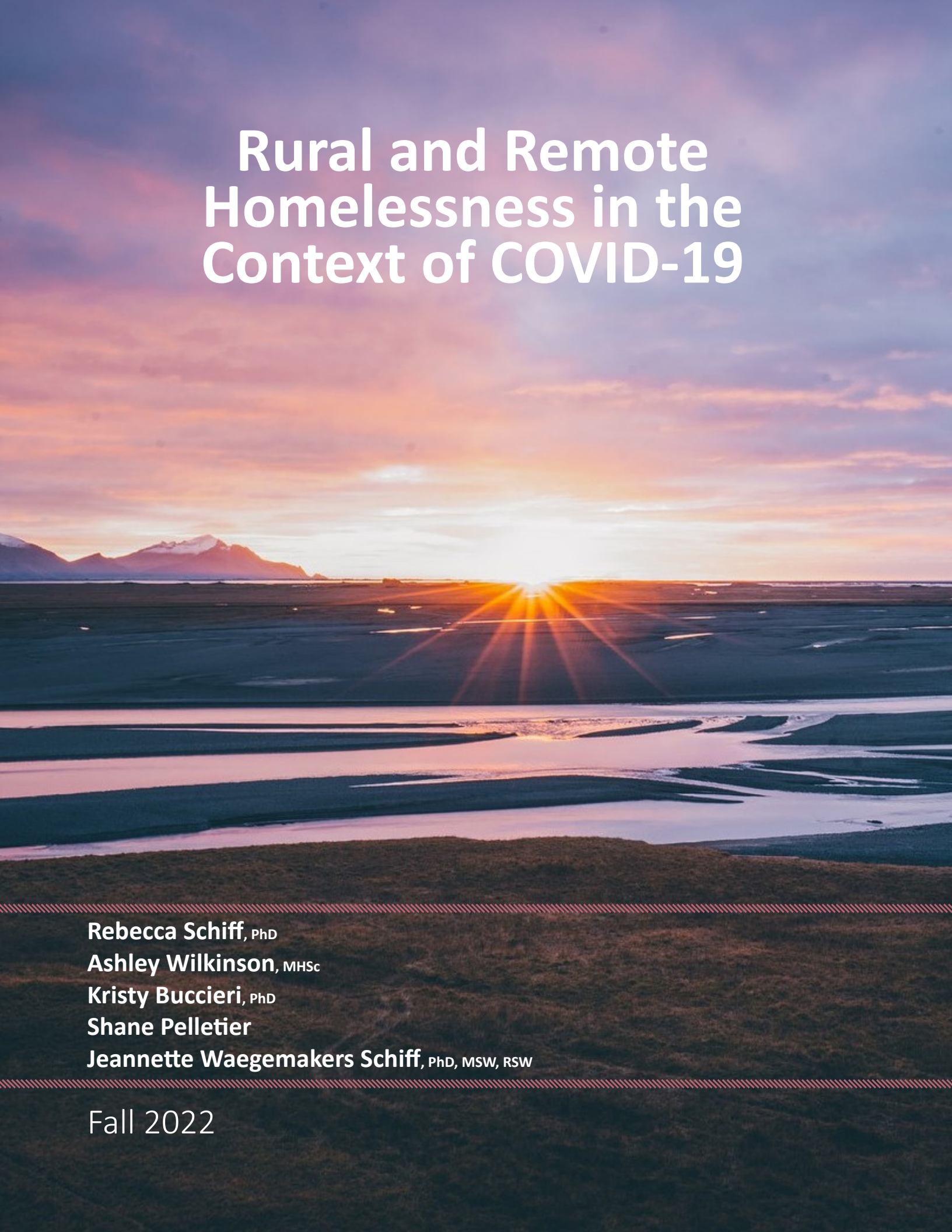

Rural and Remote Homelessness in the Context of COVID-19

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Rural & Remote Homelessness in the Context of COVID-19

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Contents

Executive Summary

This report presents findings from a project that explored the implications and impact of the COVID – 19 pandemic on homelessness and homeless service providers in rural and remote communities across Canada. The research included an online survey and semi-structured interviews with service providers across rural Canada.

The results highlighted multiple challenges of rural and remote homelessness services providers (HSPs) in the context of pandemics. This included challenges resulting from inadequate resources – this lack of adequate resources precluded the ability for rural and remote HSPs to proactively develop a pandemic preparedness plan. This in turn resulted in a lack of resources to implement health-related measures such as hand hygiene and social distancing. Inadequate funding to rural and remote HSPs prevented the ability to quickly develop alternative shelter options for quarantine needs of infected individuals.

Through interviews and comments in the online survey - many HSPs acknowledged that they received some additional COVID-related homelessness funding that eased these burdens. This additional funding was less frequently received in smaller communities, making smaller communities and persons experiencing homelessness in those communities more vulnerable. The most significant concerns expressed by all respondents (regardless of community size) were: addressing client concerns; access to transportation; stable staffing; isolation or quarantine facilities and; access to healthcare services.

The findings highlighted that federal and provincial homelessness funding mechanisms typically favour the largest municipal entities in the country. This leaves rural and remote communities competing against each other for scarce resources. At the same time, many communities – particularly smaller communities - lack the human resources and time needed to apply for funds. This research also highlighted the critical role of transportation for rural and remote regions and the challenge that lack of transportation presents for connecting with clients and delivering services. Finally, this report concluded with recommendations for revisions to homelessness funding and resource allocation to reduce vulnerability in the context of pandemics and more broadly to assist in ending rural and remote homelessness.

Background

Responding to the vulnerability and unique needs of homeless populations during pandemics has been a major component of the Canadian federal response to the COVID – 19 crisis (Office of the Prime Minister, 2020). Rural and remote communities however, have received little to no funding aid in their care of homeless people during the pandemic (Kelford, 2020). Similarly, there has been little to no research on rural communities' pandemic preparedness in the context of homelessness. For rural communities to be better prepared for the ongoing COVID-19 crisis, and future pandemics, it is critical to understand their capacities and needs for pandemic planning. Given mobility and circular migration patterns where homeless people often migrate from cities to rural areas (Kauppi, O'Grady, Schiff et al, 2017), it is important to understand whether the pandemic has affected migration of homeless people. It is also important to understand the impact of the pandemic on the ability of rural service providers and homeless individuals to access resources that are usually provided by their urban counterparts. This research aims to fill these gaps by assessing the experience of rural and remote communities during the COVID – 19 pandemic.

Methods

This research project embraced a mixed methods design and utilized an online survey and semi-structured interviews in order to address the research questions. In particular, this research responds to needs identified by the National Alliance to End Rural and Remote Homelessness (NAERRH) and asks the following four questions:

1) What is the experience of rural and remote social service and homelessness-serving systems during the COVID – 19 pandemic?
2) Has the COVID – 19 pandemic changed migration of homeless people between urban and rural areas?
3) What are the capacity and needs of rural and remote communities in responding to the needs of homeless persons during the pandemic?
4) What new innovations in service delivery were launched to rapidly house or support people experiencing homelessness during the first wave of the COVID – 19 pandemic?

Recruitment

Survey invitations were distributed by email and through the social media accounts of the partner organisation and its parent organisation - NAERRH and Canadian Alliance to End Homelessness, as well as through the contact lists of the At Home in the North Partnership, and researchers' social media accounts.

The survey included a question at the end, inviting respondents to contact the study team if they were interested in participating in an interview. Once the survey had closed, individuals who indicated interest in a follow-up interview were contacted via email. To recruit additional participants, information about the interviews was shared through the social media accounts of NAERRH and Canadian Alliance to End Homelessness, as well as through the contact lists of the At Home in the North Partnership.

Data Collection

Quantitative Data

Survey Design

A survey was created to collect information about the experiences of rural and remote based service providers during the COVID-19 pandemic. The survey was designed to be taken online using Qualtrics software. The research team developed the survey tool through two methods. First, a subcommittee of the research team reviewed a survey instrument that team members had previously used during the H1N1 pandemic [Pandemic Preparedness and Homelessness]. Relevant questions were identified and incorporated into a survey draft, alongside COVID-19 specific questions. Second, that draft survey was then circulated to all members of the research team and discussed at a meeting. Questions were edited until the team felt confident the questions reflected the research literature, addressed the research questions, and were methodologically sound.

The survey was designed in English and subsequently translated into French, allowing participants to take the survey in either official language. However, it should be noted that none of the participants opted to complete the French version.

Survey Distribution

Prior to its distribution, the Research Ethics Boards of Lakehead University and Trent University independently reviewed and approved the survey instrument, and the research project more broadly. All participants provided informed consent at the beginning of the survey and were advised their participation was voluntary, anonymous, and could be withdrawn up until the time they submitted their responses.

Electronic distribution of the survey link occurred through professional networks, such as the National Alliance to End Rural and Remote Homelessness (NAERRH). Potential participants received a notice about the survey that detailed its purpose and provided a direct anonymized link. The survey was open for participants to complete between February 12 2021 and April 15 2021. In total 175 service providers completed the survey.

Qualitative Data

Members of the research team developed a semi-structured interview guide with questions similar to those in the survey, but with less of an emphasis on demographic data.

Questions in the interview guide were divided into 3 sections: The Local Context, the Impact of COVID-19, and Pandemic Response within a Rural and/or Remote Community. Questions about organizational and community indicators were very similar to those in the survey, however additional questions were added to gather more in-depth information about the impact of COVID-19. These questions included impacts on staff, daily operation of organizations, challenges faced in dealing with clients, and challenges caused by dealing with COVID-19 in a rural/remote community.

During the interview scheduling, participants were provided an electronic copy of the consent and information forms. Participants were asked to return the consent form prior to their interview. All participants were offered an opportunity to ask questions about the project at the beginning of the interview.

Qualitative interviews were completed using Zoom software from May to June 2021. Two interviews contained multiple individuals, for a total of 23 research participants. Interview sessions varied based on participant feedback and ranged from approximately 30 minutes to 1 hour and 50 minutes in duration.

Data Analysis

Survey Analysis

Preliminary data analysis was conducted using the “Reports” feature in Qualtrics, which provided a summary of the frequencies for each question within the survey. This provided the researchers with an overview of the results but did not allow for multivariate analysis to examine whether relationships existed between the variables being considered. To address this, the complete data set was downloaded and subsequently analysed using the Statistical Package for Social Sciences (SPSS), a commonly used statistics software program. The analysis was conducted by Dr. Joshua Armstrong, in consultation with project researchers. Survey data analysis was completed in the fall of 2021.

The data set was reviewed in SPSS and participants who did not complete the COVID-19 related questions were removed to allow for

comparisons across questions. This left a total of 136 participants who completed enough of the survey that their responses could be compared. The data set was also recoded in relation to city size, combining small and medium sized cities to increase the strength of the data for those categories.

Multivariate analysis was guided by the initial report from Qualtrics, in which the research team identified questions that showed responses that were unexpected and/or where further investigation was warranted. Descriptive graphs and frequency tables were generated for each variable combination identified, to look for patterns and identity areas for further investigation. The outcomes of this analysis are detailed throughout this report.

Using the audio and video recordings from Zoom, interviews were transcribed by members of the research team and graduate students. When transcriptions were complete, the research coordinator who conducted the interviews reviewed the transcripts for accuracy.

A thematic coding framework was then developed by the research team, and the transcripts were coded using NVivo software.

Results of the Survey

Participant Demographics

A total of 175 individuals participated in the survey. Demographic data indicates that these participants were primarily female-identified (72.26%), between 31 to 50 years of age (53.20%), had worked for their current agency less than 5 years (56.41%), and were primarily in front line positions, upper management, and middle management (30.29% / 28.00% / 18.29% respectively). The participant demographic data is outlined in the table below.

