The Shelter Safety Study

An examination of violence and service restrictions in Toronto's shelter system

Final Report

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Acknowledgements

This study was led by researchers, Drs. Nick Kerman, Sean A. Kidd, and Vicky Stergiopoulos, at the Centre for Addiction and Mental Health (CAMH) in Toronto. Support with data collection and analysis was provided by Joseph Voronov and Tim de Pass. Dr. Carrie Anne Marshall was the lead collaborator for data collection in London, Ontario.

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Title page photograph provided courtesy of the City of Toronto.

The lead researchers are solely responsible for the content of the work.

For inquiries about this study, please contact:

Dr. Nick Kerman
Scientific Associate
Centre for Addiction and Mental Health
Toronto, Ontario, M6J 1H4
Email: nick.kerman@camh.ca

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STUDY HIGHLIGHTS

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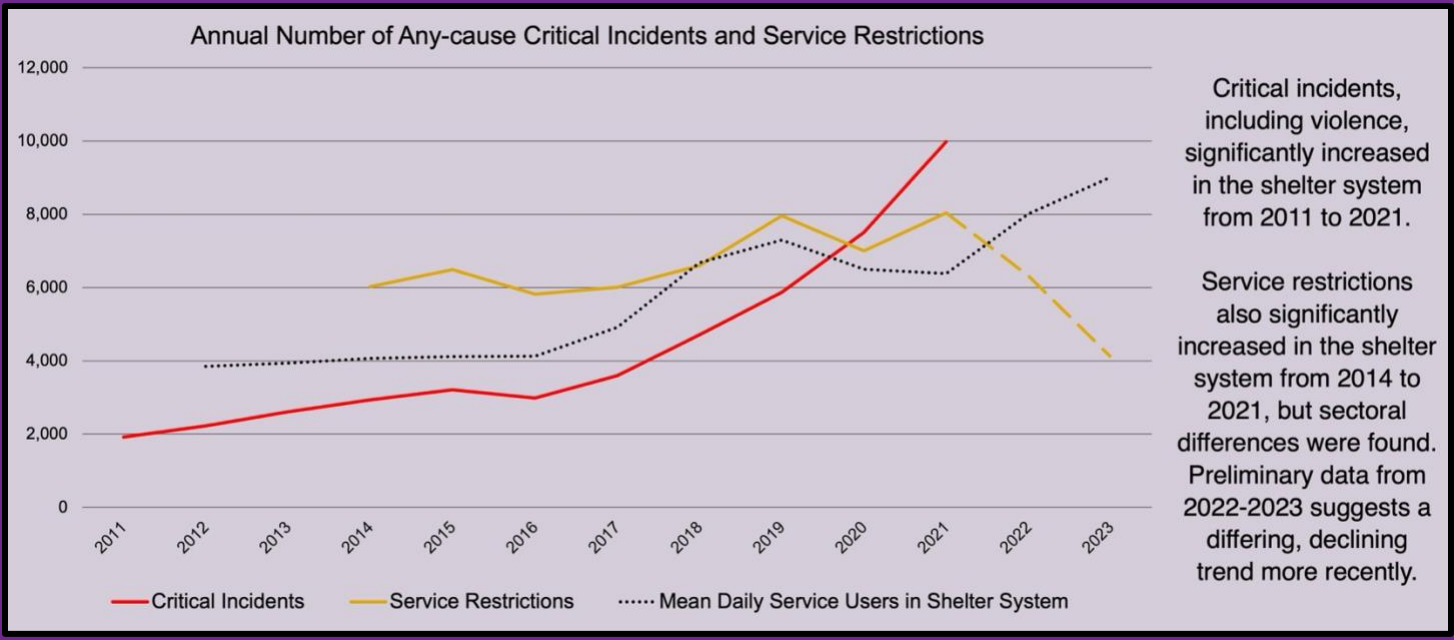
Research Objective: This multi methods, observational study examined the factors that contribute to physical and psychological safety in shelters for staff and service users, including the causes and consequences of shelter based violence and service restrictions.



Critical incidents, including violence, significantly increased in the shelter system from 2011 to 2021.

Service restrictions also significantly increased in the shelter system from 2014 to 2021, but sectoral differences were found. Preliminary data from 2022-2023 suggests a differing, declining trend more recently.

