OT's Mental Health Response to the COVID Pandemic: Persons Experiencing Homelessness

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Presenter: Caitlin Synovec, OTD, OTR/L, BCMH

- [Fawn] At this time, I'd like to introduce Dr. Christine Helfrich, who is the guest editor of this series, and she's going to give us a little bit more information.

- [Christine] Morning, thank you for attending this series on OT's Mental Health Response to the COVID Pandemic. We've had an exciting week so far, and we have another exciting speaker today, who I'll introduce in just a moment. If you've attended any of the presentations, the webinars this week, they should be available in the library soon. And we have one more tomorrow on the pandemic and older adults. Today's presenter, whom I'm very happy to introduce, is Caitlin Synovec, and Caitlin is an OTD and an occupational therapist with clinical experience in working with adults experiencing homelessness to improve quality of life and engagement in their preferred communities. She has completed clinical research to address the intersection of homelessness, poverty, traumatic brain injury, mental health, and chronic conditions and their impact on health and community living.

Caitlin's experience also includes program development for collaborative and interdisciplinary care as well as clinical education and training for occupational therapy practitioners, healthcare and direct service work providers. Most recently, she has joined the National Healthcare for the Homeless Council as the program manager for medical respite to support expansion and best practices in medical respite care. So today Caitlin will be talking about persons experiencing homelessness, and I'd like to welcome her, and enjoy her presentation.

- [Caitlin] Great. Thank you, everyone. And welcome to today's presentation on OT's mental health response and persons experiencing homelessness. So these are my disclosures for today's presentation. And these are our learning outcomes that will be covered in today's session. So hopefully, after this course concludes, those participating will be able to identify the impact of COVID-19 on persons experiencing homelessness. Participants will be able to identify the roles of occupational therapy in

addressing the impact of COVID-19 on occupational performance in persons experiencing homelessness, and, finally, identify strategies and/or resources to address the needs of persons experiencing homelessness, specifically in response to COVID-19. So Christine already gave the brief introduction about my history, background, and work. I was lucky enough in this particular presentation to be able to engage with a consumer located in New York city.

So I'm going to... So you'll see his videos throughout this presentation, and here's his introduction.

- Okay, so my name is Shams. Most people refer to me as Shams DeBaron, but in this context of my advocacy dealing with the homeless issues, I'm referred to also as Da Homeless Hero.

- And you can actually follow Shams and his story on social media, which is listed down at the bottom here. And his experience is drawn from his experience of living in a congregate men's shelter in New York City. And he is also a client of the Project Renewal program.

- Okay.

- So when we're looking at COVID-19 and the impact on persons experiencing homelessness, COVID-19 has obviously impacted all of us in a lot of different ways, but there are specific and really certain impacts that have happened for people who are homeless. One of those is that if you're living in congregate and shelter facilities, there's a limited ability to follow social distancing guidelines. And this was especially the case at the beginning of the pandemic, before there was more global knowledge about prevention efforts and mitigating the effects of COVID-19, especially for those living in these settings. People who are experiencing homelessness often more

frequently need to occupy public spaces, which could have been shut down, or because they are public, out in the open, made them more at risk for contracting COVID-19 because there wasn't a safe and private place to be.

Additionally, persons experiencing homelessness have really complex co-morbidities that impact their health. So in addition to a high prevalence of serious mental illness and substance use, often folks experiencing homelessness also experience chronic conditions such as diabetes and respiratory conditions, both of which we know can impact how a person responds if they contract COVID-19. And linked to that is that persons experiencing homelessness have limited access to regular and preventative health services. So not only are they more likely to have these conditions than the general population, but they are less likely to be receiving care, or adequate or quality care for these conditions, which means that they may be worse and, again, really exacerbating the impact of COVID-19.

And finally, if we can all think back to March, the limited access to supplies that sort of was pervasive in a lot of communities in terms of soap and sanitizer and toilet paper, think of the impact of that on folks who really are unable to access those resources at baseline. And so it made it even harder to get some of the things that they needed for basic self-care. Where were you staying before COVID-19 came to the US? Kind of before all of that, the lockdown and stuff started in March, where had you been staying prior to that?

- I was in the congregate shelter under Project Renewal. In New York city, the congregate shelter is at Bowery and 3rd Street. Mine's was on by Bowery. They have another facility on 3rd Street, so it's a congregate shelter where you might have 30 people to a floor in a dorm-style setting, which-

- Okay, so it's kind of like the open rooms, shared space, shared bathroom, all of that kind of thing. Okay. Okay.

- Prior to that, we've had other viruses that didn't really, it didn't take on life like this one did. So yeah, we had to be concerned, or certain type of facilities you had to look out for, like in NYCHA buildings and stuff like that, schools and stuff, but those were the things that were isolated to certain areas and stuff like that. So there was no real alarm initially. But when it first hit the United States, as far as people would acknowledging like, oh, wait a minute, we have a problem, and remember, all of this time, there was a lot of, I don't think the proper term is misinformation, but there was a lack of real knowledge about these things.

So we were all being misinformed because nobody actually had the right information. So we were in the same situation. We watched the news every morning. That's just something we do before we go about our day. So we're seeing stuff but not really understanding if this is something that we should be concerned with, the initial days. But when it got to the point where it's like, okay, it's here, and we've got a case here, and this thing may spread, and then it still was information indicating that we didn't have cause for alarm. But we're looking like-

- Wait a minute.

- Wait a minute. Why not, if it seems to... It's not just in China anymore. It's not just over there. Like, it's actually here, you know? So we experienced this prior to COVID. We experience the spreading of flu all the time. When you come into the shelter, I don't care who you are, you are gonna get the flu. And usually when one person gets it, you could just see it come around the whole setting. Everybody starts to get sick. That's a normal thing in the congregate shelter. So because it's not, people are not dying, you

don't... You just kind of deal with that. In this case, we know that if there's an infectious disease, and it comes here, we are all gonna get it.

So we were kind of, we were alarmed when they said, "Don't be alarmed," because we were like, well, what if it comes in a shelter?

