# There's nowhere to go: Navigating the displacement of people experiencing homelessness during COVID-19

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ER, SH, JL, PD, and TK conceived the study. All authors helped design the study. KH, JP, and CJP collected and analyzed the data. KH, JP, CJP, ER, SH, JL, and TK interpreted the data. KH and TK drafted the manuscript and all authors critically reviewed it. All authors read and approved the final manuscript.

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**Conflicts of interest**

The authors declare no conflicts of interest.

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**Abstract:**

**Background:** People experiencing homelessness are vulnerable to SARS-CoV-2 infection and its consequences. However, little research has been done to understand their experiences during the COVID-19 pandemic and the perspectives of healthcare workers caring for them.

**Methods:** We conducted an interpretivist qualitative study in Toronto, Canada. Participants were patients experiencing homelessness who received COVID-19 testing, healthcare workers who worked at a testing centre or emergency department, and homeless shelter staff. Using individual interviews, we explored the experiences of people who were homeless during the pandemic, their interaction with shelter and healthcare settings, and related system challenges. We analyzed the data inductively using reflexive thematic analysis.

**Results:** We conducted 26 interviews between December 2020 and June 2021 and identified three themes. First, participants described 'Navigating the Unknown', grappling with new and evolving public health guidelines that did not adequately account for homeless individuals. Second, they described 'Confronting Placelessness'. People experiencing homelessness often had nowhere to go due to public closures, reduced shelter capacity, and a lack of isolation options. Finally, participants shared 'Struggling with Powerlessness'. Patients lacked agency in their placelessness and healthcare and shelter workers lacked control in the care they were able to provide leading to moral distress.

**Interpretation:** Reduced shelter capacity, public closures, and lack of isolation options exacerbated the displacement of people experiencing homelessness during COVID-19. Caring for this population amidst resource constraints led to moral distress among providers. Planning for future pandemics needs to account for the unique needs of those experiencing homelessness.

## Introduction

Homelessness has been an intractable problem for decades in Canada, the US, and elsewhere. Every night, an estimated 35,000 Canadians[1] and more than 500,000 Americans[2] are homeless. The majority live in shelters, are adult men[1], and have high rates of chronic mental and physical health conditions that put them at risk for COVID-19 complications.[3-5] Shelter residents have been particularly vulnerable to SARS-CoV-2 infection. Physical distancing, maintaining hygiene, obtaining COVID-19 testing, and isolating when symptomatic are all difficult in shelter settings. Indeed, many shelters have had outbreaks during the pandemic, often with asymptomatic spread;[6-8] these outbreaks have continued despite high rates of vaccination in the general population.[9] Research has found people experiencing homelessness are not just more likely to test positive for COVID-19 but also experience complications and die from the infection[10].

As system leaders reflect on the lessons from the pandemic, we need to learn from the lived experience of people who were homeless and those caring for them—an area that has been understudied. Some qualitative research has begun to explore the impact of COVID-19 on access to hand hygiene facilities,[11] health-related resources,[13] and primary care[12] for the homeless population, as well as their experiences in the first months of the pandemic[14] or during periods of lockdown.[15] However, few qualitative studies have explored the impact of pandemic policies and procedures in North America. We sought to understand the perspectives of people experiencing homelessness who interacted with emergency departments, testing centres, and shelters during the pandemic as well as the perspectives of the healthcare workers and homeless shelter staff who cared for them and bore witness to their experiences.

## Methods

### Context and Setting

Toronto is Canada's largest city with an estimated 8715 homeless individuals in 2018, 80% of whom live in the city's 75 shelter sites[16]. Our study included participants who worked or lived at or near St. Michael's Hospital, located close to many shelters in the downtown core. On March 16, 2020, St. Michael's opened one of Ontario's COVID-19 Assessment Centres (CACs), providing free COVID-19 testing to any members of the public. The CAC was open during daytime hours; people were directed to the St. Michael's emergency department (ED) if they required a test after-hours or needed a more thorough medical assessment. Beginning on April 23, 2020, St. Michael's CAC and community partners began doing mobile outreach testing at local shelters under the direction of public health authorities[6].

### Study design and participants

We conducted an interpretivist qualitative study[17] and conducted a reflexive thematic analysis of the data,[18] aiming to understand participants' experiences and the meanings they assigned to them. We focused on four groups of participants: people experiencing homelessness who had received COVID-19 testing through shelter outreach, healthcare workers who worked in the ED or CAC, healthcare leaders who oversaw CAC or ED operations during the pandemic, and managers of homeless shelters where mobile testing occurred.

