has increased. A more intentional link between the healthcare system and outreach workers makes sense and an example of such an approach is being piloted by one of the authors of this report (Dr. Stephen Hwang) using a homelessness outreach counselor embedded in the general internal medicine department of St. Michael's hospital in Toronto, ON (<https://maphealth.ca/navigator/>). While peer-reviewed research on this form of homelessness sector-healthcare collaboration is limited for youth experiencing homelessness, one promising engagement strategy utilized a strengths-based approach (youth met regularly with an advocate) to link hard-to-reach young people (chronic homelessness, limited service use, and regular use of substances) to appropriate

services such as healthcare and demonstrated improvements in mental health during the nine-month follow-up period (Slesnick et al., 2017).

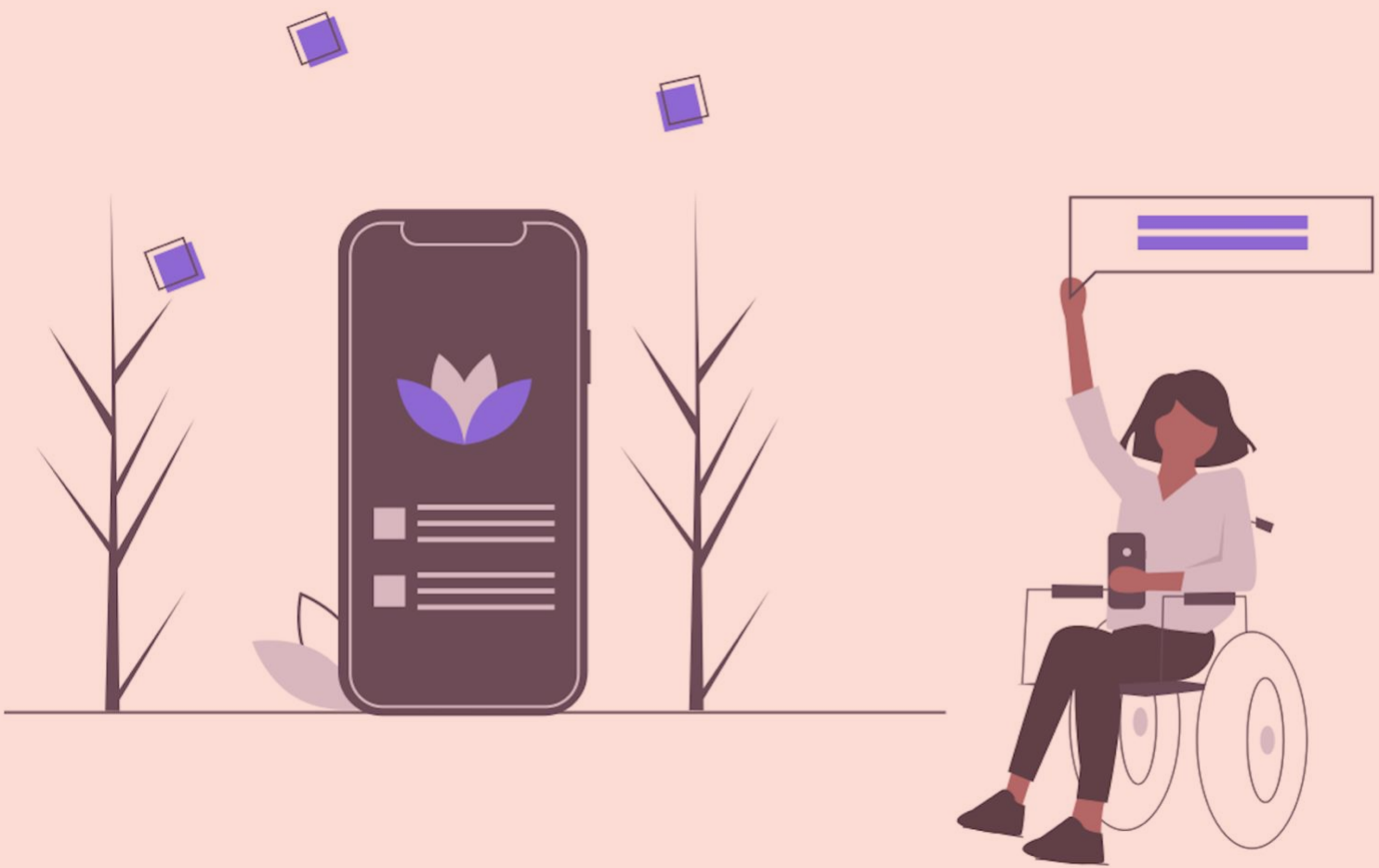
Barriers to Implementation

Regardless of whether providers are attempting to adapt their services to provide better mental health or substance use supports, their top three concerns are the same and link back to issues around equity. Providers are concerned about reaching everyone who needs services. This is understandable given current service restrictions. They are also concerned about whether clients are aware of new service adaptations. If providers have not established a plan of proactively reaching out to inform young people of service adaptations then the burden is unfairly placed on young people – also grappling with challenges related to mental well-being and economic uncertainty – to reach out for help. Finally, providers are concerned about clients having access to technology required to access service adaptations. Again, while phone/virtual practice adaptations related to mental health and substance use may be promising and represent a more efficient and effective way of managing these issues and enhancing access, we must ensure that clients have affordable/free access to the appropriate technology and the ability to communicate in a safe space.