- Right, and when you say we, do you mean sort of the residents, the residents and the staff and the people that work there, or-

- The residents. I'm sure the staff went through the same thought process but not as much as we did, because they come and go.

- You're living there, yeah.

- We have to live there. And we had this thing where the rule is that you have to leave the shelter in the morning, like at nine o'clock in the morning, you have to be off the floors and out of the building unless you're in the lounge area and stuff. So this is just a normal thing. You go into the streets, all seasons, et cetera, right. You just gotta find something to do. So when you have the libraries open, people congregate to the libraries, excuse me, Starbucks and different places of that nature. So as we start to see that this has hit New York, this is spreading, most of us became fearful, like, wait a minute, you know?

And then they start to... Now, they're starting to say, well, okay, you have to start to be careful. Remember, they didn't even know how it could be transmitted. So we were to the point where it's like, don't touch me! We don't know, you know. And it just created a real volatile environment even amongst each other. You know, a simple sneeze or cough could have somebody looking at you like, yo, you got it, you know? And nobody really understands how to get it at this point.

- Right.

- Because we're home-

- Whoops. So Shams sort of brought up a lot of really important points in this particular section of the interview, right? When there's quarantine and stay-at-home orders, we don't have a place to go. We don't have a place to quarantine. And really what this is speaking to is occupational deprivation and marginalization, which to define these, occupational deprivation is a state in which people are precluded from opportunities to engage in activities of meaning due to factors outside of their control. So often the context of homelessness is occupational deprivation, because people have limited access to self-care, ADLs, IADLs because of how we treat and manage homelessness within our country. Occupational marginalization is the injustice seen when everyday occupations or choices are not available to every member of society or the community.

And so persons experiencing homelessness really experience occupational deprivation and marginalization in typical circumstances. But this was really exacerbated, as we saw, by COVID-19 and the required lockdowns and all of the societal impacts that came after that. So we're going to look through occupational deprivation and how it impacted persons experiencing homelessness, and strategies to address it through the lens of the occupational therapy practice framework, the new version 4, which came out this year, and we're gonna highlight some specific occupations, such as ADLs, activities of living, instrumental activities of daily living, rest and sleep, leisure activities, and social engagement.

- They said that the only person that should be getting a mask... Stop panicking. It's not panicking. It's not gonna help you. Only first-line people, like in the medical field,

need masks, and to be honest, they were flying off the shelves. If you go look for a regular mask, you're paying $10 for the masks that are now sold for $1, $2, you know?

- Right. Right.

- So there were no masks anywhere unless you had that type of money, which we don't have. So it was just, but it was like, we were misinformed thinking that the mask is not a form of protection. So they said, what will protect you is, sanitize your hands, right, and use soap. In this congregate shelter where you share the bathroom, there's no soap in the dispenses, and there's no... They have dispenses for sanitizer that has never had sanitizer liquid in it. So I'm like, wait a minute. Okay, I didn't have a problem pre-COVID. But now that this coronavirus is all over the place, can we get some hand sanitizer? I mean, that's what they said will protect us.

We don't even have soap in there, like hand soap. So they were saying that, "We've ordered, but it's not coming."

- Right, yeah, 'cause that's part of the problem, too, is just supplies in general. You couldn't get soap. You couldn't get, you know.

- But they never had it.

- They never had it to start with.

- They never had it to start with, which, it begs the question of, do you prepare for these things? Do keep a safe and clean environment, period.

- Right. Right.

- So I made that point. I was arguing that point, and finally, they started to bring little hand sanitizers like... Well, I don't have it right here. I usually keep it next to me, but they're little containers, which is-

- Yeah.

- When it came to COVID, and you start seeing the refrigerated trucks and the mass burials in potter's field... You know, that sanitizer, they made the mistake the first time, and they put sanitizer near each pod. Someone came and stole all the sanitizer. So we was like, oh no, you gotta give like each person, 'cause you gotta hide your sanitizer, 'cause if you leave it out, that's like a luxury item. You could trade a sanitizer for a phone or something.

- Right, right. Yeah, exactly. So not relying, I think... One of the things you're sort of hinting at is a strategy in preparation and response is not relying on this communal setting, right? It's to really-

- Yes.

- give each individual person the power to take care of their own health in the way that they choose.

- Yes.

- So as Shams identified, activities of daily living can be really restricted under the context of COVID-19. Part of that is due to just having and provision of supplies. Often people experiencing homelessness are not at the top of the priority list for who should get particular supplies. So PPE certainly was part of that list, but even being able to get adequate soap and sanitizer for people living in the congregate shelters. Additionally,

there was closures of day and drop-in centers, and these are often locations that provide a safe space for persons to complete their ADLs, whether they're offering shower stalls or just private bathrooms where people can wash up and take care of belongings. And many of those closed, which meant that many people did not have a place that they could shower.

Additionally, most businesses and public locations were closed, and if they remained open, often closed their public restroom access, which again becomes a space where people often have to utilize for toileting, washing their hands. And even though the recommendations were to engage in these hygiene tasks more frequently, such as washing your hands, there was actually less access to those resources within the community. And for people who are street homeless, living in tents or encampments, a lot of these facilities shutting down or closing really, really significantly restricted the ability to do that, even more so than people living in shelters. IADLs were also really impacted. Again, a lot of these public programs, drop-in centers, soup kitchen, church facilities offer daily meals, and those were closed, partially because there wasn't really good guidance and really, as Shams mentioned, not a lot of understanding of how to prevent the spread of COVID, especially initially.

And so they shut down because they were unable to feel like they could provide these services. However, again, many folks rely on these to access meals throughout the day. And so unless you were living within a shelter setting or have the funds to purchase items from places that were open, food became a very limited resource as well. We've all sort of adapted to communicating in a different way. However, communication and communication tools are definitely something that require resources. So even if folks have a phone, perhaps through a government system or low-cost phone, buying the data to use that phone, having access to internet services is expensive and can be cost prohibitive. Even if all of your visits move to telehealth, that's great for healthcare access but only if your phone can support a telehealth platform.