Safety for Shelter Staff and Service Users	▪ **36.2%** of shelter staff feel very or somewhat unsafe in the workplace ▪ **43.2%** of Black and Indigenous shelter staff reported experiencing daily verbal abuse involving racism ▪ Service users feel safer in smaller shelters with private spaces and supportive staff
Key Contributory Factors in Shelter-based Violence	▪ COVID-19 pandemic ▪ Crowded shelters ▪ Winter season ▪ Shelter policies that limit privacy and control ▪ Unmet needs among service users
Consequences of Service Restrictions	▪ **44.8%** experience unsheltered homelessness immediately following service restriction ▪ Anger and fear ▪ Increased substance use and other potential health impacts ▪ Disrupted health and social service connections and relationships
Issues with Service Restriction Processes	▪ Wide variability in service restriction processes and decisions ▪ Challenges when referring service users post-restriction ▪ Lack of information sharing and availability following restrictions ▪ Limited oversight, and unclear or non-neutral appeal processes

Violence and service restrictions are serious issues in Toronto's shelter system on which more action is needed. These problems interact with other critical social issues, including the rise in unsheltered homelessness, the affordable housing crisis, a worsening toxic drug supply, and an insufficient supply of mental health services and housing-based supports. Improving safety in the shelter system will be a challenging task that requires nuanced and balanced approaches. Yet, there are opportunities to effect change by addressing key needs in the shelter system related to violence and service restrictions. This includes using a prevention lens to strengthen the availability of mental health supports, ensure continuity of support for service users through community partner collaboration, increase the use of alternative interventions to service restriction, and leverage existing data to support individuals most in need. Twenty-two recommendations are proposed for advancing safety in the shelter system for people experiencing homelessness and staff.

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Study Conceptualization and Initiation

In January 2021, researchers at the Centre for Addiction and Mental Health, Drs. Nick Kerman and Sean Kidd, in collaboration with Dr. Vicky Stergiopoulos, sought funding for a qualitative study examining service restrictions among people experiencing homelessness. Around the same time and independent from the above, Toronto Shelter & Support Services (TSSS) Division staff contacted Dr. Stergiopoulos seeking her input on how to more effectively address some of the challenging safety concerns, including violent incidents, that were being reported across the shelter system. Dr. Stergiopoulos connected TSSS staff to Drs. Kerman and Kidd in relation to their planned research. Over the next six months, the three CAMH researchers collaboratively worked with TSSS to scale-up the design of the initial study to more comprehensively assess safety in the Toronto shelter system, with a focus on violence and service restrictions. As part of this work, TSSS requested that the CAMH researchers provide a final research report to the Division at the end of the study, with recommendations for improving safety in shelters.

Study Objectives and Design

This multi-methods study examined the factors that contribute to physical and psychological safety in shelters for staff and service users. Overall, this study had five objectives:

1. To understand the fundamental components and practices for maintaining safety and preventing violence in shelters.
2. To identify individual- and temporal-factors associated with shelter restrictions and shelter-based violence.
3. To understand the causes and consequences of shelter-based violence and service restrictions.
4. To identify innovative and promising approaches for preventing and managing risk in shelters, as well as reducing harms related to service restrictions, in local, national, and international contexts.
5. To describe person-centred practices for promoting safety and reducing harms associated with service restrictions.

This study involved original data collection, secondary analysis of Shelter Management Information System (SMIS) administrative data, and a literature review. Original data collection in Toronto included: an online survey of 157 shelter staff, qualitative interviews with 26 shelter staff, qualitative interviews with 20 key informants, qualitative interviews with 56 people experiencing homelessness, and a scan of shelter innovations and promising practices.

The study was approved by the research ethics board of the Centre for Addiction and Mental Health and data were collected from February 2022-June 2023.

Safety in Shelters

- 36.2% of shelter staff reported feeling very or somewhat unsafe in the workplace. Women reported feeling significantly less safe at work than men.
- Shelter staff were exposed to a range of critical incidents and stressors in the workplace. Racist verbal abuse and threats were experienced significantly more frequently by Black and Indigenous staff, with 43.2% of Black and Indigenous staff reporting that they experienced racist verbal abuse and threats on a daily basis.
- A range of factors contributed to sense of safety in shelters for service users. Key positive contributors included: less crowded shelters, friendly and supportive staff, and a staff presence. Concern about violent and non-violent victimization was a prominent

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threat to safety. Many of these factors were consistent with literature review findings.
- Service users had mixed perspectives on building security and surveillance in their experiences of safety in shelters.