Limitations

The data presented in this preliminary report has some 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, survey participants' responses may be influenced by factors such as wanting to advocate for change, respondent fatigue, or providing answers that seem more socially acceptable. Third, we did not specifically ask providers which populations of young people they primarily serve (racialized, Indigenous, rural, etc.)

and so their unique circumstances may not have been adequately captured by our survey. Finally, and perhaps most important, is that this survey was administered to front-line providers and not to the young people being impacted by the pandemic. Thus, young people may have different perspectives on this issue than the providers who completed the survey. Our aim is to address some of these limitations by purposefully sampling (e.g., seeking respondents from various locations in Canada) in our follow-up focus groups. Additionally, we intend to seek ethical approval to conduct at least one focus group with youth who are experiencing or have experienced homelessness so they can “speak back” to the survey findings.



Recommendations

Our final survey question centred around recommendations for post-pandemic service adaptations. The responses were insightful with many providers calling for a complete overhaul of the way we currently address the mental health and substance use needs of young people who are experiencing or have experienced homelessness.



The relevance and distinct learnings gained through this survey data offers an important lens into future state mental health provision for homeless youth. From policy and practice shifts, we see important alignment with the Roadmap for the Prevention of Youth Homelessness (Gaetz, Schwan, Redman, French, & Dej, 2018). Within the COVID-19 recovery phase and through the reestablishment of collective process, we must focus on improving service provision and facilitating a prevention-based focus on mental health and substance use policy and practice.

Practice

- Increase (not decrease) outreach and do so in a proactive way; enhance staffing levels to facilitate enhanced engagement.
- Consider a blended model of virtual support (ensure adequate staff training), in-person visits, and holistic outreach.
- Be intentional about connecting with other services (e.g., healthcare) that touch the homelessness sector; be clear about/advertise what services your agency/organization offers and meet regularly to facilitate ongoing collaboration (see paper on rethinking service design in Hamilton, ON – Wang et al., 2020)

Research

- Pilot promising phone/virtual supports that have been tested in young people who have not experienced homelessness (e.g., Woebot); incorporate perspectives of young people who have experienced homelessness into all phases of the research process (crucial for any research involving young people who are experiencing or have experience homelessness).
- Incorporate the integration of virtual supports into promising wraparound supports (e.g., Kidd et al., 2019) for youth exiting homelessness.
- Adapt promising in-person interventions for young people who are experiencing or have experienced homelessness (e.g., McCay et al., 2015; Thulien & Wang, 2019) to incorporate a live virtual and/or asynchronous learning component.

Policy

- Immediately prioritize investments in agencies/organizations serving young people experiencing homelessness so they can: a) continue adapting their services using an equity-informed approach (e.g., in-person outreach to the most marginalized and free/affordable devices to access virtual/phone supports) and b) enhance staffing levels to avoid burnout.
- (Re)consider a guaranteed basic income and/or portable rent subsidies (see Aubry et al., 2020; Pankratz et al., 2017). Social rationale aside, from a return-on-investment perspective, this may prove more cost effective (and possibly safer/enhance well-being) than the current practice of moving young people experiencing homelessness into hotels (and paying for the rooms, meals, staff, etc.) to avoid overcrowded shelters. Moreover, as the economic impacts of the pandemic begin to be fully realized, we may see a surge of young people

experiencing homelessness (either for the first time or returning to this state) and will need to adopt a rapid, proactive approach to ensure they do not end up trapped in a cycle of chronic homelessness/poverty.

Conclusion

This report represents preliminary insights from a rapid knowledge synthesis of survey data collected from 188 providers who work with young people who are experiencing or have experienced homelessness. To our knowledge, this is the first synthesis focused on the mental health and substance use needs of young people who are experiencing or have experienced homelessness during the COVID-19 pandemic. Our next steps include a return to the data and peer-reviewed literature for deeper analysis, and conducting focus groups with providers and young people who are experiencing or have experienced homelessness.

As we continue to analyze the data and draw conclusions from it, we will work together with agencies/organizations, governments and funders to make strong recommendations for actions that are sustainable, equitable, and grounded in evidence. Maximizing the learnings gained through the COVID-19 pandemic will have a profound impact on the causes and conditions facing young people who experience homelessness or are at-risk of homelessness.



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