And oftentimes people are able to access internet services, again, through public spaces, such a libraries, that were no longer open and couldn't be accessed by folks. And then, again, sort of these public resources, such as transportation, in some cases, they were shut down totally. In some cases, they were only for essential workers. You could only ride if you had a mask, but before it was the time where everyone really had a mask, that could be limiting as well to be able to use those resources. And for people who maybe would spend their time or find some refuge in riding the bus or in stations were no longer able to do so. A specific IADL, an occupation of health, I'm gonna call out here, and partially that's because, again, as we mentioned, people experiencing homelessness have a lot higher health conditions and co-morbidities and generally less access to care, and this became further exacerbated with COVID-19.

Again, clinics may have closed. They may have limited their hours significantly or attempted to provide services through telehealth, all of which have certain limitations. Similarly, pharmacies had limited hours and limited interaction, which meant that somebody with a problem with their prescription, it would be additionally challenging to resolve that issue. And in some, again, some locations, depending on supply chain and how much the virus surged in that area, pharmacies simply ran out of supplies. They were unable to get medications, and people were unable to get their refills. And again, with the closing of day centers and day programs and drop-in centers, a lot of these offer a safe space for people to keep their medications locked or stored if they're medications that require refrigeration, places to store needles that are safe.

So again, all of a sudden, people have lost this access to a resource that really supports management of health overall. Again, with other IADLs, identifying and understanding how to respond effectively to safety guidelines, I think it was really confusing for everyone initially to understand, but without sort of, again, this lack of access to public information, or maybe it's becoming filtered through certain streams,

depending on who's running your shelter setting or community that you're in, not knowing how to respond or not being able to respond. I don't have hand sanitizer. I don't have soap. I can't follow those CDC guidelines that you're recommending. I don't have $10 to buy a mask right now. So I can't follow that guideline.

Again, a lot of government agencies were shut down, delayed, or limited in-person services. And so processing paperwork for benefits and income was delayed, which I think caused a lot of uncertainty. So if you were someone who was perhaps up for recertification of your benefits, it was really confusing to figure out, well, how do I get this recertification? If I don't do it, will my resources be cut off? You know, I need access to food or to income. When the stimulus money came out, I know there was a lot of confusion about, would individuals receiving SSI and SSDI receive that benefit? How would it be received? Do I need a mailing address for the check? Will be deposited?

All of that was really, really confusing and can cause a lot of stress for folks and just minimize the ability to take care of some of these things. Unemployment for people experiencing homelessness is also an issue that has many layers to it. But with an economic recession that has come out of the COVID-19, there's less employment opportunities for everyone and layoffs for a lot of different programs, agencies, organizations. And so that really limits work opportunities for people who have been pursuing that path and perhaps working towards that path. And if that is your source of income, perhaps you were someone who was laid off, living within a shelter setting. It really limits your ability to move on from that particular location.

And then rest and sleep, again, is a baseline issue for persons experiencing homelessness to get good rest and quality sleep, restorative sleep. Again, if you are someone who is living on the street or living in a tent, these day centers and day shelters maybe provide some refuge to be able to get some rest during the day in a

place where you feel safe. Closure of shelter, some organizations in communities, their response to minimizing spread among people experiencing homelessness was simply to close the shelter, which meant that people had nowhere to go to sleep, and various sleeping locations. There was also, in certain communities, a sweep of encampments, which are sort of maybe otherwise known as tent cities, so a place where people experiencing homelessness may congregate together sort of as a small community.

There's a lot of controversy around that and how cities address that. Oftentimes they come through and clear an encampment simply by taking people's possessions, throwing them away if they're not moved in time, without offering an alternative solution for housing. And that is incredibly disruptive, and even more disruptive when you are trying to mitigate a spread of an infectious disease. And then the chronic stress of homelessness and lack of safety can really impact sleep overall. And when you add in the stress of COVID, that can really, really even further exacerbate issues with sleep, which are really necessary, again, for health and being able to engage in what you want to do during the day. Leisure engagement is also really important.

It contributes to quality of life and health for all of us. Again, all of those public resources shut down, low cost resources, senior centers, stay centers. It really limited access to leisure engagement and the resources that perhaps support that. So you sort of, you have an increase in leisure time in terms of not being able to do other activities and other things but a decreased ability to do it. And leisure requires some resources to be able to bake at home, watch TV, watch Netflix, do artwork, whatever it might be to fill the time. If you don't have resources to do that, and you rely on these programs for that, the disappearance of that really results in a lot of boredom, increased stress, and inability to engage in preferred and meaningful leisure.

And social participation, again, is something that we've all really experienced, I think, an occupational deprivation in. Again, limited social interaction, if your social venues

are closed, and you don't have the supportive technology, or you don't live with others who provide that social support for you, can be really challenging. And people experiencing homelessness experience isolation and discrimination, again, at baseline. Within a pandemic, this is further increased. People's perceptions regarding hygiene, who might be a carrier of a virus... You know, if you have a chronic cough, and you can't stay home, and you're out in the community, people are gonna respond to you in a certain way. And so that can be really impactful on how people feel and engage with the community.

And additionally, as we can sort of follow, especially with Sham's story, when people have been moved from shelter settings into other community settings, there's a lot of response to, "Not in my backyard. "I don't want homeless people in my neighborhood. "I don't want a shelter here," people who normally haven't had exposure to different members of their community in that way. And so that can result in additional discrimination for people who are experiencing homelessness and really undergoing a lot of stress as it is. And again, I think we can all relate to this disruption in routine that happened along with COVID-19. Our predictable and reliable routines have closed because things aren't open, things aren't accessible to us.

And you can further exacerbate that when you're not even able to complete routine daily activities. If you can't take a shower, if you can't get your basic meals, if you can't get to your medications, those routine disruptions can be really significant. So we're gonna go into a little bit now what OTs can do about this. OTs have worked with persons experiencing homelessness for a long time now in different capacities. So we're gonna look at this really specifically in the context of persons experiencing homelessness in COVID-19 and those specific considerations, and really, hopefully, to address some of the deprivation and marginalization that's occurred. I will say that any of the strategies and recommendations that are implemented by an OT should be client-centered and should be focused on client priorities.