Rates of Critical Incidents in the Shelter System

- The annual number of any-cause critical incidents increased from 1,914 in 2011 to 9,982 in 2019 at a rate that was similar to the rise in the number of daily service users in the shelter system; however, there was a marked increase in the number of critical incidents during 2020 (up 1,633 incidents from the previous year) and 2021 (up 2,477 incidents from the previous year), whereas the number of service users decreased during these years. Overall, critical incidents have significantly increased from 2011 to 2021, after controlling for the number of daily service users and other factors.
- The steep increases in critical incidents in the Adult Women sector in 2020 and 2021 suggest that women experiencing homelessness in the shelter system may have been disproportionally harmed by the COVID-19 pandemic.
- The number of incidents of physical and interpersonal violence (the latter includes several forms of physical and verbal violence) in the shelter system have increased over the past decade for all sectors (excluding the Families sector, which was not examined in this research), though differing trends were observed over this period between sectors and in relation to the number of daily service users. The rates of physical and interpersonal violence per 1,000 service users from 2012 to 2021 were highest in the Mixed Adult (All Gender) sector. Overall, each type of violence (assault of shelter staff; assault of service users; verbal abuse of shelter staff; verbal abuse of service users; threats of death or harm; harassment; property damage; thrown objects) significantly increased from 2011 to 2021, after controlling for the number of daily service users and other factors.
- The number of suspected overdoses in the shelter system has increased substantially in recent years, with the Mixed Adult (All Gender) sector having the highest rate of overdoses per 1,000 service users.
- It is important to recognize that the observed trends in critical incident rates may be partially attributable to policy and practice changes that occurred throughout the shelter system during the same period.

Effects of the COVID-19 Pandemic on Critical Incidents

- Rates of almost every type of critical incident significantly increased during the first 661 days (approximately 22 months) of the pandemic, compared to the previous 661 days. These increases are not explained by changes in the daily number of service users in the shelter system, nor season of the year.
- The findings indicate greater exposure to workplace violence among shelter staff during the pandemic.
- There has been an alarming rise in suspected overdoses in the shelter system following the onset of the pandemic.

Correlates of Shelter-based Violence

- Although larger shelter programs typically had higher rates of violence per 1,000 service users prior to the pandemic, increases in violence rates were highest in small programs in many sectors during the pandemic. The findings suggest that crowdedness in shelters may be a more important risk factor in violence rates than program size alone.

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- Higher rates of shelter-based violence generally occur during the winter season.
- Physical violence was more likely to occur in the evening, whereas interpersonal violence was more likely to occur in the morning. These findings suggest possible temporal differences in manifestations of interpersonal conflict and expressions of anger.

High-Incident Service Users

- A small group of service users is involved in a sizable number of total critical incidents across the shelter system. In 2021, 24 service users accounted for 6.6% of all critical incidents and 5.8% of all service restrictions that year. Critical incidents in prior years were common among this group as well.
- High-incident service users were involved in a range of critical incident types, suggesting that this group's difficulties in shelter may manifest in different ways during their stays.
- SMIS data can be routinely used to identify recent high-incident service users for subsequent support and intervention.

Perspectives on the Contributory Factors to Shelter-based Violence

- Shelter-based violence is a complex problem that was perceived to result from an interaction between systemic, environmental, programmatic, interpersonal, and individual factors.
- Enhancing safety for both service users and shelter staff is key to reducing violence.

Individuals and Groups At-risk of Shelter-based Violence

- Five types of individuals and groups were perceived to be at heightened risk of shelter-based violence: [1] people with mental illness and cognitive impairment; [2] people who use substances; [3] transgender and non-binary individuals; [4] Black, Indigenous, and People of Colour (BIPOC); and [5] women.

Consequences of Shelter-based Violence

- Shelter-based violence can cause physical and psychological injuries, and avoidant behaviours for both service users and staff.
- 2SLGBTQ+ individuals may hide their gender and sexual orientation identities in shelters to avoid further victimization.
- Shelter agencies were described as primarily responding to violence through the use of service restrictions.