Characteristic	Category	Total*	%*
Sex	Female	38	24.52%
	Male	112	72.26%
Age (Years)	20 to 30	24	15.38%
	31 to 40	41	26.28%
	41 to 50	42	26.92%
	51 to 60	31	19.87%
	61+	18	11.54%
Number of Years Working in Current Agency	0 to 5	88	56.41%
	6 to 10	26	16.67%
	11 to 15	20	12.82%
	16 or more	21	13.46%
Current Position Type	Upper management	49	28.00%
	Middle management	32	18.29%
	Front line work	53	30.29%
	Coordinator / Admin	8	4.57%
	Volunteer / Placement	5	2.86%
	Board member	3	1.71%
	Research	1	0.57%
	Elected Official	1	0.57%

***Note:** Participants were given the option "prefer not to answer" for each question, so not all counts and percentages represent the full sample.*

Organization Demographics

The participants in this study were asked to provide demographic information about the organization in which they worked, and its geographic location. Results of the survey indicated that amongst the 175 participants, most worked at an organization that had been in operation for 16 or more years (70.67%), employed 16 or more part-time and/or full-time staff members (60.00%), and served more than 300 clients annually (57.43%). Respondents were largely working in Ontario-based communities (65.75%) that were not northern (60.42%) but had population sizes in the 10,000 to 50,000 range (40.97%). They further reported that 75% to 100% of the clients they served were from rural and/or small towns (56.34%). The organization demographics are detailed further in the tables that follow.

Organization Demographics

Characteristic	Category	Total*	%*
Years in Operation	0 to 5	21	14.00%
	6 to 10	4	2.67%
	11 to 15	12	8.00%
	16 or more	106	70.67%
Number of Paid Staff (Full and Part Time)	0 to 5	25	16.67%
	6 to 10	13	8.67%
	11 to 15	19	12.67%
	16 or more	90	60.00%
Average number of clients supported yearly	Less than 50	8	5.41%
	51 to 100	19	12.84%
	101 to 200	7	4.73%
	201 to 300	11	7.43%
	More than 300	85	57.43%
% of clients from rural and small towns	75% - 100%	80	56.34%
	50% - 74%	26	18.31%
	25% - 49%	22	15.49%
	0% - 24%	14	9.86%

Location Demographics

Characteristic	Category	Total*	%*
Organization in a northern region	Yes	52	36.11%
	No	87	60.42%
Location	Yukon	1	0.68%
	Northwest Territories	11	7.53%
	British Columbia	6	4.11%
	Alberta	7	4.79%
	Saskatchewan	1	0.68%
	Manitoba	2	1.37%
	Ontario	96	65.75%
	Prince Edward Island	2	1.37%
	Nova Scotia	3	2.05%
	Newfoundland & Labrador	17	11.64%
Population size of the community	Less than 1000	2	1.39%
	1000 - 5000	11	7.64%
	5001- 9999	22	15.28%
	10,000 - 50,000	59	40.97%
	50,001 - 99,999	14	9.72%
	More than 100,000	34	23.61%

***Note:** Participants were given the option "prefer not to answer" for each question, so not all counts and percentages represent the full sample.*

Results of Rural Service Provider Survey

Findings Section 2: Survey of Rural Service Providers

The following section of this report highlights key findings that emerged from the survey of rural homelessness service providers. This section begins with a profile of respondents - based on demographic data provided through the online survey. It then describes the findings of the survey related to key questions about homelessness service provider (HSP) experiences during the first two waves of the COVID-19 pandemic. Analysis of survey responses was focused on responding to our initial four research questions which also guide the organization of this section.

1) What is the experience of rural and remote social service and homelessness-serving systems during the COVID – 19 pandemic?
2) Has the COVID – 19 pandemic changed migration of homeless people between urban and rural areas?
3) What are the capacity and needs of rural and remote communities in order to respond to the needs of homeless persons during the pandemic?
4) What new innovations in service delivery were launched to rapidly house or support people experiencing homelessness during the first wave of the COVID – 19 pandemic?

Profile of Survey Participants

In total, there were 135 valid responses to the survey (i.e. those that were completed in full and allowed for analysis across variables). Of these responses, at least 50% were from individuals in management positions in their organisation, while at least 34% were frontline workers. Some (15) respondents replied "other" to this question, many of whom indicated roles as program coordinators or combined management/frontline staff positions. Most respondents (53%) were between 31 – 50 years of age. A majority of respondents (56%) had worked at their organisation for less than 5 years. Almost 17% had worked at their organisation for 6 – 10 years, while 25% had worked at their organisation for more than 10 years.

To check for rural / remote location, the survey included a question on location of respondents' organisation. Of the 135 responses, 32 were from organisations that were located in large, southern (non-northern / remote) locations. We conducted analysis of the data set with and without these responses. In some cases, the responses from organisations located in southern cities (non-rural locations) provided a comparison for responses from rural and northern (remote) locations – as such they are included for comparative purposes. Figure 1 demonstrates the proportion of respondents from different community sizes / locations. For the purposes of this analysis – we defined rural according to three categories, represented by small communities with fewer than 10,000 residents, medium communities with 10,000 to 50,000 residents, and large communities with greater than 50,000 residents. 34 respondents were

from communities with more than 100,000 residents.

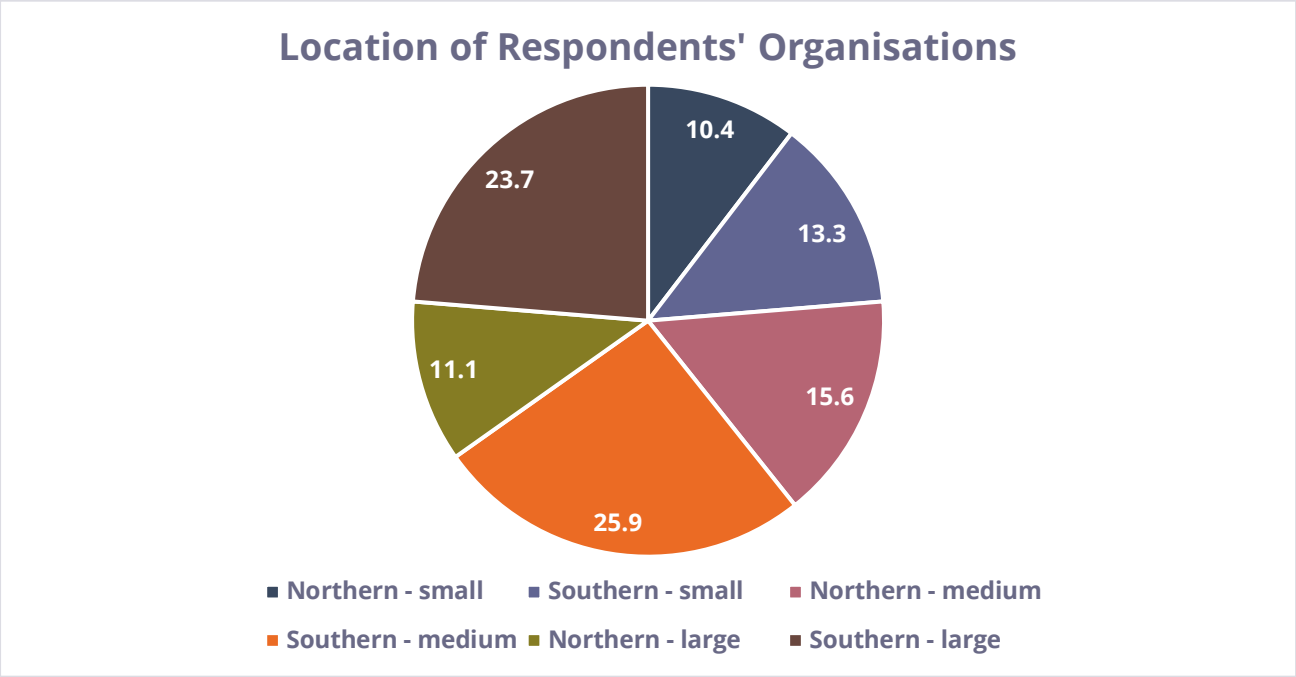

Figure 1: *Location / Size of Respondents' Communities (in percentage)*

To further clarify the rural / remote relevance of service provision, we also asked respondents about the number of clients their organisations serve that are from rural locations. Over half of all respondents reported that 75 – 100% of their clients were from rural locations, while most respondents (75%) indicated that at least 50% or more of their clients were from rural places. We further separated this according to size/location of respondents. What we can see from this analysis is that some rural organisations serve clients from urban locations – a potential indicator of urban to rural migration:

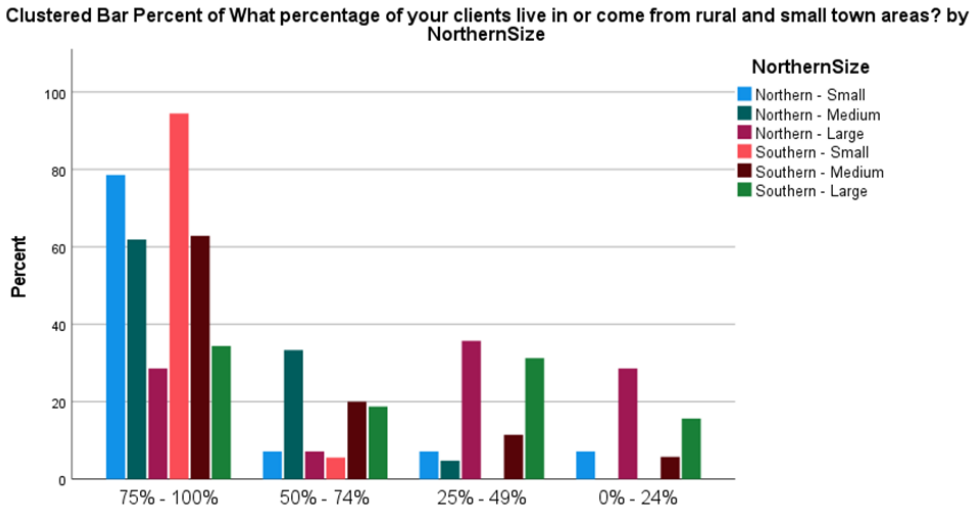

Figure 2: *Percentage of Clients from Rural Locations*

Survey Findings: Experiences during First Two Waves of COVID – 19

Pandemic Preparedness and Supports

In general, HSPs in the smallest rural towns / regions were least prepared and received the lowest level of supports during the pandemic. In terms of pandemic preparedness, most organisations – over 51% - did not have a pandemic or emergency preparedness plan prior to the COVID – 19 pandemic. This was amplified at the small (< 10,000) and medium (<50,000) size rural locations where over 60% (small) and 50% (medium) of respondents indicated that there was no pandemic plan in place prior to the pandemic. HSPs in small centres were least likely to have quarantine accommodations for symptomatic individuals. They also more frequently reported that quarantine accommodations were not available at all in their town / area:

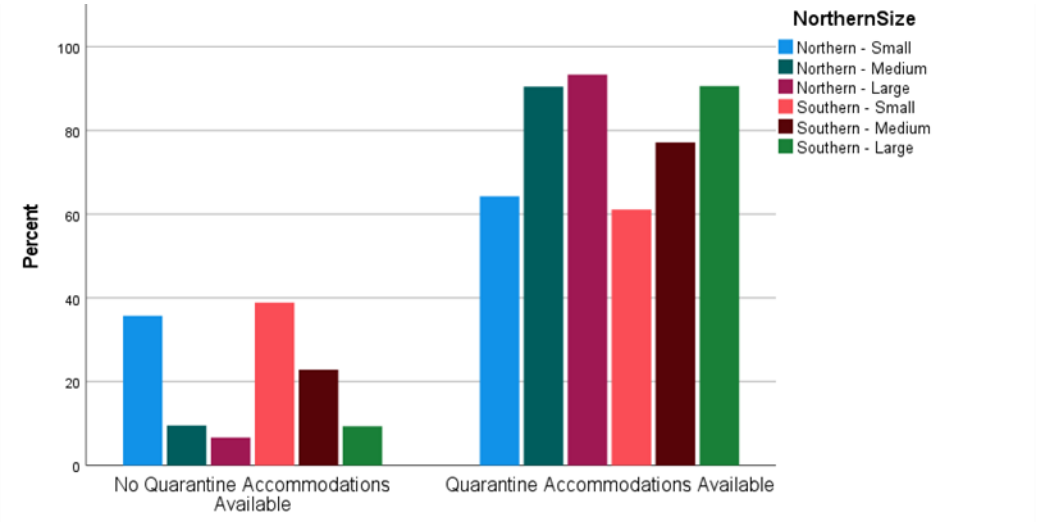

Figure 3: *Percent of organisations reporting availability of quarantine accommodations for homeless individuals at their organization or in their community*

We also asked HSPs about capacity for social distancing and additional funding received to support organizational needs during the pandemic. A majority of organisations (66%) reported adequate facilities for social distancing; HSPs in small communities reported less capacity for social distancing in their facilities, followed by those in large centres. Over 75% of HSPs reported that they had received additional funding to support their needs during the pandemic. There was little difference in terms of size and location of those who did not receive additional funding:

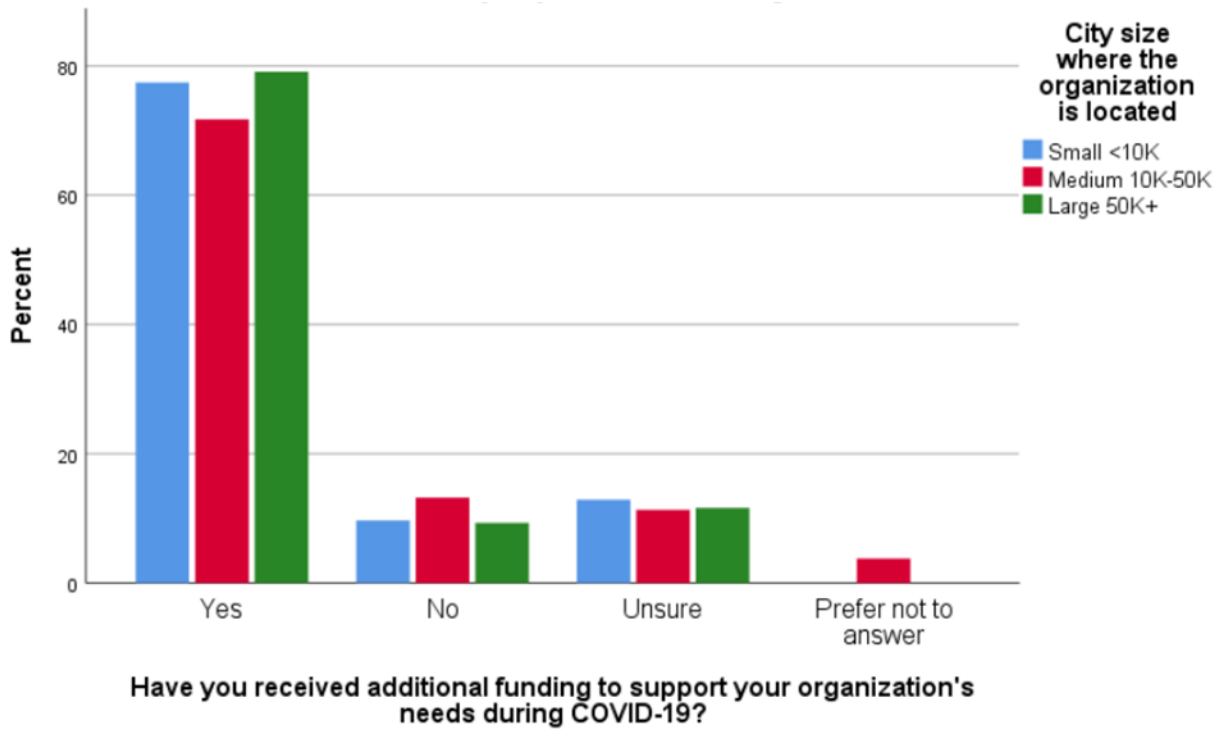

Figure 4: *Percent of organisations that received additional pandemic funding*

The most common use of funding was for personal protective equipment (PPE) (27%) followed by disinfecting supplies (19%), staff (18%), and food (17%). 54 HSPs reported that they had received funding for new infrastructure or a new program. When asked what types of new programs / infrastructure had been created, responses included creation of: a rural homelessness systems navigation program; new emergency housing; a digital navigator program; new emergency shelter; a Sunday lunch program; additional food and supplies for Inuit Elders; basic needs program – such as providing furniture and electronic devices to clients; out of the cold programming; COVID-19 drop-in location; mobile programming – vehicles to deliver programming; landlord engagement programs and; transitional housing programs among others.

In terms of funding source, we noted that HSPs in large centres (over 50,000) reported receiving regular funding (n=9) and pandemic funding (n=6) through the Rural and Remote Stream of Reaching Home. It remains concerning that HSPs in very small and even medium sized towns must compete against organisations located in large centres for funding that is meant to support rural communities.

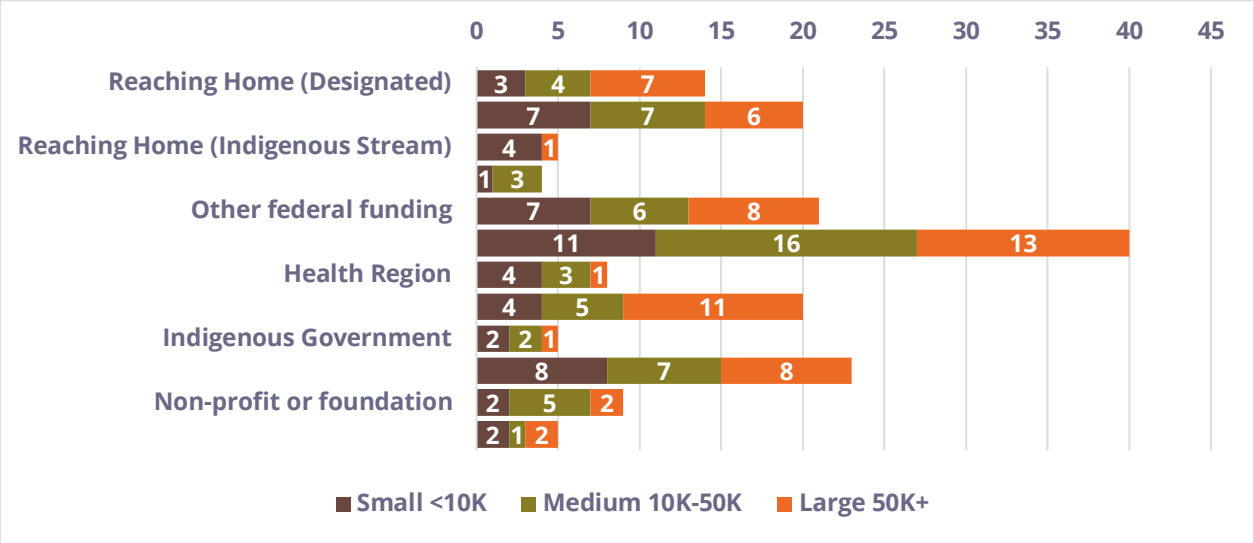

Figure 5: *# HSPs Receiving Source of Pandemic Funding by Size of Community*

Challenges and needs of rural and rural – serving HSPs during the pandemic

Turning to an investigation of adverse impacts, we asked respondents about any challenges faced by their HSP or by other HSPs in the community as a result of the COVID – 19 pandemic. The most significant concerns expressed by all respondents (regardless of community size) were: addressing client concerns and access to transportation. Stable staffing, isolation or quarantine facilities, and access to healthcare services were also reported as significant challenges. The latter two were more urgent among HSPs in small communities, while stable staffing was more urgent for those located in medium and large centres. Other notable challenges, particularly for those in small centres, were: stable volunteer support; stable food supplies; access to wifi and; access to COVID – 19 testing:

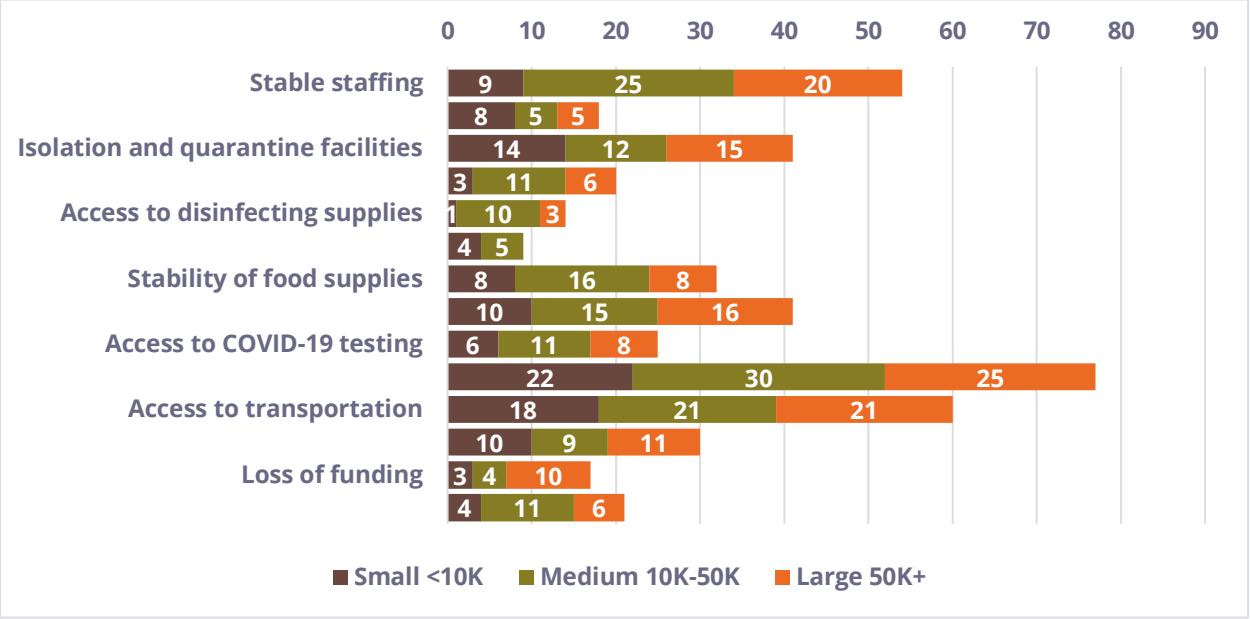

Figure 6: *# HSPs reporting different types of challenges due to the COVID – 19 pandemic*

We also examined this question across a North / South divide:

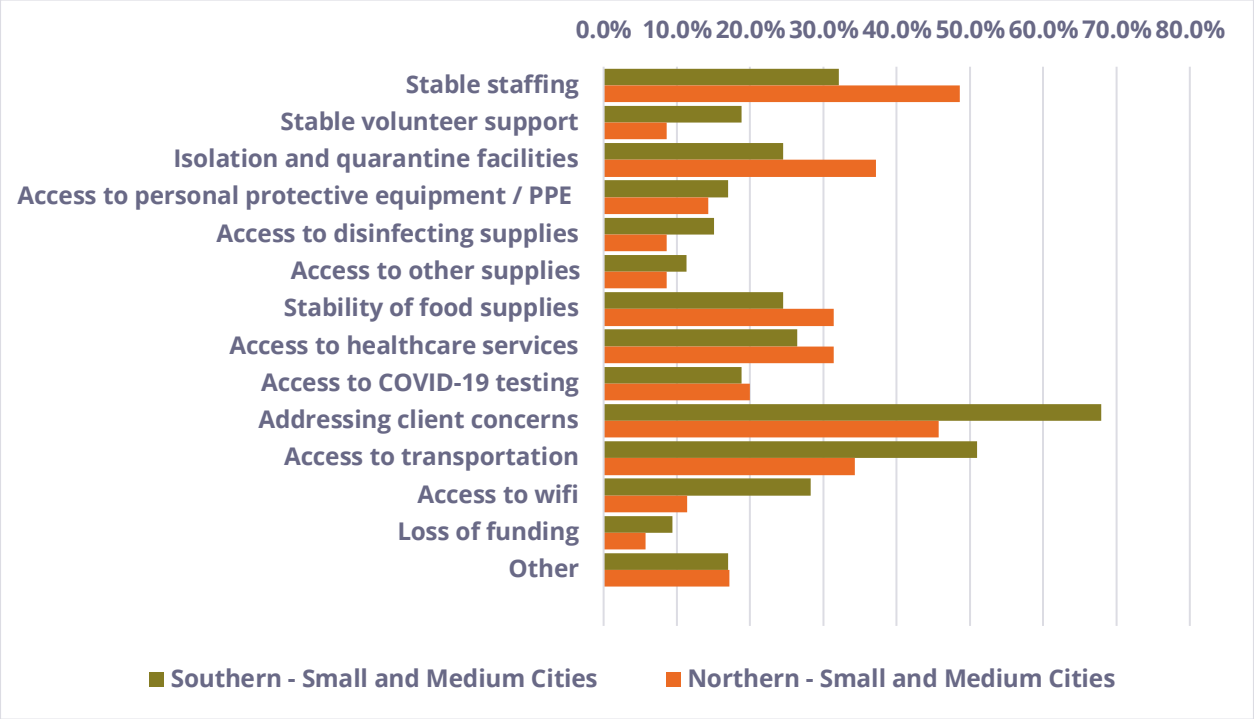

Figure 7: *# HSPs in small and medium centres reporting different types of challenges due to the COVID – 19 pandemic in northern and southern locations*

In terms of "Other" types of challenges, respondents reported the following issues: lack of housing; Finding alternative ways to provide COVID-friendly resources/programs for clients - mostly mental health and addictions supports; and infrastructure to provide resources that allows for appropriate social distancing. A majority (75%) of respondents felt that other organisations in their community were facing all or some of the same challenges. Notably, 21 HSPs (18% of respondents) reported that there were no other homelessness organisations in their community.

In general (not specific to the pandemic) HSPs reported a number of services needed in their jurisdiction to respond to homelessness as well as recommended policy changes. There were 84 recommendations provided regarding additional services needed in respondents' communities. Thematic analysis of these responses revealed the most common needs as: short term emergency housing; more affordable housing; regulated rent; cross cultural frontline training (Indigenous populations); more supportive housing and support workers; emergency shelter beds; post-housing supports to stabilize clients once they have housing and; wrap around services. Recommended policy and practice changes included 73 recommendations, which after thematic analysis revealed the following most common responses: regulatory changes to increase affordable housing construction, protection, and conversion; proportional funding for rural & remote communities; people should not have to leave their communities, families and homes to access services/resources and; mandatory anti oppressive, anti-racism, and Indigenous cultural safety courses.

Changes in Homelessness During the Pandemic

We asked respondents about changes in homelessness in their community during the pandemic. Most respondents (73%) indicated that homelessness had increased in their community during the COVID – 19 pandemic. There were some variations in response according to community size / location:

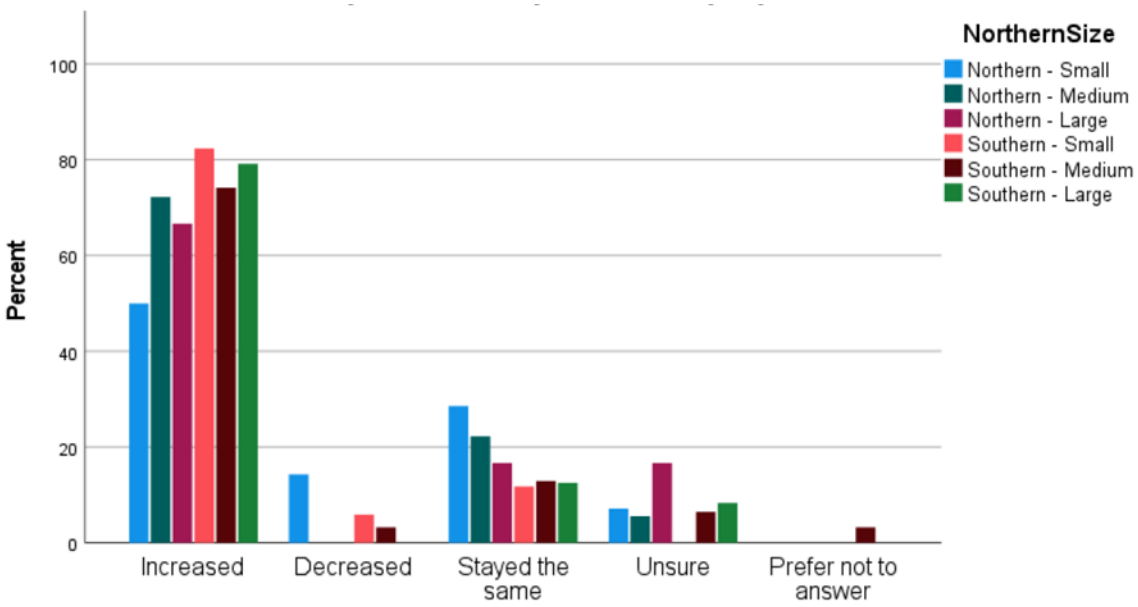

Figure 8: *Percent of organisations indicating increase, decrease, or no change in homelessness as result of the COVID – 19 pandemic*

Notably, at least 50% of respondents in all community size / location combinations indicated an increase in homelessness during the pandemic. Over 41% of respondents indicated that more people experiencing homelessness had migrated to their community during the pandemic. Another 30% were unsure and only 16% had indicated that there had been no change during the pandemic.

Additional Information

The survey also asked a number of general questions about homelessness and homelessness service provision in the communities; i.e. not specifically related to the pandemic. These included questions regarding the demographics of people experiencing homelessness in the region, types of service provided, approaches to enumerating homelessness, funding sources, and types of homelessness. These questions will be analysed separately and in comparison with previous surveys (see Buccieri and Schiff, 2015 and Kauppi et al, 2017) on these topics. Information regarding these questions and responses will be reported elsewhere and is available on request.

Limitations

We note several limitations in this survey. While there were responses from almost every province and territory, a first and significant limitation was related to the large proportion of responses from the province of Ontario. This may have skewed findings towards Ontario – specific experiences. A second and related limitation was in the number of responses from providers not located in rural areas. While almost all of these providers serviced individuals from rural locations, this may have impacted the capacity to understand rural – specific experiences. There may be confusions created at the federal level by Reaching Home funding categories in which some cities over 50,000 population are not "designated communities" and as such need to apply to the rural / remote stream. This could lead to a perception by these communities that they are rural despite their urban status. These responses from larger centres did however provide some basis for comparison between pandemic experiences in large centers as compared to those in only rural locations. A response to these two limitations could be for future surveys to explore other sampling and data collection methodologies. This could include the use of telephone and targeted / purposive sampling along with incentives to ensure distribution and rural responses. Future surveys could also consider asking respondents to provide their postal code to ensure accuracy of community size. These measures could ensure greater accuracy in rural / urban analysis and a more even distribution of responses across the provinces and territories.

Another limitation could be related to the capacity for those in the smallest and most rural locations to respond to online surveys. Many small rural locations do not have homelessness services and those that do are often significantly underfunded and might lack human resources, capacity, and time to respond. An additional related challenge could be the poor quality or lack of internet access in rural and remote Canada. Given the online nature of this survey, this might have impacted capacity to respond. We attempted to adjust for this limitation by conducting interviews (see qualitative data section) online or by phone.

Results of Service Provider Interviews

Interviewee Characteristics

In order to understand the experience of rural and remote social service and homelessness-serving systems during the COVID-19 pandemic, interviews were conducted with homelessness service providers across the country. Participants were asked to provide additional demographic information (i.e., age, gender, ethnicity, education) and location. A summary of participant characteristics is provided in Table 1.

Participant Demographic Data

Characteristic	Category	Total (n=20)	%
Gender	Female	16	80.0%
	Male	3	15.0%
	Non-Binary	1	5.0%
Year of Birth	1981 – 1996	10	50.0%
	1965 – 1980	6	30.0%
	1955 – 1964	2	10.0%
	1946 – 1954	2	10.0%
Ethnicity	Canadian Anglophone	14	70.0%
	Indigenous	3	15.0%
	First Nations (Status)	1	5.0%
	Métis	1	5.0%
	Inuit	1	5.0%
	Canadian Francophone	1	5.0%
	Other	1	5.0%
	Did Not Disclose	1	5.0%
Education*	Bachelor's Degree	7	35.0%
	Post-Graduate Degree	5	25.0%
	Some University	5	25.0%
	Community College Diploma	3	15.0%

Characteristic	Category	Total (n=20)	%
	University Diploma	1	5.0%
	Some Community College	1	5.0%
Location	Central Canada (QC, ON)	10	50.0%
	Atlantic Canada (NFLD, PEI, NS, NB)	3	15.0%
	Prairies (MB, SK, AB)	3	15.0%
	Northern Canada (NU, NT, YT)	3	15.0%
	West Coast (BC)	1	5.0%

***Note:** Some participants held multiple degrees, so totals exceed 100%*

Homelessness in Rural Canada

In order to contextualize information about pandemic experiences, we asked participants what homelessness looked like in general in their communities. When asked about the prevalence of homelessness, all participants considered homelessness to be a pressing issue in their communities. In many cases, participants described an increasing number of people experiencing homelessness (PEH) – including absolute homelessness (sleeping outdoors) due to a variety of factors including changes in the housing market, overcrowding in shelters, migration, and the impact of COVID-19 on policy and regulations:

> *Absolutely. It's become more prevalent, and more obvious. Now, I think as the housing bubble that has happened in the last year and a half is just leaving people completely without options, you know, they're getting evicted from their homes. (Participant #11 – Ontario)*

> *There were a lot more people needing help to get through the winter and we've got about 130 homeless people on [the island] …I think it's 22% of the population or something like that… it's increased every year substantially since then. More and more homeless people are coming to [the island] because it's safe and we don't have all the hard drugs here that they do in the big city, so people that are trying to get away from the hard drugs tend to come here. (Participant #3 – British Columbia)*

With the increased prevalence of homelessness in many communities, participants identified key groups who were experiencing or at risk of homelessness. Some of the groups identified as being at higher risk included Indigenous Peoples, youth, families, seniors, women fleeing violence and 2SLGBTQ+ individuals.

> *So – we do point in time counts. I have got some of those numbers down…18% identify as Indigenous, and they make up 2% of the population, right? So, they're overrepresented. Until a month ago, there was really no Indigenous services run by Indigenous people in our area. And now we've partnered to bring that in because it made sense and was very much needed. (Participant #10 – Ontario)*

Participants described both visible and hidden homelessness, with some variation depending on the resources, demographics and geography of each community.