So the recommendations here are sort of a menu or hopefully a place to seek inspiration, but it's not prescriptive. Everybody's needs and what is gonna be important to them and important to have access to is gonna be varied, so going back to our core roots as occupational therapists and making sure that what we're doing is at the goal of the client and what is really important to them right now. General, kind of throughout this whole process, what about anything of OT has helped you or what advice might you give to occupational therapists about supporting people who are living in a shelter or experiencing homelessness and sort of dealing with all of this that's happened because of COVID?

- Well, that's the great thing. One, we have to kind of keep ourselves educated on COVID and learn from the mistakes that were made and also figure out how to create safer environments, whether it be an occupational therapy setting or in shelter settings, and how to also teach those that are their clients and that are living in shelters or experiencing homelessness how they could create safe environments and engage in safe activities. From the sharing cigarettes or sharing narcotics, you know, those things, people have to be educated on the dangers of that, especially if we ever get to post... Well, we'll hopefully get to post-COVID. 'Cause we're still in the pandemic. You know what I'm saying.

- Right.

- And then deal with the psychological trauma associated with it. A lot of us don't understand trauma. A lot of us don't understand what that anxiety can induce, certain things within the body that can offset you, the stress, and how do we get educated on things that are directly affecting us? How do we process misinformation? Or how do

we engage? Like, where do we go to for proper information? You know, I was able to really become empowered by the fact that we stopped all of the regular programming and said, we have to deal with the fact that we're now in a pandemic, and our clients, talking about myself, according to how the recovery center responded, was by saying, the clients, we have to deal with them in their current situation.

This is beyond narcotics use. They're dealing with a whole 'nother set of trauma on top of the trauma they already dealt with. And we have to process how to properly deal with them. And the same has to be done in every setting for someone that's an occupational therapist. We're learning, like I've mentioned the breathing, because let me tell you, that could be the one thing that saved my life. But the importance of engaging in activities like that, pre, post, current COVID, we have to understand the value of that, the value of regulating our lives. I like to use the template of the eight dimensions of wellness in order to create a more whole life or a balanced life, and a lot of us don't know that.

I didn't know that. Now I'm understanding the value of making a phone call to my children and how that improves my spirit. But I'm learning that in occupational therapy. I'm learning that in therapy and stuff. And then your environment has to also be educational, access to information, not always just telling somebody something, not always just saying, "Here, this is a leaflet," engaging them in a way where people can learn from experience as well.

- Right, and I like that empowerment piece, so that people know how to find the information themselves and know, is this information good information, bad, like any of that, yeah.

- Yeah, and that's what I think helped me a lot. Like I said, I went to the CDC website because I was just as uninformed as anybody else. Uninformed is the best way to put

it. And then I went to DHS sites. So by me knowing the protocol, I kind of was able to advocate better for better conditions. You know what I'm saying?

- Right.

- Even though I became a victim of COVID, and these things happen for a reason, 'cause now I'm able to talk about it and help the conversation so that we can provide better experiences in times of pandemic. But I was educated. Through the education I was empowered. And that should go towards people. What happens in this process is they don't want you to know that information because they feel you're going to panic. So the less they know, the better off things will be. No!

- No.

- No, not at all. Let me know exactly what's going on so I can properly deal with it. if you minimize it, and it's really bad, I may, more than likely, make a mistake. You know.

- Right.

- So that's not empowerment. That's disempowerment.

- So I just love how he described what he's been working on in occupational therapy. I think it's really wonderful to see what he's gained from that. But one of the biggest takeaways, I think, is sort of that needing to create a safe space and a feeling of safety and also empower the folks that we are working with regardless of the setting that we're in. So in persons experiencing homelessness, some strategies really for occupational therapy, the first thing is to create a safe space and creating a physically safe space. So is the space that you're working in, whether it is in a drop-in center or a shelter or a community program, or perhaps you're in another health care facility,

whatever that might be, make sure that the space is following the recommended guidelines and that the people who are receiving services there know what the guidelines are and know what you're doing to create a safe space for them, whether it's you've improved your cleaning practices.

Really, as Shams was mentioning, the more that the person knows about it, the more transparent you can be, the safer people are gonna feel. And again, I love that piece on, like, educate us. Tell us how to find out the information. Again, this is tricky, because I think that's something, maybe even as providers, we struggle with. But I think that authenticity of saying, "This is what I think. "This is what I'm using for myself," can be really, really helpful. And again, emotionally safe, right? Check in with people, how they're feeling and what they need. That can change day to day, depending on what is happening in the community that you're living in. In some communities where things are a little bit calmer, perhaps sort of focusing on activities and topics as usual might be the best thing.

But in places, again, where we're starting to see surges and rises, that anxiety might be increasing, and it's meaningful to acknowledge that and digest that and process that, and really, I think, validating what those feelings might be. And Shams mentioned, which isn't shown in the video here, but also it's really important for providers, for us to address our own trauma and anxiety. So this is a situation that has affected absolutely every single one of us. Perhaps we ourselves are survivors of COVID. We have had family members who've had COVID. Maybe we've lost people close to us due to COVID. And so those feelings are gonna carry over into whatever setting we're in. And so that piece of self-care and addressing trauma and our own anxiety is important so that we can create a safe and therapeutic space for the people that we're working with.

And I think validating the COVID experience is, again, really important, validating the loss that's come. We've lost resources. we've lost activities that were meaningful to us.

We've lost relationships, people that we haven't seen and will not be able to see for a long time, support systems that we're no longer able to access. And that's significant. Again, validating it for ourselves is really critical to helping validate for clients, and then also providing validation to them that, yes, you're feeling a loss. You might be feeling grief. You know, we don't necessarily have the ability to fix that, but I think letting people know that their feelings matter and are accepted is really important, and additionally validating fears. There's a lot of anxiety regarding, will I catch COVID?

What is safe for me to do? What's not? I'm not sure. And that's a real and relevant fear, especially for people who maybe have higher risks if they were to catch COVID. And I wanna acknowledge, although there's not really the depth of this presentation to go into it, during this pandemic we've also experienced some pretty significant and political upheaval and contention, especially in certain parts of the country. And that can really be traumatizing and re-traumatizing for people who have experienced systemic racism throughout their entire lives, who have fear regarding what the political system may or may not allow them to do and access. And so I think validating fears regarding that is really important as well.