Key Components of Violence Prevention in Shelters

- Staff training and engagement of service users were perceived as fundamental for the prevention of shelter-based violence. This included ensuring that staff: have adequate training and make use of de-escalation skills, are focused on building supportive working relationships with service users, are visible and accessible to service users in the shelter, and support service users to engage in social and recreational activities.
- Other important approaches for preventing shelter-based violence included: transparent shelter rules, policies, and expectations; critical incident documentation, debriefing, and use of safety plans; and access to mental health supports.
- Service user belonging searches and the presence of security guards were seen as less beneficial for the prevention of violence.
- It is essential for violence prevention policies and practices to be embedded within trauma-informed, anti-oppressive, and anti-racist frameworks.

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Rates, Causes, and Durations of Service Restrictions in the Shelter System

- Any-cause service restrictions have significantly increased from 6,026 in 2014 to 8,037 in 2021 across the shelter system.[1] The service restriction rate per 1,000 service users was higher in the Youth sector than the adult sectors; however, there has also been a downward trend in the use of service restrictions in the Youth sector over time.
- Whereas many service restrictions for reasons involving violence and potential victimization have significantly increased from 2014-2021, service restrictions for non-violent causes have decreased.
- Frequent use of ambiguous categories for recording service restriction reasons in SMIS, and overuse of the "other" category, limits a more reliable understanding of service restriction trends in the shelter system.
- Service restriction durations vary widely across the shelter system, including between sectors. Nevertheless, there has been a significant decrease in the mean duration of service restrictions between 2014 and 2021, with a marked decrease in 2016 following an update to the Toronto Shelter Standards.
- Use of 89-day service restrictions increased in 2020 and 2021, compared to previous years.

Effects of the COVID-19 Pandemic on Service Restrictions

- The pandemic had varying effects on service restrictions, with rates not significantly changing for most service restrictions involving violence and potential victimization. In contrast, restrictions for non-violent causes significantly decreased.

Frequently Restricted Service Users

- Like critical incidents, a small group of service users receive a sizable number of service restrictions. In 2021, 17 service users accounted for 6.5% of all service restrictions, the majority of whom were youth.
- SMIS data could be used to identify frequently restricted service users for subsequent support and intervention. However, due to many of their restrictions having ambiguous or unknown cause categories in SMIS, it is difficult to interpret what are their support needs, thus requiring additional information be gathered for potential intervention.

Perceptions of Service Restrictions among Service Users

- People experiencing homelessness who participated in this study were generally supportive of the use of service restrictions for violence. However, the importance of preventing unsheltered homelessness following service restriction implementation was underscored. People experiencing homelessness were less supportive of service restrictions for non-violent incidents. Here, they wanted there to be more discretion in the use of service restrictions and greater consideration of how restrictions might affect the individuals who receive them.
- Many of the concerns identified by people experiencing homelessness in regard to service restrictions were similar to issues raised by shelter staff and key informants.

[1] Aggregated SMIS data on service restrictions from 2022-2023 were made available to the research team in mid-January 2024. These data are presented in an appendix of the full report and revealed a sharp decrease in any-cause service restrictions in 2022 and 2023, which would likely nullify the significant increase reported here if these data were analyzed in greater depth at the individual restriction level.

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- Unbeknown to study participants, several of their recommendations on reducing service restriction-related harms were aligned with existing policies in the Toronto Shelter Standards (e.g., referral to another shelter following service restriction, use of service restrictions as "a last resort," suspension of service restrictions during weather alerts). Thus, ensuring that the Toronto Shelter Standards are being consistently followed for service restrictions would likely appease some (but not all) of the concerns raised by people experiencing homelessness.

Perceptions of Service Restrictions among Shelter Staff

- Most shelter staff were supportive of service restrictions and may perceive these practices as beneficial for violence prevention. Among shelter staff who disagree with their use, service restriction policies and practices are likely a source of job dissatisfaction, as well as potentially a mental health burden.
- There was general consensus among shelter staff and key informants that violence and other forms of victimization would be grounds for service restriction in most programs. However, views were more varied on whether or not service restrictions should be used in response to substance use, verbal abuse, and service non-engagement or case plan non-adherence. The importance of considering situational factors on a case-by-case basis during service restriction decision-making was also emphasized.

Issues with Service Restriction Processes

- Consistent with findings from the SMIS data, shelter staff and key informants perceived wide variability in service restriction processes and decisions within and across agencies.
- Shelter staff reported difficulties in supporting service users to find a new shelter bed following a service restriction due to the limited availability of beds in the shelter system on any given night. Even fewer suitable options were reported to be available for service users with extensive histories of violence and service restrictions.
- Consistent with findings from the SMIS data, some shelter staff and key informants reported that service restrictions of 89 days are issued to permit these restrictions from being reviewed by TSSS per the Toronto Shelter Standards.
- Concerns were expressed with regard to availability and accessibility of information on service restrictions, both to service users and other agencies supporting them.
- Shelter staff and key informants perceived that BIPOC service users were at greater risk of service restriction, though data on service users' race (with the exception of Indigenous status) were not collected until late 2020, precluding any conclusions at this time.