Using in-depth individual interviews (conducted by KH, JAP, and CJP, female researchers), we explored participants' perspectives of COVID-19 testing, the procedures surrounding testing, and the broader challenges facing people experiencing homelessness during the pandemic. Interviews were conducted

online or by telephone from December 2020 to June 2021. Interviews were 30-60 minutes in length and were audio recorded and transcribed verbatim. The interview guides were created by the team. The patient interview guide was reviewed by a Community Expert Group comprised of people with lived experience of homelessness via a virtual meeting.

Ethics approval was granted from the Unity Health Toronto Research Ethics Board.

Participant recruitment

We used convenience sampling to recruit patients. Homeless individuals who received mobile outreach testing through St. Michael's hospital and who consented to be contacted for future research opportunities, were contacted by telephone and invited to participate in this study. We also contacted representatives at shelters involved in mobile testing and asked them to share recruitment flyers with patients who had consented; flyers instructed shelter residents to contact the study team. We scheduled telephone interviews with everyone who agreed to participate.

We used a mix of purposive and convenience sampling[19] to recruit the remaining participants. We invited select healthcare leaders to participate via email. We then asked them to recommend HCWs in the CAC and ED who supported people experiencing homelessness and send recruitment emails to those individuals, and their teams, on our behalf. We also sent recruitment emails to managers and directors of shelters that were involved in mobile testing. Where possible, we selected participants to maximize diversity in roles and experiences. All participants, except healthcare leaders, were given honorariums.

Analysis

We concurrently generated and analyzed data using reflexive thematic analysis,[18, 20–21] which involves reading the transcripts, inductively coding the data, and grouping the codes into interpretive themes reflecting commonalities in participants' experiences. The analysis was led by KH, in collaboration with JAP and CJP, who are all experienced qualitative researchers, with iterative input from the full team of clinicians, methodologists, and content experts.

KH first coded the data by participant group using NVivo, and brought initial codes and reflections to JAP and CJP for discussion. KH then generated cross-cutting themes through constant comparison of the data and iterative analytical discussions with JAP and CJP. Theme descriptions and accompanying codes were presented to the remaining authors for additional interpretation and refinement. The themes were iteratively updated and data collection and analysis continued until the team agreed we had reached thematic sufficiency. We engaged in reflexivity throughout this process, continuously questioning our assumptions and viewing the data from multiple perspectives.



**Results**

We interviewed 26 participants, including: 11 patients experiencing homelessness residing at one of 3 shelters, all men with a mean age of 52.4 (range 28-68); 9 HCWs involved in COVID-19 testing, including physicians, nurses, clinical support staff, and administrative support staff, mean age 40.8 (range 33-59); 4 HC leaders; and 2 managers of different homeless shelters. We generated three cross-cutting themes described below.

***Navigating the Unknown***

*"We were all in the dark. Nobody had any idea what to anticipate and the whole world shut down." HCW05*

Participants spoke about uncertainty that was pervasive, particularly in the early months of the pandemic. HCWs and shelter managers highlighted how knowledge of the virus and how to confront it was constantly evolving along with relevant public health guidance. Shelter managers also expressed their uncertainty in how to follow directives that did not easily apply in their context:

> "One of the first things that was talked about was physical distancing. So what do you do when you've got a congregate setting of almost 600 people in dorm style?… What does it look like to isolate somebody who [has a history of substance use] or who has a psychotic disorder or who has liver failure or who's in our managed alcohol program? It's not so easy." ShelterManager02

Hospital leaders described the uncertainty they faced developing processes when "there was really no rulebook" (HCLeader01). HCWs who needed to follow these protocols noted how directives changed rapidly, leaving them unsure how to respond on a given day. They also described problem-solving in the absence of clear guidelines, most notably supporting patients experiencing homelessness who could not self-isolate:

> "And then [we] dealt with 'where does this patient go?' So we'll just put them in our waiting

room to wait, but it put a lot of pressure on the emergency department... we didn't know where to send people because there was no real clear communication [about that]." HCW09

HCWs noted that patients experiencing homelessness were often unaware of protocols, and would sometimes arrive at the testing centre or hospital not knowing they would be unable to return to their shelter while awaiting test results.