And acknowledging, again, as a provider, perhaps you don't have the training or skillset to specifically address it, but I think even if not, you can ensure that someone, that their fears and their feelings are legitimate in these circumstances. And then focusing back to the practice framework and occupations that really may have been impacted, excuse me, I'm gonna go through some strategies now on different ways that we can address some of this deprivation and marginalization. You know, OTs, we're really good problem-solvers, and we're really creative. And so I think this is, again, sort of a framework for folks, but I'm sure, hopefully, this will inspire you to think through some ways to adapt this within your communities and settings as well.

So identifying alternative methods for hygiene, carrying baby wipes has always been a really good go-to source for people who have limited access to showers, but even just for basic hand-washing and cleaning your hands before you eat, administer your medications. Sanitizer is a little bit easier to get nowadays but helping people access that supply and helping people create face coverings. I know there was a lot of people... Initially, you couldn't get masks. Now they're pretty widely available. But also educating people that a face covering can be created from a lot of different things, you don't necessarily have to buy a mask. You can use an old T-shirt to protect your face, and using resources that people have readily available.

Also, helping folks identify resources, if people don't have access to technology and information in the way that they did before because of limited access to Wi-Fi and data services, helping people figure out, where can I go to eat? Where can I get food that helps with my dietary recommendations? Who's offering food right now? Who's offering food in a way that I feel safe getting? Identifying new places to access Wi-Fi, so I know that the library system in Baltimore City eventually opened up their Wi-Fi hotspots in their parking lot and outside the building. So even though people couldn't go into the buildings, they could come, and they had marked out six-foot little blocks so people could stay socially distanced but still access Wi-Fi, which I thought was a really great and creative resource.

And so places like that, things like that can be helpful to help people find where those are in the community. And how to access benefits and navigate those systems, locally and statewide and nationally, are frequently changing and often in response to what the pattern of of COVID is doing in that community. And so, again, if you have access to that information, sharing how to get that information and sharing what that information is is really important. And establishing new routines, you know, again, I don't know that any of us would say that they have figured out the COVID routine in a way that they feel like they're thriving, but it is important to figure out, how can I

respond to the new routine and circumstances to be able to promote some sort of wellbeing and take care of myself?

Again, this might include incorporating new strategies for completing ADLs, if there's a resource that's open differently in the community, trying to address strategies for sleep and relaxation. Shams mentioned the breathing, meditation, things that are gonna sort of bring a sense of calm and bring that heart rate down for individuals. Trying to help identify new and alternative leisure activities and activities you can do when your time isn't structured, and I'm gonna go into that one a little bit more, and then also providing a safe space for occupational engagement. Depending on the program you're located in, you might be able to figure out a way for people to use your facilities and resources in a way that's safe, that they're able to still really engage in some of these important tasks.

- But that's the main thing. And as a person that's in recovery and dealing with mental illness, anxiety is one of those things, and depression and feeling a sense of hopelessness. I end up getting the same thing. I think I've relapsed one time. I forgot what was the reason, but I was like, oh my God, you know. But I do have the support system of outpatient. And we immediately had to address COVID and what everybody was going through, and because... You know, we had structure and different things, but it was like, this COVID thing, we had to create a safe space to be able to discuss our fears and anxiety. But in shelter system, that didn't exist.

- It's not there.

- So there, I'm with eight people. In the shelter with hundreds, over a hundred people. So it was like, can you imagine the anxiety that was going on? People would... I mean, it was like, if it was bad before then in terms of drug use and stuff, this was really horrific.

- Right.

- So...

- So yeah, so I think Shams' experience here really talks to the importance of creating that safe space. And even if we can't necessarily change the shelter system or the larger system that people are existing in, is our place that we're providing services, is that a place of respite for individuals? I know that there was a client I was working with who was sleeping in an encampment on the street and kept himself really busy by going to different programs and public resources during the day, and all of that absolutely closed. And so our occupational therapy sessions were basically just having him come in and getting a break from being exposed out in public all the time and not having a safe space to go, that we had been working on certain goals for him, but we we took it back a step to just say, I want you to feel safe for 30 to 60 minutes right now.

I want you to feel like you can relax, that you can close your eyes if you need to, that you can listen to music that's gonna put you in a safe mental space. And that, I think, really did a lot for him during that time when that was not available anywhere else.

- but- Sorry. So health management, some strategies for addressing health management. Accessing supplies to follow COVID-19 guidelines, again, maybe your facility can help distribute supplies for folks, especially those who don't have income or are unable to go places to get these supplies. Again, providing that education and education inclusive of not only what are the guidelines now, but how can you find out

this information yourself, right? If you're the program, and you're a source of information for people, and your program shuts down, are your clients enabled and empowered to be able to find that information without you? And I think that's a really important way to think about it to be able to know, am I giving education to clients on how to get this information?

And working on coping strategies to manage the long-term stress of the pandemic, I think we've moved from those immediate coping strategies to thinking about sort of the complex and the long-term trauma. And those strategies are a little bit different. I had a coworker who said the other day, "Yoga is just not cutting it anymore." You know, and not to say that yoga and those self-care practices aren't important, but there is a little bit of a deeper dive that needs to happen in responding to this chronicness, and that's going to be continuing, it seems, for a little bit more time. Harm reduction for substance use, which I'm gonna talk a little bit more about later, but educating folks on how to use safely.

I think there have been really good harm reduction practices in terms of needle exchange and reducing reuse of needles. But because this infectious disease travels through respiratory systems, sharing supplies that maybe weren't as dangerous to share before and giving people that education, right, and not saying, "Don't use substances," because if someone is in active addiction, that's not really realistic. That's not client-centered. But thinking about, if you're going to use, how can you do it in a way that's safe? And communicating to providers regarding client's health access and what their needs are, sometimes as OTs, we're the advocate and the liaison. And we can teach that to our clients. How do you communicate with your provider that you don't have access to telehealth and that you need to be seen in person to address this issue, and really being clear so that people get the best care they can.