Consequences of Service Restrictions: Experiences of Service Users

- 44.8% of the 29 study participants in Toronto experienced unsheltered homelessness for one or more nights immediately following their past-year service restriction, with an additional 34.5% experiencing unsheltered homelessness at some point in the weeks and months that followed.
- Increased substance use was commonly reported following service restrictions.
- Service restrictions could impede access to support networks and yield a sense of mistrust for some study participants upon re-entering the shelter system.
- Anger and fear were very common emotional reactions to being service restricted.

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Consequences of Service Restrictions: Perspectives of Shelter Staff

- Consistent with the experiences of service users, shelter staff and key informants perceived that service restrictions could yield a risk of unsheltered homelessness and impede access to supports (e.g., healthcare, housing casework).
- Service restrictions contribute to a sense of relief for shelter staff following volatile situations, but could also be a source of tension due to the moral implications of such decisions and disagreements within teams on how issues should be handled.
- Service restrictions were generally not perceived to reduce risk of violence or precipitate change in the behaviours that cause service restriction.

Conclusion and Recommendations

Violence and service restrictions are serious issues in Toronto's shelter system on which more action is needed. These problems interact with other critical social issues, including the rise in unsheltered homelessness, the affordable housing crisis, a worsening toxic drug supply, and an insufficient supply of mental health services and housing-based supports. Improving safety in the shelter system will be a challenging task that requires nuanced and balanced approaches. Yet, there are opportunities to effect change by addressing key needs in the shelter system related to violence and service restrictions.

Twenty-two recommendations are proposed to advance safety in the shelter system for people experiencing homelessness and staff. The recommendations are presented to the right and described in further detail in the full report.

1. Engage community partners providing mental health services in the shelter system to explore opportunities for enhancing crisis intervention
2. Implement more intensive, team-based mental health supports in the shelter system
3. Develop accessible, around-the-clock supports for people experiencing homelessness who use substances
4. Identify service users with the highest rates of critical incidents and service restrictions, and prioritize them for supportive housing and other health service linkages
5. Develop a specialized program to support people with extensive histories of violence and service restrictions
6. Establish more supports for shelter staff following critical incidents and workplace violence
7. Develop and pilot a flexible, minimally demanding restorative justice intervention model framework for implementation in response to interpersonal conflict and shelter-based violence
8. Increase access to recreational, social, and physical activities for service users in the shelter system
9. Prioritize the reduction of crowdedness in shelters
10. Foster more collaboration and information sharing between shelters and with healthcare professionals who support service users
11. Establish more consistent service restriction processes and decisions within and between shelter organizations
12. Prioritize use of multi-hour, non-bed loss service restrictions for escalating interpersonal conflict and verbal abuse
13. Expand the meaningful inclusion of people with lived experience of homelessness in TSSS' committees and decision-making processes related to service delivery
14. Establish an accessible source (e.g., Central Intake) where service users can obtain information on any active service restrictions, including their lengths and appeal rights
15. Build capacity within TSSS to provide greater oversight and respond to issues pertaining to shelter-based violence and service restrictions
16. Strengthen training for shelter staff on practices for supporting service users who use methamphetamine
17. Evaluate the extent to which the training competencies matrix, including the individual trainings, are meeting the needs of shelter staff
18. Develop a staff training program and educational resources focused on person-centred safety interventions adapted from the Safewards model
19. Develop performance indicators on shelter safety
20. Collect and analyze data on the role of race and ethnicity in service restrictions
21. Reduce the use of the "other" service restriction category in SMIS reports
22. Consider further study of shelter-based violence, service restrictions, and safety needs among families in the shelter system

Definitions

Assessment and Referral Centre

This is a unique service location within the homeless service system at 129 Peter Street in Toronto. The Assessment and Referral Centre offers a range of supports, including walk-in services and a bedded program. Given the key role of this service location in relation to the broader shelter system, the Assessment and Referral Centre is occasionally named in some findings in this report.