> *For the size of our community, it's actually quite shocking… It is a visible issue, you just need to drive down the main street. The post office is a big one, the liquor store you see it, outside of Walmart you see it, outside the day shelters you see it. (Participant #2 – Northwest Territories)*

> *I think it's both visible and hidden. There are certain areas of [this town] that they're privileged enough to be in a location that's kind of away from everything, whereas the majority of the homeless services are kind of in that downtown core of [this town]. So, I think it's visible because of the impact and like the magnitude of how many people are really there. (Participant #20 – Alberta)*

When describing homelessness in their communities, several participants noted that women, youth and families were more likely to be experiencing hidden homelessness.

> *I do think that we have more individuals that are maybe youth or women experiencing homelessness that have maybe like a couch to sleep on or someone to stay with that they would be technically homeless, but they're not as visible. (Participant #16 – Alberta)*

Overall, participants provided detailed descriptions of homelessness in their communities that help to contextualize the challenges they faced as rural and remote homelessness service providers during the COVID – 19 pandemic.

Pandemic preparedness in rural & remote settings

Organizational Pandemic Plans

When asked whether their organization had a COVID-19 pandemic plan, only one participant reported having a pandemic plan in place. In this instance – in the latter half of March 2020 – the organization implemented a pandemic plan they had initially developed during the SARS outbreak. In some cases, participants mentioned having organizational plans for other emergency situations, but not specifically for pandemics:

> *We have an emergency response plan. But it didn't, it wasn't specific to pandemics. It was more of those kind of common fire accidents, gas leaks, spills, that type of thing. Yeah, we didn't specifically have one for pandemic. (Participant #20 – Alberta)*

However, the majority of participants reported being caught off-guard by the pandemic, and having no plan in place:

> *Not that I'm aware of, as far as I mean, no, I'm pretty sure not…I think, like a lot of smaller non-profits, we were kind of just caught off guard and didn't really know what to do. So, we were taking a lot of guidance from other organizations that had experienced or had some other knowledge around this. But no, we didn't have any policy in place. So even it took us a couple of months before we had some written documents around, you know, screening protocols. (Participant #6 – Ontario)*

This is consistent with previous literature that has demonstrated how limited resources in the homeless sector, and infrastructure designed

to respond to homelessness, cause organizations to be ill-prepared for a pandemic (Gaetz & Buccieri, 2016; Waegemakers Schiff et al., 2017; Schiff et al., 2020). All of these factors are exacerbated by the unique challenges of living in rural and remote communities (Waegemakers Schiff et al., 2015; Schiff et al., 2021). This was encapsulated by one participant who shared:

> *What I saw when COVID kind of arrived – no one agency – no one – has the capacity to really make the proper planning. So, one of the things that I think that is urgently needed, especially for front lines people to – actually to do the work that they need to do is more oversight on planning and you know, policy and procedures… I think COVID highlighted how much that lack of planning creates such stress on front line staff, the ones that are kind of like in the throes of it. They don't feel heard or supported. (Participant #8 – Nova Scotia)*

COVID & Pandemic Planning Information Source

To gather further information about resources for planning when the pandemic started, we asked about the source of COVID-19 and pandemic planning information. Most participants identified public health units or health ministers as their primary sources:

> *Very early on, we had a community vulnerable persons Committee. The Health Unit…was the sort of catalyst on that and brought us – like all of the sort of the agencies that are dealing with vulnerable populations and [this town] together… so most of our information and supports around COVID came through that group. But as far as protocols… That all came through that and through the health unit. (Participant #12 –Ontario)*

Other information sources reported by participants included government sources such as Indigenous Services Canada (ISC), Ministry of Health, media sources including local news and internet sources or non-profit organizations such as the Canadian Alliance to End Homelessness and The Red Cross. While some participants felt that they had sufficient information, others felt that information from their sources was inadequate, or that sources were slow to provide guidance on what to do:

> *So, when the pandemic first hit in 2020, we relied on the internet. We got some advice from the government of Nunavut, maybe a month or a month or two in, but it was guidelines, and it wasn't helpful. So, it's taken the government of Nunavut a while to get up to speed. As Iqaluit finally got COVID – actual COVID cases – in April [of] this year, then the government of Nunavut has stepped in. (Participant #14 – Nunavut)*

> *Oh officially it would be probably [the health region]. They were our biggest sources of information through the pandemic… it was an adequate from a knowledge dissemination point of view, it was not adequate from a planning point of view… I ended up having to really rely on models out of Brazil, and other places that were experiencing the pandemic ahead of us…to have enough information to make decisions. (Participant #9 – Manitoba)*

Strengths and Challenges of Rural/Remote Communities for Pandemic Response

Challenges

Due to the unique difficulties of living in rural and remote communities, many participants reported that their organizations experienced challenges in responding to COVID-19. The biggest challenge that participants described was related to service provision. When it came to providing services, many participants

reported that their organizations or communities were under-resourced and were unable to provide adequate support to their clients as a result:

> *Is it really a good idea to send them home to a dry community, where sometimes the nursing stations are not prepared to deal with withdrawal, and they just turn it on, send them back to us. But I think, really, and truly, we needed facilities, where we could keep people safe, we needed facilities where people can gather safely. And those were the things we were really lacking. (Participant #12 – Ontario)*

> *I think the biggest difference is the availability of resources and support. With bigger urban centers, there's typically more manpower, more capacity, more resources, more funding. Once you start getting into those smaller rural and remote areas, the availability of resources and support is limited. And when you add in COVID, it really stretches those organizations and those supports thin. (Participant #20 – Alberta)*

In addition to these challenges with directly providing services, many participants described lack of transportation services as a major challenge:

> *Another issue in our area is [that] there is no public transportation, there are no taxis, there are no bus services, nothing. If you're not walking, you're not getting there and when it's really rural…like I said, the nearest city is an hour away - so if you don't have a car, you're not getting there. The lack of public transportation in our province is a huge issue, particularly in our county, and it means people are really isolated and people don't have agency to do things for themselves. (Participant #4 – PEI)*

In some cases, organizations adapted their services to support clients without access to transportation by providing transportation to healthcare appointments, court hearings, or other essential services. However, adapting their services in this way places additional strain on organizations with limited financial and human resources. Stemming from the challenges created by a lack of transportation services in rural/remote communities, many participants described health concerns faced by their clients, particularly high-risk groups such as women and seniors:

> *Being isolated with abusers, and potentially, like in the middle of nowhere. You know, when you're able to get out and you're able to be in your community, you're a little bit safer, and you have somebody knowing what's going on, versus being stuck at home, you know, 40 minutes from the closest town. (Participant #11 – Ontario)*

> *So, I know last September, I started to see a lot of very isolated, very frightened seniors, because they couldn't get out. They didn't know how they were going to get their food; they couldn't do their shopping easily, they didn't have cars. (Participant #17 – Ontario)*

While isolation requirements at the beginning of pandemic were designed to reduce the spread of coronavirus, these requirements had unintended side effects. Previous literature has called for additional attention to impact of the pandemic restrictions on seniors' mental health, due to the increased social isolation (Banerjee, 2020; Armitage & Nellums, 2020). Additional literature has demonstrated that rates of domestic violence and negative mental health outcomes among women have increased during the pandemic (Sediri et al., 2020; Flores et al., 2022). One of the reasons domestic violence has increased is because of the aforementioned restrictions which "shut

off avenues of escape, help-seeking and ways of coping for victim–survivors. Restrictive measures are also likely to play into the hands of people who abuse through tactics of control, surveillance and coercion" (Bradbury-Jones & Isham, 2020, p. 1). The limited transportation options, access to reliable telecommunications and limited services in a rural/remote community exacerbates these problems.

Strengths

While participants reported numerous challenges related to service providers capacity to respond to COVID-19 in a rural/remote setting, many participants also reported strengths. The main strengths shared by participants were collaboration, sense of community, and reduced COVID spread. Almost every participant described how being in a rural/remote locale fostered a sense of community wherein service providers felt connected to their clients. Some speculated that because the communities were smaller and often more isolated, this connection was greater than it would be in a larger urban area. An example of how this sense of community emerged was through greater collaboration between service providers:

> *Our agencies are able to communicate. So, if we do have clients, you know, we have something called the situation table, where agencies will come like, I think it's every two weeks, and social agencies will come together…and if there's, say, a client who's sharing services among those, they're able to maybe problem solve, getting that person support, in whatever way that looks like… we know each other because we're each other's neighbors, right? We know the services, we know where to send people, and who to check in with if we haven't heard from somebody. (Participant #11 – Ontario)*

> *One thing that could be seen as a strength is that like we are a smaller community, so we know a lot more about our clients and see our clients more often… you might have better relationships with other service providers too, as you're collaborating with each other. (Participant #16 – Alberta)*

> *So, [the city] was really good with that, they created this community COVID response group so that we could talk to each other every week and find out what was going on. But then we already all knew each other because we're all working with the same community… I think that's a strength that that small network and allows you to act a little faster sometimes even though you know, you have the difficulties, sometimes a supplier or whatnot, and amount of resources. And then everybody's pretty committed… I think that's a strength of this community. (Participant #14 – Nunavut)*

Finally, a few participants emphasized being more rural or remote as a strength that helped to prevent the spread of COVID-19 in their communities.

> *I realized we had no cases [in this area] – eventually I think we probably had 8 or 9 cases of COVID on the island, that was it, and none of them spread, even to family members. There's been no spread, we've been very, very lucky. I gradually stopped being quite as cautious, and there were a couple of times I couldn't help myself and would give somebody a hug just 'cause they needed it so badly. (Participant #3 – British Columbia)*

> *So I would say the strengths are we were able to keep COVID out, we didn't have any community spread which is huge. We were able to offer vaccines to homeless individuals quickly and prioritize them so I think they*

started getting offered in January or February. (Participant #2 – NWT)

Overall, participants in rural/remote communities faced a unique situation in responding to COVID-19. While there were numerous challenges related to transportation and service provision, participants also reported strengths that included collaboration and reduced disease transmission.

Pandemic experiences

Funding

For many rural communities, funding for homeless services and homelessness counts is limited. While 29% of the Canadian population are rural residents (Canadian Rural Revitalization Foundation, 2021), in 2019 only 8% of federal funding was assigned to the "Rural and Remote" stream (National Alliance to End Rural and Remote Homelessness, 2021). Other streams of federal homelessness and housing funding also disproportionately favor large cities. This includes the Rapid Housing Initiative which includes a "Major Cities Stream" and no stream of funding specific to rural, northern, and Indigenous applicants. With this information in mind, we sought to understand what funding rural and remote homelessness organizations received during the COVID-19 pandemic.