And then, again, technology use, I had a few clients who were suddenly really interested in learning how to use technology better because it was a requirement. Again, that skill building piece to build technology skills for communicating, whether it be over the phone or FaceTime or video chat, health access for telehealth appointments, or even leisure engagement, you know, maybe you didn't use your phone to watch Netflix before, but you wanna learn that now so that you have access to that resource. And I would say with technology use, again, focus client priorities. If you're not as familiar with technology, it can be a little bit overwhelming. So what are the skills to be able to do what's a priority for you at this moment?

And it might be leisure, and that's okay, because leisure is important for managing our health and wellbeing. And working on communication skills, engaging in-person is very, very different than communicating over the phone. And so sometimes people need to rebuild or revisit their skills to be assertive over the phone when you can't see that person, and you don't know how they're responding. Reaching out to providers and accessing help if you need it, and relearning social cues and body language, I think this is huge. We not only have to keep six feet from each other, but we can't see half of a person's face anymore. And so there's so much that happens through facial expressions. And so not to say that any of us are the experts in this now, but I think it's important to address that with people and say, like, how are you responding to people, are you uncomfortable, not uncomfortable, and getting familiar with what the social world is gonna look like a little bit now.

And then leisure activities, So activity packets was something we did at our clinic for people who were in a permanent supportive housing program. We offered a variety of activities that could be done safely at home. And instead of just sort of mass-mailing these packets, we had people look through the menu of things that we had and pick what they were interested in. So this included supplies for art, various types of puzzles, word searches, crosswords. We offered everything in large print and at different reading

and education levels. We were able to make a relationship with a book-lending library to get a bunch of donated books that we were able to mail out to folks so that they had something to read.

And media mail, through the post office, makes that actually a really cheap resource. And so there was all kinds of activities, home exercise activities, probably missing some, writing, all these types of things so that people who usually don't have access to those supplies had access to them. And it helped encourage, also, people to stay home, which is really important. And so whether you're in a program, or you can provide supplies, or even just, in your space, provide a space to be able to do these activities. And educating on what's safe, again, as Shams mentioned, we just didn't know a lot at the beginning, and people weren't sure, like, can I go for walks outside? If I go for walks, do I need to wear my mask?

Is it safe? Is it not? And as that changes, I think we can help people problem-solve what's available and what is safe to do. And another important part that we did... I was working in a healthcare clinic. We were testing for COVID-19. And so when someone had identified as a need to move to an isolation facility, that was in partnership with the city and could take several hours from the time entering our clinic to actually going the isolation space. So in order to keep people engaged and minimize risk of them leaving, because they were sitting, essentially, in a garage space by themselves, we offered these activities as well so that, to help kind of make that transition from the the testing space to the isolation space.

And social, again, I don't think this is something that we all have figured out now, but it can be helpful to problem-solve with people. What is safe social engagement? And what are you comfortable doing? And what can that look like for you? Strategies for managing grief and loss, for certain populations, persons experiencing homelessness, there is a significant number of people who died in certain locations in the country from

COVID, and acknowledging that loss and helping people grieve maybe some of the supports that they had built without being able to say goodbye or be there at the end for people. Helping people adapt to new procedures at public spaces, right, people can respond very strongly if you're not following social-distancing guidelines, and so ensuring that people are able to navigate these spaces, going into a store, so that it minimizes conflict and distress.

And managing anxiety in social environments, there are a lot of people now who experience some fear and distress just going out in terms of, am I gonna catch COVID, am I gonna give it to someone else, and so dealing with those feelings of anxiety to get done what needs to get done per se, such as going to the pharmacy or buying food. And then, also, how do you respond, how do you keep yourself safe, if you are somewhere, and someone is refusing to maintain social distancing, is refusing to wear a mask, is sort of violating these new social norms. How do you respond to that and keep yourself safe? Do you take yourself away from the situation versus engaging with the person?

So just strategizing and problem-solving with people through that and in, how do you manage that when you're in a situation where you can't necessarily get away? If you're in a congregate shelter setting, you are there next to people. And what do you do if your bunkmate isn't gonna follow that? And how do you respond to keep yourself safe? And self-advocacy, again, I think Shams brought this up as well, just being able to find your own information. Shams was able to advocate at his shelter to say, "Hey, we have stay-at-home orders, "and you're telling us we're supposed to leave by 8:00 am. "How about you let us stay here during the day?" Right, and that required some self-advocacy.

And he mentioned being able to read the CDC and Department of Housing Services guidelines to advocate for that within his setting. Again, advocacy in healthcare, you

know, if someone loses a safe space to keep their medications or to keep, say, their insulin, to talk with their providers about that and saying, "We've gotta change something, "'cause I can't do this right now." I also wanna mention advanced directives. It's something that a lot of people experiencing homelessness don't necessarily do, but in a time where there's increased mortality, I think it's really important to offer people the opportunity to do advanced directive so that they have control over what happens to them should they need end of life care or should medical decisions be made.

And this is for a group of people who don't necessarily have immediate support systems or families that they would feel comfortable making those decisions for them. There was a study done actually in a shelter, I believe in Canada, where they offered the opportunity to complete an advanced directive, and 50% of them took it. So that just shows that it's something that, given the opportunity, people are gonna do. So I think that can be a really important role, for us to help folks think through that and just logistically complete the paperwork. And another really big advocacy role in preventing homelessness for people in maybe supportive housing, transitional housing, low-income housing, we know that the CDC put in place an eviction moratorium that ends at the end of the year, and there's not been steps made to do anything about what will happen with that.

But that also required the tenant to complete paperwork. It was not just automatically applied to folks. And so if you have a person in that situation, navigating that system, completing the paperwork, presenting it to the required resources, having the landlord sign it, that will be really critical in preventing housing loss for individuals. And then recovery from COVID, and this is really important because people experiencing homelessness have had increased exposure to COVID and in some cases were more likely to get it than the general population. That was not true for every community, but it

was for a certain ones. And so post-COVID recovery, we're finding people have really significant fatigue and decreased energy, ongoing neurological and cognitive impacts.