Critical Incident

Critical incident refers to a range of serious incidents that occur in the shelter system. This includes different forms of shelter-based violence, as well as other types of incidents (e.g., overdose, self-injury or suicide attempt, medical emergency). When used in relation to data from the Shelter Management Information System, critical incidents refer to the 22 types of incidents captured on the Incident Report module.

Directly Operated Shelter (DOS)

A shelter that is directly operated by the City of Toronto.

Homelessness

Individuals who do not have stable, safe, or permanent housing and are experiencing either sheltered or unsheltered homelessness for one or more nights as defined below (see: *sheltered homelessness* and *unsheltered homelessness*).

Purchase of Service (POS) Shelter

A shelter that is funded by the City of Toronto and operated by another agency.

Safe Haven

A formal shelter model that has space for up to 25 service users, uses a low-barrier approach, and provides private or semi-private rooms. The target population of Safe Haven programs is individuals experiencing chronic unsheltered homelessness that have a serious mental illness, with or without co-occurring substance use problems, and who are inadequately supported by health and social services. There are no known Safe Haven shelters in Canada, though it is highly likely that there is model overlap with some existing programs.

Service Restriction

The denial of a service user's access to shelter services and supports for a limited duration of time for a specified reason. This definition is largely consistent with the one used in the Toronto Shelter Standards.

Service User

An individual experiencing homelessness who uses shelter services.

Shelter

An emergency shelter that is accessible to individuals experiencing homelessness with or without a referral, with the intention of providing short-term accommodation and supports. Shelters for families experiencing homelessness are not included in this definition and are specified as "family shelters" where relevant.

Shelters in the Toronto shelter system are categorized into one of five sectors based on the service user groups that they serve: [1] adult men, [2] adult women, [3] mixed adult (all gender), [4] youth, and [5] family. Of note, the mixed adult sector was sometimes formerly referred to as the "co-ed" sector.

Shelter Hotel

An emergency shelter that is located in a hotel or motel building. This shelter model typically involves private or semi-private rooms.

Shelter Management Information System (SMIS)

The City of Toronto's web-based information management system, which is used by programs

Definitions

that provide services to individuals and families experiencing homelessness. SMIS is administered by the City's Toronto Shelter & Support Services Division. SMIS is primarily used by City-funded shelters, 24-hour respite programs, and COVID-19 temporary shelter programs to conduct service user intakes, admissions, case management, and discharges. It is also used by service programs (e.g., Streets to Homes, Central Intake).

Shelter-based Violence

Any experience of physical, sexual, or verbal violence that occurs on shelter premises. These incidents may be interpersonal in nature or involve violence toward property. It is also recognized that there can be subjectivity in experiences of violence, meaning that individuals, including study participants, may perceive or experience violence differently than others.

Sheltered Homelessness

Individuals who are using overnight shelters for people experiencing homelessness. Individuals accessing shelters for people experiencing family and intimate partner violence are not included in this definition. This definition of sheltered homelessness is narrower than *Emergency Sheltered* in the Canadian Definition of Homelessness (Canadian Observatory on Homelessness, 2012).

Toronto Shelter & Support Services (TSSS) Division

TSSS is a Division of the City of Toronto that directly operates and funds community agencies that provide emergency shelter, 24-hour respite and drop-in programs, wrap-around support services, and street outreach. TSSS was formerly named the Shelter, Support and Housing Administration (SSHA) Division and any references to SSHA in participant quotes included in this report are referring to TSSS.

Toronto Shelter Standards

The Toronto Shelter Standards is a set of expectations, guidelines, and minimum requirements for the provision of shelter services in Toronto. All directly operated shelters and purchase of service shelters are required to adhere to the Toronto Shelter Standards. The Toronto Shelter Standards were most recently updated in March 2023 (City of Toronto, 2023). A different set of standards apply to 24-hour respite sites in Toronto.

Unsheltered Homelessness

Individuals who are typically staying in locations not designed for human habitation, including public spaces (e.g., streets, parks), vacant or derelict buildings, cars or other vehicles, and makeshift shelters or tents. Individuals may access shelters or other emergency accommodations only during crises or extreme weather events. This definition is consistent with *Unsheltered* in the Canadian Definition of Homelessness (Canadian Observatory on Homelessness, 2012).

Youth

An individual between the age of 16-24 years.