The majority of participants reported receiving government funding (federal, provincial or municipal) during the COVID – 19 pandemic. Other sources of funding reported by participants included health organizations, private donations, and fundraising. In some instances, participants reported being funded by multiple sources:

We're funded through federal government so Public Health Agency of Canada… as well as Alberta Health Services and the provincial government…we also get grants from United Way funding. We have a community association in [this town] that we've accessed funding from…we also access funding through the [municipal government], and I believe that funding comes from the province. (Participant #16 – Alberta)

Acquiring government funding (especially federal) can be difficult, particularly for non-profit organizations in the homeless sector (Valero et al., 2021). The inadequacy of funding was also felt by participants:

The funding is so inadequate and barely enough to run a program. Let alone, making sure the program is doing what it needs to do, and have accountability back to the funder and community. So, if that's the situation in urban centres, it is even worse in rural centres that I have been witnessing. (Participant #8 – Nova Scotia)

Many rural homelessness organisations received funding specifically related to the pandemic. As a result of the additional funding, some participants reported new programs and initiatives that emerged during the course of the pandemic:

We actually just got funding for - from July through to December for something we were calling an in-reach worker, that will work within the hospital system. So, the hospital will have a person that will go to and they'll connect anyone leaving emergency into services, right? So, we're experimenting with that. So, I - my hope is to prove - to get a proven model out of it, that we can then get funded and grow. (Participant #10 – Ontario)

With COVID we had a COVID isolation hotel that was funded through Alberta Health Services that we got asked to kind of manage just because we have experienced with the population. So it would be for individuals at the shelter that were either close contact or had a confirmed case of COVID, then they would go to a different hotel (different than the [local hotel] that we have) to isolate for two weeks. (Participant #16 – Alberta)

Interestingly, while most participants identified benefits to the additional organisational-level COVID funding, a few participants noted challenges related to individual-level COVID funding such as the Canada Emergency Response Benefit (CERB) for clients:

One thing that we experienced over this pandemic was a lot of challenges around the CERB money… a lot of people who were not eligible for it received it because they kind of like you heard from their friends or family members, like it's easy money, you just go get it... And then when it stopped, now, we're in a position where everybody has to pay back because they weren't supposed to get it. So, like after taxes were filed in April, now in May we had like a ton of people who like missed out on their rent money and are also getting their child tax clawed back... So, like the fallout from that is crazy. It's crazy. (Participant #18 – Northwest Territories)

When everything cool came out with COVID, and CERB, that was a huge I don't even know how to explain it. A lot of our outreach claims were collecting CERB, even when they weren't supposed to be so this tax year, it really messed up their taxes, and they're ending up owing the government a lot of money. So I feel like that was a downfall on the government, because everyone was able to apply. So therefore, whoever could would, and then they're getting all this money and accepting it all. And they're not realizing what's going to happen. (Participant # 7 – Ontario)

Overall, many participants reported receiving organisational funding during the pandemic, from a variety of sources. Many reported that their organizations and communities were able to use the funding to provide additional COVID-related supports to clients. These supports included: funding to support hiring new or additional staff and; funding to provide clients with internet access and electronic devices. However, capacity to take advantage of funding and resources continues to be challenging in rural/remote communities:

Anyway, capacity is completely devastated amongst the rural communities…they cannot fill out the stupid form, let alone report on, you know, every single receipt that they need. They're just trying to keep their families' head above water and we're asking too much of these rural communities to be able to self-generate, when we've defunded them over and over and over and over again .(Participant #9 – Manitoba)

Clients

When describing pandemic experiences from the organisational perspective, some participants provided their perspective on the ways that clients were impacted. This included primarily negative effects, but a few positive effects as well. Participants also discussed challenges related to COVID testing for clients.

Negative Effects

The majority of participants described negative effects on clients, related to isolation as a result of COVID-19 restrictions. In many cases, these restrictions limited the contact clients were able to have with service providers, leading to social isolation:

So, not being able to connect with clients was a big one because if we weren't able to, well, clients weren't able to gather anywhere, then we weren't able to access them through those typical means, a lot of our clients experiencing homelessness don't have a phone. (Participant #16 – Alberta)

We saw a tremendous amount increase in isolation and the impact that that sheer volume of loneliness has on people. (Participant #1 – Ontario)

Due to restrictions, organizations had to adapt their service delivery, as mentioned previously. However, restrictions constantly changed throughout the pandemic and there were times when many communities were in lockdown. Participants described the impact of those organizations being closed, and services being unavailable:

One thing I would say is that when pandemic hit, a lot of the churches in [this town], also had soup kitchens and meals. And when the pandemic hit, they all shut down. (Participant #17 – Ontario)

But the tangible resources…things got pushed back, detox only had so many beds now…Groups, like men's groups all went to virtual, when I'd say the majority of our clients don't have access to technology sources, right? So, things that were in place that were meant to improve the quality of life for people experiencing homelessness or overcoming addictions, now those services and programs were almost unattainable. (Participant #20 – Alberta)

We had Alberta Health Services Identification Program in our community and during COVID, it just kind of shut down and… we weren't made aware of whether it was going to reopen or not. It just kind of fell off the face of the earth and then we didn't really have anywhere for our clients to access identification and without being able to access ID, or without having ID, clients can't really access anything. They can't access financial supports, housing, anything like that… So, that was a big way that our clients were affected. (Participant #16 – Alberta)

The challenges in accessing services created by the restrictions had significant effects on clients' health. A few participants noted that COVID exposure and overdose risk increased for their clients:

Our clients were also impacted because of the outbreaks in the shelter. So basically, almost all of our clients either got COVID or were in close contact multiple times of COVID…We had to reduce capacity and did closure of our office and then reduced capacity. At other times we reduced the capacity in our supervised consumption site. Our overdose numbers as a province increased significantly during COVID. (Participant #16 - Alberta)

The ones who, clients who use drugs were even more reluctant to go to quarantine, because that risk of overdose is significantly higher, knowing that they're usually alone in a room that it's not monitored by cameras, there's not people going in and out. (Participant #20 – Alberta)

Positive Effects

While the majority of participants reported negative effects on clients, some reported positive effects as well. The majority of positive effects on clients were related to new services being implemented by organizations or governments. Benefits of these new services included: greater connectivity through cell phones being provided to clients; clients being able to contribute to programs through new volunteer opportunities and; fewer clients losing their housing due to rent increase

freezes and eviction bans put in place by some provincial governments. As one participant shared:

> *Getting to see clients step and be a part of the solution and be a part of the whole organisation, right. It went from them being just a client to actually contributing to the success of the programs that we offer. (Participant #20 – Alberta)*

COVID testing

Clients testing positive for COVID-19

Responses from participants about clients testing positive varied, with some reporting no outbreaks among their clients and others reporting several. Participants also described organizational protocols for dealing with clients who tested positive, which primarily included isolation and quarantine.

Identifying clients with COVID-19

In order to identify clients with COVID-19, many participants reported that their organization had implemented screening and testing protocols. In many cases, the organizations implemented routine screening for clients and staff:

> *There's daily screening every day to get temperatures, people will come and go, to take temperatures. (Participant #10 – Ontario)*

However, some participants shared that their screening protocols varied between client groups:

> *Luckily, our transitional program wasn't affected because they're given their own room, like a kind of a small unit. And then the other one would just be the, I guess, before it was a lot easier. Someone shows up, okay, yeah, come on in. We didn't have to do pre-screening questions. We didn't have to ask all those like close contacts, taking temperatures. If someone came from out of province, we would have to get them tested and isolate them until the results came back, and then they could move back into that general population. (Participant #20 – Alberta)*

> *We would ask them if they…done the questions. Have you been out of the province, but most of the time we know who they are. And we know they haven't left the province. So quickly that those questions became pretty redundant. But if there's somebody new at the door, or something that we actually had to interact with and bring into the building, we would have those screening questions. (Participant #9 – Manitoba)*

Concerns raised about COVID-19 testing

Many participants described concerns raised by clients related to COVID-19 testing and vaccination including clients refusing to get tested, limited adherence to COVID-19 protocols, and lack of vaccine uptake. As one participant shared:

> *There was a few occasions where clients - they did not want to be tested. It created a really difficult situation. So, we have to think about the safety of all clients who access shelter. So, the couple of people that were refusing to get tested, if they were symptomatic, we had to kind of be firm and safe. If you don't get tested, you can't access services. Some clients too at first, were really reluctant to the hand washing, to the mask wearing, to the screening questions but it kind of became routine for them. And staff really had to verbalize and encourage the clients like, we're doing this for your safety. (Participant #20 – Alberta)*

In addition to refusing to be tested, some participants reported that their clients were hesitant, particularly regarding the use of rapid antigen tests for asymptomatic individuals. As one participant explained:

> *Some questions around the rapid antigen testing that we're rolling out now. The testing in and of itself is to target asymptomatic individuals, so you're asking people who are feeling perfectly fine to swab their nose and many people are a bit leery [about] where's the information going, so lots of communication around that. (Participant #1 – Ontario)*

Fortunately, some organizations got creative and were able to address vaccine uptake issues by removing some of the barriers for clients. In many cases, these barriers included transportation challenges, low health literacy and clients having limited information about vaccines. One participant described their organization's strategy:

> *We just had our vaccination clinic and we were trying our best to reach out to everybody to try and see if any of our homeless clients wanted to come. We offered transportation, there was a free meal and things like that, and I think we only had maybe 10 people in total sign up - 10 or 12 - we ended up having more than that show up which was great, but a lot of our clients were like 'nope, I don't want that', 'there's not enough research'. (Participant #5 – Ontario)*

While these approaches had positive outcomes, some of the concerns shared by participants were rooted in deeper issues, particularly for Indigenous clients, such as historical mistrust of the healthcare system:

> *Because being, you know, the freshest ground of colonization in Canada. So, we have people living in the shelter who grew up on the land. So, we have that generation, the last generation who grew up on the land and the shelter and their experience with the mainstream society, with colonized medicine [has] not been good. There's a lot of mistrust… and they still get treated very poorly in comparison to southerners or non-Inuit in the medical system. And so out of respect for their experience, I did not, I didn't have a program of trying to get vaccine uptake. (Participant #14 – Nunavut)*

> *Yeah, I have a lot of team members within the First Nations here, and then a couple of my team members don't want it. And I can't push it. I just give them the information… I understand the hesitancies of it. The conspiracy theories. I hear a lot [of] them, from them. (Participant #13 – Ontario)*

Overall, participants described challenges with getting clients to accept COVID tests, follow protocols and get vaccinated. For some participants, this was clearly linked to the impacts of colonization that have and continue to effect how Indigenous Peoples interact with the healthcare system. While these challenges go beyond following protocols, some organizations were able to address these issues and keep their clients safe during difficult times.

Staff

In addition to the impacts the pandemic had on clients, staff within homeless serving organizations were also impacted. In order to understand how staff were impacted, participants were asked about positive and negative effects on staff, concerns raised by staff, and pandemic-specific training.

Negative Effects

When it came to negative effects, the most significant theme reported by participants was

the impact to the mental wellbeing of staff within their organizations. Participants described these impacts as: burnout; stress; fatigue and; languishing due to the challenges of working during the pandemic:

> *I think COVID highlighted how much that lack of planning creates such stress on front line staff, the ones that are kind of like in the throes of it. They don't feel heard or supported. They don't feel that they're given the right - just the right – the right resources to do their jobs on a day-to-day basis. They're not given the space to practice adequate self-care. So, the burn out, I felt, COVID was kind of highlighting something that existed that we easily ignored pre-COVID. (Participant #8 – Nova Scotia)*

> *Languishing. Languishing which greatly affects morale. The whole situation is something that no one's gone through before… I think languishing is probably the best way to capture how people are feeling. It's almost a sense of - like it feels unjust that we're continuing on in this, even though it's got nothing to do with social justice at all. People are just worn out and tired, and when your job is to hold that hope up like I was talking about, you've gotta make sure that you've got energy coming from another source so that you're not completely burnt out. So, I would say there are major concerns with respect to morale and languishing. (Participant #1 – Ontario)*

In addition to the negative effects participants reported, they also shared concerns raised by staff within their organizations. The majority of participants reported staff being anxious or scared about contracting COVID-19, management not being responsive to the needs of staff, and staff taking on additional duties beyond the scope of their training or abilities. As one participant summarized:

> *At the beginning of the pandemic, there was such a push that we provide our services… we had to remain very active because of course, the funding was still coming in and there's always that pressure to rationalize, you know, your funding and whatnot. So, there was so much pressure to maintain our presence in the community… but staff were - myself included…we really wished that management could have seen we needed to just like chill out for maybe a week or two, you know… It's a worldwide pandemic, and like we're stressed… of course, we're supposed to be providing services to others. Yet at the same time…there was a little bit of a misstep as far as not recognizing that staff just needed to…take stock of this new situation that was occurring, rather than feel like these new impending pressures to perform in whole new ways. (Participant #15 – Newfoundland)*

The responses of participants highlighted significant impacts on staff health and well-being. The mental health impacts to staff in the homeless sector, due to the pandemic, are also being examined through other research (Carver et al., 2022; Waegemakers Schiff et al., 2021), although there is less documentation of impacts specific to rural and remote communities.