And so managing those, and what is it, what strategies do you need to put in your day, compensatory strategies to help manage this? And that might be part of restructuring the routine, compensatory strategies for memory loss, you know, decreased attention. Those are things that are in our OT wheelhouse and certainly can be applied here. Shams also mentioned that he's had the opportunity to participate in research for people who have had COVID. And so, again, that's another place to be an advocate and engaged in the community, if people are interested in comfortable with doing that. And then, again, addressing the anxiety and trauma from being significantly ill, we know that that chronic and significant illness can impact people's mental health, and so if it was someone who was sick, allowing them to to manage the anxiety from that healthcare experience, which could be incredibly frightening.

So I'm gonna go through what... So as Shams mentioned, he was a survivor of COVID-19, or is a survivor of COVID-19. I'm gonna go through what he outlined as his COVID-19 experience, and then he's sort of gonna round it out for us here today. So the first thing, part of his experience was that he needed to advocate to shelter residents and staff to make sure that people were reporting and monitoring symptoms. So whenever someone presented with symptoms, were they reporting it to staff? Were staff aware and taking the proper steps to care for it for that individual? Unfortunately, although he himself was really taking measures to try to keep safe, he was exposed to others who were symptomatic simply by the nature of the congregate, the setting.

Additionally, there were... Many individuals were released from prison in an effort to prevent the spread of COVID within that setting as well. And we know that those were a group of people who had higher rates and higher mortality from COVID. In Shams' particular situation, his shelter was one of the places where people who were released

from prison went for accommodation. So although people were released, there was no plans of transition into the community. So many went to shelters but were not tested when they were released from prison to ensure that they were not symptomatic, and went to stay in congregate shelters. So Shams believes that this partially may be what was the source of his infection.

So he engaged with someone who was symptomatic, and a few days later he reported not feeling right. He went to rest in his shelter bed. He left his program and then went to meet with his case manager, where he expressed that he was not feeling well. Because of his symptoms and the reporting that, they followed the protocol and had him moved to an isolation hotel, but it did require a lot of advocacy on his part to sort of insist that the symptoms were serious and were problematic and required some care and treatment, which, once he was moved to the isolation hotel, he experienced a worsening of symptoms and a near-death experience. And following his stay there, he actually had to advocate to stay in the quarantine for the full time.

Once he sort of moved past this death experience, they were ready to move him back to the shelter before the 14-day isolation period. And he advocated, "No, I'm not going back "until these symptoms have resolved."

- Or high, so I didn't have a temperature. The symptoms I had was the... Like I was sick. I was weak, and I had fatigue, and I think I was... I don't remember really coughing in the early days, but the fatigue and just being really weak. So that was the first couple of days. And they was great because I had medical attention. You know, nurses came, they done all of that. They gave me juice, food. I was able to rest. I was isolated. So I felt my anxiety was down and stuff like that. But by the third day, I was like, oh, my chest. And I also have one of the underlying conditions, which is high blood pressure.

So I always worry my about breathing and my heart and stuff like that. So I'm like, ooh. So I call the nurse and I say, "Hey, I feel a little kind of tightness in my chest." So they come, they check. And they're like, "Okay, well, you know, "your temperature is still fine, so you should be fine." So I said all right. They said, "We'll check on you again. "Do you feel like," you know. I said, "No, it's just a little tightness." Like, it's definitely different. But I'm kind of getting nervous, right. So at night, I call them again. I said, "Hey, it's getting worse." So they said, "Okay, we'll check on you." So the next day, they took so long.

So the whole day, I'm saying, when's the nurse... They usually come in the morning. They skipped me. And I was like, what is going on? So it's getting worse. So now I'm like, I'm struggling to breathe, and I'm panicking. So they come in and they... You know, this is in the afternoon and almost maybe like three or something like that. And they're like... Okay, so they bring in the oxygen thing. I'm like, oh God. Like, what is going on? So I'm like, forget... I'd rather them have what they need, but they put it on me, and immediately I felt that they put too much. I didn't know what was going on, but my body freezed, like it got so cold.

So now I'm getting scared, 'cause I'm thinking, does this mean I'm dying? So I'm like, and then my my energy's drained, and I can't... I start to move. So I get scared, and I try to move to the computer, 'cause I wanna call my son, 'cause I experienced almost dying before, and I was like, I wanna tell my son what's going on. And I couldn't move. So I'm like, I don't think the oxygen is working. I think something's wrong with it. You know, I'm like, this is not working. And was like, just relax, just relax. And I'm like, no, this is, something's wrong. So they reduced it, and it sort of calmed me. But my oxygen level, I felt my body.

.. It was like the life was being drained from my body. I got a weak. I couldn't move. I started talking real slow. And I was asking him, "Am I gonna die? "Am I gonna die?"

And they're just looking at me saying, "We can't tell you that." I'm like, in my mind, my mind is still thinking, and I'm saying, what the fuck? Tell me something.

- Right.

- Can you take me to the to the hospital? They said, "That might not be good." So I'm like, "Well, what can you do?" They're just like, "We really can't do anything. "You just have to relax." So I'm like, oh my God, I'm gonna die. So now I'm starting to think about the mass graves. I'm starting to think about the being buried in potter's field and being homeless. And I'm saying, damn, my whole life, this is what it's come to. I'm gonna die like this. You know, I'm thinking about my children. I got six children, four grandchildren. I'm like, this is, oh my God, this is crazy. And one of the nurses... I couldn't talk. The nurse reached out and grabbed my hand.

And I felt that she was trying to comfort me, like she knew that this could be it. And you could see in that look on their face, like, damn, you know. But they were nurses, I guess they're trained for that. And I'm looking, and I look, and her touching me made me think... I said, no, hell no. This can't be it.

- This isn't gonna be it.