Study Background and Objectives

Context

There are high rates of victimization among homeless populations. It is estimated that 28.6% of people experiencing homelessness have been physically assaulted within the past year – a rate that is 11 times higher than the general population (Ellsworth, 2019). Sexual violence is also common, especially among women and transgender individuals experiencing homelessness (Ecker et al., 2019; Kushel et al., 2003). Further, older adults, people with longer histories of homelessness, and those with mental illness are at greater risk of violent victimization (Ellsworth, 2019; Roy et al., 2014; Tong et al., 2021). The victimization experienced by homeless individuals contributes to their vulnerability and increases their risk of traumatization or retraumatization.

Shelters are a crucial and widely used component of the social service system for people experiencing homelessness. Given that approximately 9,000 people use a shelter in Toronto on any given night (City of Toronto, 2023), violence is not uncommon in these predominantly congregate settings. In addition to the potential health harms caused by such violence, qualitative research has found that feeling unsafe in shelters can lead service users to sleep outdoors where their ties to providers may weaken and they experience other harms related to unsheltered homelessness (Donley & Wright, 2012; Wusinich et al., 2019). Despite high rates of violence, there remain many unknowns with regard to risk factors for shelter-based violence and victimization among people experiencing homelessness. Moreover, to our knowledge, no comprehensive study on this subject has been conducted.

According to Statistics Canada, as of 2021, there were more than 1,500 workers in the homeless service sector in Toronto (McNamee et al., 2023).[2] Violence in shelters also yields risks and consequences for staff working in these settings. In a recent, national survey of direct service providers working with people experiencing homelessness, 34.6% of those who worked in shelters reported experiencing physical violence in the workplace on a monthly or more frequent basis (unpublished data from a subset of study participants in Kerman et al., 2023). Further, 75.9% of shelter workers reported verbal abuse involving threats to their safety or discriminatory language (i.e., racism, homophobia or transphobia, xenophobia) monthly or more frequently. These experiences may undermine a sense of physical and psychological safety in the workplace, and lead to greater employee turnover within shelter organizations.

Service restrictions are a known practice for managing risk and responding to shelter-based violence. However, service restrictions have the potential to leave people experiencing homelessness without needed supports and connection. Very few studies have been conducted on service restrictions. A recent Canadian study examined predictors of service restrictions from shelters among homeless adults with mental illness and youth experiencing homelessness (Kerman et al., 2022). Findings showed that individuals with criminal justice system involvement were significantly more likely to be restricted from a shelter, as were those who experienced homelessness at an earlier age. The study also highlighted the limits of individual-level predictors, as adults with mental illness in Toronto were significantly more likely to be restricted from a shelter than study participants in four other Canadian cities

[2] Per information provided by TSSS staff directly to the research team, this figure likely underestimates the size of the shelter system workforce in Toronto; however, data to make a more reliable estimate were unavailable.

Study Background and Objectives

(Vancouver, Winnipeg, Montreal, and Moncton).[3] Overall, the study findings highlighted that some service users may be more at-risk of experiencing service restrictions, although it is also necessary to consider how individual characteristics interact with shelter policies and practices to produce restriction risks.

Although violence and service restrictions are known issues within shelters, there is limited research on how to optimally prevent associated harms and foster safety in shelter settings. Further, many shelter systems have been transformed since the onset of the COVID-19 pandemic, which has implications for safety, as well as who accesses shelter. For example, in 2021, there was an increase in the number of people entering the shelter system in Toronto from correctional institutions. More recently, the shelter system has seen an uptick in the number of refugees and newcomers who are accessing it. These service user groups, as well as others, may have differing safety and support needs that are important to address in service delivery. Accordingly, this study was conducted to address the critical evidence gap, and identify practices and policies for advancing safety in the Toronto shelter system.

Study Conceptualization and Initiation

In January 2021, researchers at the Centre for Addiction and Mental Health, Drs. Nick Kerman and Sean Kidd, in collaboration with Dr. Vicky Stergiopoulos, sought funding for a qualitative study examining service restrictions among people experiencing homelessness. Around the same time and independent from the above, Toronto Shelter & Support Services (TSSS) Division staff contacted Dr. Stergiopoulos seeking her input on how to more effectively address some of the challenging safety concerns, including violent incidents, that were being reported across the shelter system. Dr. Stergiopoulos connected TSSS staff to Drs. Kerman and Kidd in relation to their planned research. Over the next six months, the three CAMH researchers collaboratively worked with TSSS to scale-up the design of the initial study to more comprehensively assess safety in the Toronto shelter system, with a focus on violence and service restrictions. As part of this work, TSSS requested that the CAMH researchers provide a final research report to the Division at the end of the study, with recommendations for improving safety in shelters.