Positive Effects

Overall, positive effects on staff were limited. The positive effects reported by participants included COVID funding being used to provide a pay increase for staff, greater cohesiveness among staff, and support from other community organizations. As participants shared:

> *The one thing it did on the positive note, it really brought the team together. We saw people working more cohesively than they ever had. (Participant #20 – Alberta)*

I think I'm just very proud of my community. And I'm very proud of the surrounding communities that we came together for the first time in a long time. It's been a fight to try and get there because like I said, we're always fighting over proposals or money from the government. But we came together…it's got us nations finally talking and I think it's beautiful. It's got this team stronger. We're more of a family now than we've ever been, even the ones working at home, they call daily and ask how we're doing. Do we need help for deliveries? I've never seen this much help in a long time. And it's beautiful. (Participant #13 – Ontario)

Pandemic-Specific Training

In addition to adapting service provision, trying to find funding, and supporting staff, organizations also had to provide training for their staff. While some organizations received pandemic-specific training, most participants reported that this was not something their organization had offered. In some cases, organizations had provided information on safety protocols, with no follow up. As one participant shared:

I don't see anything about training, it's mostly read the documents and then like 'this is how you properly put on gloves', 'this is how you dispose of gloves', 'how to put a mask on'. (Participant #5 – Ontario)

Other organizations had ongoing discussions about pandemic procedures but did not provide any training. As one participant explained:

I don't know if you mentioned this yet, but pandemic specific training, like we haven't done any kind of specific training. We haven't really, like we started to talk about our pandemic planning procedures, but we haven't reviewed it. (Participant #6 – Ontario)

Among those whose organizations did receive training, the majority of participants reported that they received training related to personal protective equipment (PPE). Most of the training consisted of online resources (webinars, modules), but in some cases, health organizations provided on-site training.

Yeah, webinars on donning and doffing gowns, how to put on a mask, that's really about it actually. (Participant #1 – Ontario)

[The health region] helped us with doffing and donning procedures and training for doing that stuff (Participant #9 – Manitoba)

Yeah, [training] from the Red Cross. PPE and sanitization. You know, social isolation or isolation or distancing. Yeah, just those basics. (Interview #14 – Nunavut)

Overall, training was not provided to staff in all organizations, information was often provided through online resources with no follow-up, and was primarily related to PPE. As mentioned previously, some participants reported increased mental health issues, overdoses, and COVID cases among their clients. Staff in many organizations were also dealing with mental health issues, burnout, stress and fear related to COVID-19. Additional training on topics such as mental health first aid, crisis intervention and crisis and emergency risk communication could have been beneficial in helping staff to deal with the challenges of the pandemic (Chirico et al., 2021; Brooks et al., 2017).

Organisational infrastructure and resources

Access to Personal Protective Equipment (e.g., masks and gloves)

At the beginning of the pandemic, supply chains for numerous items were affected by national lockdowns which slowed or even

temporarily stopped the flow of raw materials and finished goods, disrupting manufacturing and limiting available supply. As a result, access to PPE like masks and gloves, as well as other essential products like hand sanitizer was limited. Some participants reported significant issues with obtaining PPE at the beginning of the pandemic, however this was not consistent across the participant pool. Many participants reported having timely access to PPE at the beginning of the pandemic when the supply chain was greatly affected, and up to the point of interview during the third wave of the pandemic.

Design and set-up of facility

Due to the implementation of government protocols such as social distancing, many organizations had to re-evaluate the design and set-up of their facilities and adapt their services accordingly. Measures such as decreasing the number of available beds, building plexiglass barriers, and reorganizing office space to allow for one-way traffic were reported by participants. As some participant shared:

> *It's really changed kind of how we can implement any of our programs, really, because of the mostly the physical distancing. So not being able to have so many individuals in a space, we've had to get creative on…how can we split it up and kind of break the program down into two locations without purchasing a building to put them in. So, the one thing, our MAT program, we've had to actually create two different locations for it - splitting it up so the numbers could be safely distance from one another. (Participant #20 – Alberta)*

> *With the outbreak of one in the building, we have an upstairs and downstairs. Food bank is down below, so is our office, and the kitchen dining area is upstairs. For a while…what the Health Unit told them to do is "do not mix the two halves of the building". People downstairs stay downstairs, the ones upstairs stay upstairs, no mixing of the two. There's only one problem with that, the food is downstairs so, you gotta find a way to get the food upstairs. (Participant #17 – Ontario)*

Isolation and quarantine arrangements

In addition to having to adapt their services based on the layout and design of their facilities, organizations were also tasked with making isolation and quarantine arrangements. Several participants described using off-site isolation and quarantine arrangements for their clients including hotels, community centres, and re-purposing buildings such as schools and hotels:

> *I worked with the municipality to develop a separate isolation space in an old school with equipment donated by the [government] so that if you were homeless or living in a congested environment and needed to isolate, there was actually a space for you to go and safely do that. (Participant #1 – Ontario)*

> *We did actually become part of a working group that put together a self-isolation center. So it was through the county, it was collaboration through the county, mental health, and then us, and we had a couple hotel rooms; we still actually have it available for anyone who tests positive, if they're living in a, you know, in a shared accommodation, if they're living at the shelter, then they have a safe place to go. (Participant #11 – Ontario)*

> *So, we can't isolate in the facility… I know some shelters in the north, for instance Yellowknife… cut down their occupancy rates, but we can't do that…So, we really don't have an opportunity to do that without creating*

homelessness…So, public health jumped in, and they started renting a floor of a hotel in order to isolate people who tested positive, or those people who also use the same bedroom as those people who tested positive. (Participant #14 – Nunavut)

Innovative Approaches

In spite of all the challenges that communities have faced, participants shared several examples of unique and innovative approaches for dealing with COVID-19. Many of these innovative strategies emerged through collaboration and resource sharing between organizations and provided immense supports to clients. Some examples aimed to increase the availability of services and resources to clients during the pandemic, removing barriers to necessities like housing. As one participant shared:

We took a page out of Calgary's book, we did something called the 200 doors campaign. So, we got some funding and 10 organizations came together and said, you know, let's stop competing for landlords for our clients. Let's have one person bringing in all those and they asked the landlord who are you looking for? So together, we're going to house 200 people and we knew we'd do much more than that. But it's one group we were able to do a lot of marketing and media around the campaign, raise awareness and do that. (Participant #10 – Ontario)

Other examples include organizations working with local businesses during lockdowns and closures, in order to maintain the local economy and provide services for clients. One participant shared an especially innovative idea that emerged in their community:

One of the neat programs put in place was different businesses from around the county could make donations. Let's say I run some water business that has stayed open 'cause it's essential, I can make a $1,000 donation to the European bakery, [and] that's $1,000 the European bakery wouldn't've had before. With that $1,000 they make up microwaveable meals of lasagna, and then they give that to United Way, United Way provides it to outreach services, and the meals are taken out that way. The business wins 'cause in reality it's a tax write-off, the restaurant wins 'cause that's a $1,000 they wouldn't have, and the 55 plates of lasagna that you get for $1,000, well now there's 55 people eating at night that wouldn't have eaten before. (Participant #1 – Ontario)

Finally, other innovative strategies revolved around helping clients navigate services in spite of all of the disruptions, misinformation, and closures while also maintaining a sense of community. One participant shared an example of how this emerged in their community, inspired by a similar program in an urban centre:

Ask Auntie has been our communication strategy for dealing with clients through COVID…I'm not sure if you know Call Auntie out of Toronto. So, it's an Indigenous focused organization that is a pathfinding organization. So, you call them whatever your social ill may be, and they'll direct you to the organization that you need to be in touch within Ontario. Obviously, we're dealing with a different population, and we don't have phones, so instead of having a call center, we have a couple dedicated individuals, and a building that's located downtown. They know that Ask Auntie is around, we're out, we're helping… Ask Auntie became the de-facto catch all for pathfinding and a little bit of

housing placement...we've kept in touch with the community, obviously, through social media and Facebook a little bit…but in a community like this, it's got to be boots on the ground, and you have to be visible…Ask Auntie is the most innovative and well received program that we we've launched honestly. (Participant #9 – Manitoba)

Overall, many organizations were creative in finding ways to navigate the unique challenges of COVID-19 in their communities. In addition to demonstrating the innovation among rural homelessness service providers, these innovative solutions may also highlight ways that systems could be improved, or new strategies could be implemented permanently so that organizations are better able to serve their clients.

Needs & Recommendations

As part of the final interview questions, participants were asked about needs and recommendations to better support rural/remote communities during a pandemic. Aside from additional funding to support people experiencing homelessness, participants identified transportation, internet access, and more affordable housing as key issues:

You know, even before the internet, I'd love to see transportation in this area. And it's, again, it's an ongoing issue, and it's been an ongoing issue for - since the community started, the community started growing as well. Transportation, and but also just building that affordable housing and making sure that, you know, especially like in places like [the town I live in] where the building is happening so rapidly, and so quickly that, you know, within those spaces, there's affordable options for the people who already live here. (Participant #11 – Ontario)

Participants also described the need for more support services, in particular mental health supports as described by the interviewee from Newfoundland & Labrador:

It's an ongoing issue as far as mental health support… we've known for some time that our suicide rates are so high, and we're often scrambling for psychologists and mental health therapists who remain long enough in the community. So yeah… More mental health supports…I think people really appreciate the in-person relationship. But there certainly are like helplines and there's more of this kind of platform available. And probably the younger people may access that more and more comfortably, but certainly, our seniors aren't that comfortable with these platforms. Yeah, so that's the aim. For my mind, that's the number one, some more health resources, especially in the mental health field. (Participant #15 – Newfoundland & Labrador)

A most significant concern is related to the capacity of rural, remote communities and small organisations to compete for and take advantage of funding opportunities. This participant from Nunavut offered recommendations for addressing this issue at regional and federal levels:

I think that, you know, there was a lot there was - there were a lot of funding streams that went out around COVID. From the feds, and from all over the place, I think that it was, it was a little bit dizzying and difficult for small organizations to really manage taking

advantage of that. We're in the middle of trying to deal with it at the service level, and then to try to also do all of that. So, I think some kind of inter-governmental, or organizing body or office or something would have been helpful around just even the funding streams, and the access to them. (Participant #14 – Nunavut)

All of the needs highlighted by participants are linked to the unique contexts of rural/remote communities, discussed previously, and reflect a needs for systems level changes related to funding and supports for homelessness organisations as well as supports needed at a larger scale – including for mental health and healthcare. In order for these communities to be able to adequately meet the needs of their clients, more attention needs to be paid to the unique challenges that exist in rural/remote communities, with recognition that existing funding arrangements, financial, human resources and infrastructure resources require attention to achieve health equity in these regions.

Limitations

During the initial waves of the pandemic organizations serving homeless people reported that they were beset by multiple requests for research participation, while simultaneously having to cope with a constant barrage of changing operational guidelines to address public health concerns (Campbell, Noël, Wilkinson, Schiff, & Waegemakers Schiff, 2022). These demands on under-staffed and under-funded small rural organizations made it difficult to respond to requests for participation of any surveys and/or follow-up interviews. Thus, the response rate was biased towards larger organizations with greater resources and staff availability and most often these were close to urban locations. Another potential influence was the use of a generalized requested for participation, as targeted emails to specific individuals may have yielded a greater response rate.