In trying to provide safe and effective care amidst so many unknowns, HCWs and shelter staff spoke about the intense stress they experienced early in the pandemic:

"The emergency department at the time felt a bit like a ticking time bomb. It was tense. Because there were a lot of people [there], and we didn't know that much about the virus, none of us were vaccinated at the time… It was a stressful period, that's for sure." HCW08

***Confronting 'Placelessness'***

*"The general order is stay at home. [But] what if you don't have a home to stay?" Patient05*

Participants highlighted the pervasive 'placelessness' of people experiencing homelessness throughout the pandemic. This was most acute in the early pandemic when test results could take three to seven days and HCWs needed to make space in the ED for patients to stay while awaiting results:

"The ED basically became an area that took over lodging and feeding of people that were homeless who were not able to go to the shelter system anymore because there [were]

concerns that they were infected with COVID or that they were in close contact [with someone who was]. And early in the pandemic, the infrastructure wasn't set up for the city to manage homeless shelters… so it ended up falling on the [COVID Assessment Centre], of which then it sort of fell back on the Emerg." HCLeader02

Patients spoke about a broader sense of displacement they felt throughout the pandemic due to physical restrictions both inside and outside their shelters. In shelters, certain common rooms were closed and sometimes bedrooms needed to be vacated for extended periods for enhanced cleaning protocols. This reportedly led to residents congregating in hallways while bedrooms and common spaces were inaccessible. Patients also noted being limited in where they could go outside their shelters at this time due to widespread closures of public places:

"When you're in a shelter, you're allowed to be inside for a certain period of time and you've got to be out for a certain period of time. Well, where do you go? Everything's closed." Patient11

HCWs noted that ongoing public closures exacerbated the vulnerability of homeless individuals by reducing access to other healthcare or social supports:

"For somebody who was homeless and living on the streets, it became a really dire situation for them. They were already in a crisis situation, and then on top of that, you're compounding all these other issues where they can't access their caseworkers, they can't access mental health, they can't access their medications… It really started to pile up and it was a pretty tough time." HCW05

One participant noted that these closures not only limited people's access to services but potentially destabilized them psychologically, as the physical and emotional connections that comprised their lives were suddenly unavailable to them. Some participants linked the cumulative impact of such destabilization to increased mental health issues and opioid-related deaths among shelter residents. Some also noted that many of these issues are longstanding, but were exacerbated and illuminated by the pandemic:

> "People dealing with severe mental health issues, with trauma, with substance abuse issues... One of the important things that keeps those people stable, to some extent… [is] connections… Once COVID shut everything down… all of those folks weren't able to connect with the life that they built." HCW06

***Struggling with Powerlessness***

*"At the end of the day, we're there for the clients that we serve.*

*So you have to just keep showing up." ShelterManager02*

HCW participants spoke extensively about the lack of control they felt in providing adequate care for patients experiencing homelessness, noting the tension they felt in the care they could offer versus the care they wished they could give:

> "The patient might have been going through severe withdrawal… and once that was taken care of, the person was put into a makeshift shelter [in the ED] and we sort of looked after them that

way. But really 'looking after them' was you maybe hand them a meal or you spoke to them from a distance to say, 'Hey, do you need anything?'… But they couldn't leave, they couldn't go anywhere... It was horrible." HCW06

One participant described the distress of needing to discharge patients once the ED reached capacity, even if they did not have anywhere else to go:

"If we were at max capacity, and somebody came in and their COVID swab came back negative, we still were not able to obtain a shelter but we basically had no other choice but to discharge them… And it became very difficult and disheartening at times." HCW05

Shelter managers also conveyed their lack of control in effectively serving residents, given the lack of supports available to them:

"People with mental health issues rapidly decompensated because their supports were taken away... We could see people getting more and more sick on the streets, decompensating, knowing that the only thing we could do is call the police and tell them we need a mental health team to respond." ShelterManager01

Ultimately, these participants felt limited in their abilities, as if they were "caught in the middle of the process" (HCW07), without agency:

"We were the messenger, and that was hard. Because understandably, [patients] were extremely angry. But underneath that anger was fear… And we were managing that in a space

where we, too, felt really overwhelmed by the responsibility, that we were the last resort." HCLeader04

Moreover, HCWs spoke about the psychological toll of witnessing patients' powerlessness throughout the pandemic:

"Every time we saw someone at the COVID Center that came for a test and perhaps they weren't aware that they were going back to their shelter because, until they received the results, they were not welcome back. So often we were the folks telling them, 'Hey, listen, you're not going back to your home. You are staying with us. We actually don't know where you're going to go. You might need to stay at the emergency department. We don't know how long you're going stay there.'… Those are some of the biggest challenges I think we experienced." HCLeader01

In contrast, patients described a different kind of powerlessness. They spoke relatively positively about healthcare interactions, noting that the testing they received at their shelters was "very straightforward" (Patient08) and that they had "no complaints" (Patient05) about staying in an isolation hotel. However, some expressed frustration about the ongoing restrictions and general atmosphere within shelters conveying a sense of powerlessness:

"There's a culture here [in the shelter]… If you want to start complaining, it feels like, because they are in charge of some of the grants for our rent, housing, they feel like we cannot do nothing about it… they feel like we don't have a voice. And at the same time, you don't want to get kicked out of here… And that's why I was struggling." Patient08

Other patients, conversely, spoke positively of their shelter experience and seemed to recognize the powerlessness of shelter staff during this time. When asked about what other supports might help people experiencing homelessness during a pandemic, most could not identify any, instead conveying a sense of relative gratitude for their situation:

> "I never have any serious problems with anything here, with what the shelter has to offer. They're doing the best they can with what they have… They're helping me out as best they can, and I'm grateful for that." Patient03

**Interpretation**

For years, our health and social systems have struggled to meet the needs of people experiencing homelessness. Our qualitative study provides a nuanced picture of how the pandemic heightened existing challenges. Participants described how COVID-19 exacerbated the placelessness of an already destabilized population. With the closure of public spaces and restrictions within shelter settings, people experiencing homelessness literally had nowhere to go. Early on, shelter residents who required self-isolation often ended up with unplanned overnight stays in the emergency department because there were no other systems in place. Both patients and providers felt they were left to navigate the uncertainty of the pandemic on their own and felt powerless in their situation. Shelter and healthcare workers described directives and resource constraints that prevented them from delivering the kind of care they wanted to provide.

Our findings are consistent with other research that has highlighted the compounding marginalization of homeless populations during the pandemic. People experiencing homelessness were more likely to acquire COVID-19, become seriously ill, and die from the infection.[14,22] Others have also described increased food insecurity due to widespread closures,[14] a loss of 'place' amidst restrictions and distanced services,[23] a rise in overdose deaths,[24] and increased fear, confusion, and uncertainty.[14,23] In some regions, vaccinations have been slow to reach people living in shelters, leading to outbreaks even while other parts of the population were protected[25].

Healthcare workers and shelter staff in our study faced an emotional toll from trying to care for patients experiencing homelessness within a system that did not adequately support their efforts. Other researchers have described the adverse psychological impacts of COVID-19 on frontline healthcare workers[22,26-30] and the rise of moral distress—being unable to take the right or ethical course of action because of institutionalized obstacles.[31-34] Moral distress can in turn lead to burnout [33] and intention to resign,[34] both notable trends in recent surveys.[35-36] These effects on the workforce may make it even more challenging for people experiencing homelessness to receive the care they need in the future. In our study, people experiencing homelessness seemed less distressed about their circumstances than those caring for them which may relate to differing expectations.

Our study has limitations. First, we focused on the experiences of participants in one geographic region and were only able to recruit male patient participants which limits the generalizability of our findings. Second, there were temporal differences in what participants explored which may have impacted thematic sufficiency. Some highlighted early pandemic experiences while others reflected circumstances at the time of the interview, almost one year into the pandemic.

Our findings highlight that our society needs to do better to meet the needs of people experiencing homelessness now and in future pandemics. During interviews, participants spoke about some of the system changes required including better communication and collaboration between stakeholders, centralized oversight of the response, more mental health and addiction supports, and most importantly, housing integrated with social supports. These suggestions did not reach thematic sufficiency in our study but should be explored in future research that guides pandemic planning. On the one hand, the pandemic has exposed the limitations of shelters as even a temporizing solution to homelessness. On the other hand, it has shown us that we can use existing infrastructure, such as unused hotel rooms, to rapidly house people.[37] Ultimately, a better pandemic response would include creative solutions to end homelessness.[38]

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