- This, no, we're not doing this. I'm dependent, I'm gonna be honest with you, and I'll go through this. I said, I'm dependent on the doctors to save me. I've never called God once. So I said, oh God, oh Allah, oh Jehovah, oh Yahweh, oh Krishna, oh Buddha, oh whoever. I just don't wanna get this wrong. So whoever made me, help me right now, you know. I don't wanna die. This can't be it. And then I said... It's funny now, but it... And then I kind of laughed when I thought of it. I said, wait, faith without works is dead. You have to do something. And here go where we get to occupational therapy. Thank God for occupational therapy.

- I didn't pay you to say that. That was-

- Oh, no, definitely. But I'm being honest. I thought about the breathing exercises. I always speak of how I could talk and this and that, and I don't take time to breathe. I always talk how could be walking and doing this, and I don't take time to breathe. My anxiety goes up, and I don't know how to regulate my body. But through breathing, I'm learning that. So I started doing that. I remember doing the yoga and the doing the... What is it, six-second deep breath in and four seconds out, or vice versa? And I started doing that. And I'm also calming down. I'm also regulating my thoughts and my body. And I started feeling the life come right back.

And the nurses is looking, and they say, "Okay, keep breathing. "It's going up. It's going up." And as they're saying that, I'm getting strength again. And I got, not normal, but I was good, I was okay. They were able to-

- So certainly an intense experience, I think, and really acknowledging the difficulty of going through being ill with COVID and the fear that comes with that, sort of speaks to the need to address that post-COVID response, and also, I think, a ringing endorsement of strategies to help with that. It really can be carried over for people in ways that we don't even anticipate. I'm sure his OT didn't anticipate that the deep breathing would be something that would really help him in a really dark moment in dealing with COVID. So just for the sake of time... And there's a few slides left here, and I also wanna be able to answer questions. But I think there's always space for an occupational therapist to be an advocate.

We are client-centered, and we are here for our clients. But there's a space for us to identify where the systems maybe aren't meeting needs for people and limiting occupational engagement, and doing something about it. And so the first step, I think, is always, everybody's community is different, so engage the consumers and service users of your community, and identify what their needs are and what's missing in this particular space right now. You can also advocate for universal testing at shelter and congregate housing settings. Universal testing can identify asymptomatic cases and mitigate the spread of COVID in these particular situations. There's also been a development of medical respite care sites, which provide a place for people to recover after hospitalization.

This model has been adopted as alternative care sites for people who don't require hospitalization for COVID-19 but are symptomatic, for people to be able to isolate in recovery. And so advocacy for those in your community could be really helpful. And then funding and support for shelter settings to be able to implement safe social-distancing guidelines and isolation for people that need it, and transition potentially to alternative sites, such as hotel sites, which has happened in a lot of cities, but also always, I think always advocating for a long-term solution to homelessness through housing. And for time, I think we will skip this video on harm reduction. And there's actually a really great comment in the feed that I am, the question-and-answer, that I will go ahead and answer here, and is that.

.. And it's this, I'm so glad you brought this up, so harm reduction for substance use. Harm reduction is really a way of being consumer and client oriented. So that is not requiring persons to engage in abstinence to be able to receive services. But the second part that Linda brought up here is also offering alternatives. And it's not forcing someone to go into treatment when they're not ready but allowing people to know that treatment options are there. And treatment options do not always necessarily mean abstaining entirely but can be through medicated assistant treatment through

Suboxone or buprenorphine. And so there are options for people out there. And I thank you for bringing that up, and where people can access that and those services.

Again, those maybe have something that have been limited in response to COVID with programs shutting down, so helping people find that source if they're ready. And the other piece of harm reduction that I'm going to talk about, too, is just that there's a lot of issues with people wanting to go into isolation and shelter units, because it's requiring people not to use, and people have a fear of, not only do I have symptoms of COVID, but now I'm gonna have to go through detox and withdrawal. And so people are opting not to do that. And if anyone's ever been around someone in that state, I can understand why that we need to be, want to be avoided, or for persons who are simply not ready to stop using.

But to really minimize risk in our communities of transition, there needs to be an option for people who are using a neat isolation, whether that's offering them some of these medicated assisted treatments while they're there, that can be really, really helpful. Yeah, and I just think continued advocacy of OTs to fight the NIMBY mentality for alternative shelter sites, making sure alternative shelter sites are accessible, mobile shower settings are accessible, and preventing homelessness. There's a lot of people who are going to be facing eviction very soon. And so it's gonna take some action to be able to prevent that to increase the number of people experiencing homelessness. In Shams' words, again, I'll summarize as, he's really recommending for OTs, for us to continue what we're doing here.

So there are some resources that are available in the slides from various organizations on responding to COVID-19 for this population, mental health support, and racial and social equity tools, which are very integrated in what we're managing with homelessness right now and COVID-19. And you can also follow the experience of Shams on social media and read more about his experience. There was an article

published in "The New York Times" regarding his shelter's transition to a hotel site and through his program at Project Renewal. Okay, so I will pause here for questions, and then we can play the final video perhaps for those at the end, depending on time. But I'm happy to take any questions. And yes, a huge thanks to Shams who was willing to do the interview with me.

- [Fawn] Thank you so much, Caitlin, for a great talk today. Those videos were so great. There are several people just chiming in here, saying thank you to you as well as to Sham for sharing his story. That was very powerful, I believe. So I'm waiting to see if we have any more questions. But in the meantime, I did wanna ask you, how did you get involved with this population?

- I would say, so I started working... I became interested in mental health in college. I had a really great level one fieldwork experience. So shout out to all those fieldwork educators out there. And I was working in an inpatient psychiatric setting, which was the community floor of the hospital. So a lot of my patients there were experiencing homelessness, and with that, I became more aware of the community agencies that... And so I was able to transition from the hospital actually to a Healthcare for the Homeless Site to do direct services in the community, which is great. And now I'm working with the National Council, so more programmatic and population health, but it's really been a wonderful transitions of opportunities, I think.

- [Fawn] Okay, well, I don't see any questions coming in, just plenty of people chiming in to say thank you. They thought it was a great presentation. And so I think, thank you and Sham for your time.

- Sure. Thank you so much.

- [Fawn] Hope everyone enjoyed today's talk and you joined us again for the last day of our virtual conference on mental health and OT's response to COVID. Thanks, everyone.