Internet access is also a greater challenge in rural locations, which leads many to abandon attempts at participation as the "net is slow or down". The response rate to the survey might have been further impacted by email recruitment which has historically provided response rates that are low (Shih & Fan, 2008). Email requests also lack the personal component that has been shown to be effective in increasing organizational participation (Schiff, Weissman, Scharff, Schiff & Knapp, 2022). As a result, the convenience sample may not be representative of all rural and remote locations.

The over-representation of organizations based in Ontario can not be entirely attributed to email recruitment, but the reasons for the lack of robust participation from Western regions (Prairies and BC) as well as the Northern Territories and Nunavut, are not well understood and make it impossible to ensure that study results apply in all of those locations.

Respondents focused almost all of their comments on structural issues that impact the delivery of goods and services to persons in housing need. However, the lack of attention to the providers who deliver these services leaves a gap in understanding how best to meet rural needs. Other work has reported that staff in serving homeless and vulnerable people often lack the education and adequate supervision (Schiff & Lane, 2019). Lack of expertise may be experienced at all levels of small organizations in rural communities and this in turn impacts their ability to apply for necessary fiscal supports from regional and provincial authorities. Further work should include a specific target on staffing issues and needs as other pandemic research has also emphasized the critical importance of frontline services providers.

Conclusions & Recommendations

While the COVID-19 pandemic impacted communities around the world, we set out to explore the experiences of homelessness service providers in rural and remote Canadian settings. Throughout this report we have outlined the findings of a mixed methods study that included a national survey and set of interviews with rural and remote based service providers. Below we offer a summary of the key findings and, where needed, specific recommendations based on these learnings. The findings and recommendations are dived according to four guiding research questions.

Research Question 1

What is the experience of rural and remote social service and homelessness-serving systems during the COVID-19 pandemic?

Managing COVID-19 strained already over-burdened rural and remote homelessness service agencies

Many rural and remote service providers noted that theirs is the only organization available in the town where they work. The additional strain of operating existing programs while taking on new pressures, responsibilities, and constraints was considerable. Many reported that it was not possible to continue running all the supports that were available pre-COVID, such as food banks and harm reduction programs.

Recommendation:

As a nation, Canada is increasingly shifting towards a preventive approach to addressing homelessness. Rural and remote communities would benefit from this approach but may need even more funding and resources to help them recover from the impacts of the pandemic while moving towards a preventive model.

Rural and remote homelessness service providers shared many common concerns during COVID-19

Addressing client concerns, accessing transportation, and ensuring stable staffing were the primary three concerns of rural and remote homelessness service providers during COVID-19. Additional mid-level concerns included isolation and quarantine facilities, access to health care services, stability of food supplies, access to COVID-19 testing, and access to wifi. Less frequently cited concerns included stable volunteer support, access to personal protective equipment, access to disinfectants, and the loss of funding.

Recommendation:

Communities have a keen sense of their own needs. Funding should be provided on an "open-basis" that is less proscriptive and allows them to direct it towards the areas of support they deem to be most critical for supporting their community members.

Homelessness service providers in rural and remote settings experienced burnout, stress, fatigue, and languishing during COVID-19

There was a considerable amount of pressure on service providers to maintain – and even increase – the amount of support they were able to provide. This occurred at the same time that there were constraints placed upon them. Service providers expressed feeling overwhelmed and as though they did not have adequate opportunities to reflect on their feelings and engage in self-care practices.

Recommendation:

Stress and fatigue were not limited to rural and remote homelessness sector workers, but they did carry a high level of responsibility with few resources during the pandemic. As COVID-19 levels decrease, organizations should be funded to provide benefits to their staff. These include additional paid vacation time and mental health benefits. Managers may also wish to implement self-care practices into their organizational practices, such as through 5-minute guided meditations at staff meetings.

Public Health Units served as the primary source of information about COVID-19 in rural and remote communities

Access to information about COVID-19 was generally attained through Public Health Units, whether based within the community itself or at the provincial / territorial level. Other sources of information included Government agencies, non-profit organizations, the news, and the Red Cross. Access to information can be challenging in rural and remote communities where internet access is not always reliable or available.

Recommendation:

Public Health Units should continue to reach out to rural and remote communities and provide timely and tailored information to homelessness service providers in these areas. They must also make efforts to use non-internet-based means of communications, such as the telephone.

There was a lack of COVID-19 specific training in rural and remote homelessness service agencies

Many service providers indicated that while training was provided, it generally occurred through online videos about wearing personal protective equipment. This approach meant that they did not have the opportunity to ask questions or receive clarification on the procedures shown.

Recommendation:

Homelessness service providers in rural and remote communities may require outreach training from public health nurses and health promotion workers. These could be offered at a central location in small towns and may even be grouped with other professionals (such as teachers).

There was some resistance to COVID-19 testing, protocols, and vaccination amongst people experiencing homelessness in rural and remote communities

While resistance was not widespread, there were some individuals experiencing homelessness who raised concerns about COVID-19 testing and vaccination. This was largely attributed to uncertainty about what would be done with the information collected and/or a lack of trust in the government. This latter reason was particularly evident amongst Indigenous individuals.

Recommendation:

It is important to listen to people with lived experience of homelessness. For some, fears or resistance may be addressed by talking to them about their concerns and sharing information. For others, mistrust of government or misalignment of cultural health practices may be the driving factor. These reasons must be heard and respected. General uptake of vaccines may be improved by offering site-specific clinics, such as in shelters or programs that offer food onsite.

Research Question 2

Has the COVID -19 pandemic changed migration of homeless people between urban and rural areas?

Visible homelessness increased in rural and remote communities during the COVID-19 pandemic, particularly as people relocated from urban areas into small and/or southern towns.

Nearly three-quarters of rural and remote homelessness service providers reported that homelessness increased in their community during the pandemic. This increase was particularly evident in small and southern-based communities. The findings of this project indicate that there was a notable migration of people from urban settings into rural communities, likely contributing to the increase of people experiencing homelessness in these areas.

Recommendation:

Rural and remote communities need designated funding and resources for deeply affordable housing. With an increase in clients – and a migration from urban to rural – this demand will continue to grow. The affordable housing stock must be increased and must be made available to those in even the lowest income brackets.

Research Question 3

What are the capacity and needs of rural and remote communities in responding to the needs of homeless persons during the pandemic?

Funding for COVID-19 support was available, but inequitably distributed to smaller towns

Approximately 75% of rural and remote communities reported they received additional funding to address COVID-19 needs for people experiencing homelessness. This figure, while seemingly robust, indicates that 1 in 4 rural and remote communities did not receive dedicated pandemic funding. This lack of funding disproportionately impacted smaller towns.

Recommendation:

Federal funding for rural and remote communities is inequitable as most funding is channelled to the 62 designated communities (CABs) across the country. All other towns, villages, and rural areas are left to compete for a small residual amount of money. The competition for scarce resources adds a greater disparity for rural and remote communities. The federal government should review and revise the criteria for rural and remote community funding streams to ensure the communities most in need are able to apply and receive funding, without it being diverted to larger communities that are already eligible to benefit from other competitive funding streams.

Small towns were less equipped to respond to COVID-19 than medium and larger size communities

Homelessness service providers in the smallest rural towns and regions received the lowest levels of external support during the pandemic and subsequently were the least prepared to respond. Over half the organizations did not have a pandemic plan, which was more likely to be reported by those in small towns, where 60% did not have a plan in place. Homelessness services in small towns were least likely to have quarantine accommodations for symptomatic individuals and had limited capacity for social distancing.

Recommendation:

Granting processes should include additional application supports for small organizations in rural and remote communities. This may include having a dedicated member of the granting agency reach out to rural and remote communities to ensure they know about the funding, and have support to access, complete, and submit the forms.

Implementation of social distancing guidelines meant that many agencies had to physically redesign their spaces to accommodate clients

Government-issued mandates changed during different waves of the pandemic. These changes meant that homelessness serving agencies in rural and remote communities had to physically adjust the layout and design of their facilities. They also had to make isolation and quarantine arrangements, such as through hotels, community centres, and by repurposing buildings.

The administration of the Canada Emergency Response Benefit (CERB) may have forthcoming detrimental impacts for people experiencing homelessness

Many rural and remote service providers indicated that clients they serve applied for the CERB because they needed money and it was an open application process. However, these individuals did not qualify under the guidelines and are now being assessed for that money through their taxes. These individuals, who are living in poverty and/or experiencing homelessness, are being asked to return this money to the government.

Recommendation:

People who are experiencing homelessness or housing precarity should be exempt from returning the CERB benefit, even if they received it without meeting the eligibility criteria. Requiring that they return money will only serve to place them at further risk. It could also lead to longer term consequences, such as lowered credit ratings that impact rental abilities.

Some populations may be at increased risk of (and from) homelessness in rural and remote settings

Rural and remote homelessness service providers identified Indigenous Peoples, youth, families, seniors, women fleeing violence, and 2SLGBTQ+ individuals as being disproportionately at risk of homelessness in these areas. They also noted their experiences may be different, such as being amongst the hidden population experiencing homelessness in a community.

Recommendation:

Dedicated funding is needed in rural and remote communities to help them ensure their programming is as broad and inclusive as possible. Smaller towns may not have the capacity to have entire services dedicated to sub-populations but with additional funding they may be able to offer increased tailored supports within existing agencies.

Government-issued lockdowns led to isolation that was dangerous and frightening for seniors and those living in abusive situations

Homelessness service providers in rural and remote communities generally understood the need for lockdowns as a means of controlling the spread of disease but also emphasized that these measures negatively – and disproportionately – impacted some vulnerable populations more than others.

Recommendation:

Funding for navigator and outreach positions is critically important for isolated and vulnerable populations, such as seniors and people living in abusive situations. Having these supports available are particularly important in rural and remote settings, as other resources may be limited and having someone “check in” on isolated individuals can be life-saving.

Research Question 4

What new innovations in service delivery were launched to rapidly house or support people experiencing homelessness during the first wave of the COVID-19 pandemic?

Service providers and clients fostered a strong sense of community in rural and remote settings

Despite the incredible challenges of managing homelessness in the midst of a global pandemic outbreak, rural and remote communities banded together to find locally-inspired means of providing support. What is evident in this research is the resilience, creativity, and capacity of these providers and their clients to come together.

Rural and remote communities showed remarkable innovation in supporting people experiencing homelessness during COVID-19

With the funding they received for COVID-19, rural and remote communities undertook a broad range of initiatives. Examples of these include the creation of a rural homelessness systems navigation program, new emergency housing, a digital navigator program, new emergency shelter, a Sunday lunch program, additional food and supplies for Inuit Elders, basic needs programs such as furniture and electronics, out of the cold programming, COVID-19 drop-in locations, mobile programming, landlord engagement programs, and transitional housing programs. A novel organization created an "inreach worker" position to help patients connect with services and supports during their stay in hospital. Another organization created a linked system of donation, to support businesses that were closed to the public so they could provide products (such as meals) to people experiencing homelessness.

Recommendation:

Homelessness service providers in rural and remote settings work hard to support and empower people experiencing homelessness in their communities. They should be recognized and commended for their efforts.

The findings of this study provide evidence for the degree of struggle that rural and remote communities endured during COVID-19, but they also offer insight into the remarkable strength and creativity that exists. We must commend these homelessness service providers for the work they did while also recognizing that they should not bear the weight of the lack of funding. Particularly in small communities, the impact of the pandemic has been significant. These are strong and resilient communities but must be supported to continue the work of ending homelessness in rural and remote parts of Canada.

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