Study Objectives

This first-of-its-kind study examined the factors that contribute to physical and psychological safety in shelters for staff and service users. Further, organizational approaches for managing and mitigating risk, including service restriction practices and outcomes, were explored. Overall, this study had five objectives:

1. To understand the fundamental components and practices for maintaining safety and preventing violence in shelters.
2. To identify individual- and temporal-factors associated with service restrictions and shelter-based violence.
3. To understand the causes and consequences of shelter-based violence and service restrictions.
4. To identify innovative and promising approaches for preventing and managing risk in shelters, as well as reducing harms related to service restrictions, in local, national, and international contexts.
5. To describe person-centred practices for promoting safety and reducing harms associated with service restrictions.

[3] Of note, this study used data from the *At Home/Chez Soi* demonstration project, which are now over a decade old (data collection occurred from October 2009 to June 2013).

Study Design

This two-year, multi-methods study involved original data collection, as well as secondary analysis of administrative shelter data. Each research activity is summarized in the table below and explained in detail in this section of the report. The study was approved by the research ethics board of the Centre for Addiction and Mental Health.

Recruitment of study participants for the online survey and qualitative interviews occurred at six shelter sites in Toronto. The six sites were selected in consultation with staff of the Toronto Shelter & Support Services (TSSS) Division. The six sites were selected on the basis of achieving a diverse representation of types of shelter programs (i.e., shelter size, model, populations served, shelter operator type). The six shelter sites are not named in this report.

Online Survey of Shelter Staff

An online survey was administered to service providers working in the shelter system in Toronto at six sites. Data were collected from April-September 2022. Service providers were eligible to participate if they: [1] were 18 years of age or older, [2] worked in one of the six shelter programs, and [3] could understand English.

The online survey gathered quantitative data on the workplace experiences of shelter staff. The survey involved a mix of standardized scales and items developed specifically for this study. All scales and items were based on self-report. The

Research Activity	Description
A. Online Survey of Shelter Staff	157 staff working in six shelters in Toronto were surveyed to understand their workplace experiences of shelter-based violence, service restrictions, and sense of safety.
B. Qualitative Interviews with Shelter Staff	26 shelter staff in Toronto were interviewed to understand organization- and system-level processes related to shelter-based violence and service restrictions, as well as their recommendations for improving safety in the shelter system.
C. Qualitative Interviews with Key Informants	20 key informants with expertise in shelter system delivery, oversight, policy, and advocacy, as well as the provision of adjunct services to people experiencing homelessness (e.g., healthcare, community services, legal supports) were interviewed. These interviews focused on recommendations for improving safety in shelters and creating more procedurally just service restrictions.
D. Identification of Shelter Innovations and Promising Practices	A scan was completed to identify shelter agencies and systems undertaking promising practices for reducing shelter-based violence and service restriction harms. A total of five shelter innovations and promising practices are profiled in this report. These descriptions were principally developed using publicly available information and/or qualitative interviews with individuals involved in the programs.
E. Qualitative Interviews with People Experiencing Homelessness	Two types of interviews were conducted with people experiencing homelessness. The first type was interviews with individuals who had been service restricted from a shelter in the past year and the second type involved interviews with individuals who had experienced shelter-based violence in the past year. A total of 56 interviews were conducted with people experiencing homelessness in Toronto. An additional 24 qualitative interviews were conducted with people who had been service restricted in London, Ontario. This report excludes data from the London study participants; however, some findings are compared to narratives from the London interviews for contextualization.
F. Secondary Analysis of Administrative Shelter Data	Administrative data from the incident report and service restriction modules of the Shelter Management Information System (SMIS) were analyzed to identify trends and factors associated with shelter-based violence and service restrictions. Complete data were available for critical incidents from January 1, 2011 to December 31, 2021. Complete data were available for service restrictions from August 1, 2014 to December 31, 2021.
G. Literature Review	A literature review using a systematic search was completed to examine the factors that contribute to safety in shelters.

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domains of the online survey are described below:

- *Demographic Information*: Single items were used to collect data on study participants' age, country of origin, ethnicity, gender, sexual orientation, and level of education.
- *Occupational Information*: Single items were used to collect data on employment history in the homeless service sector, current program of employment (i.e., shelter or shelter hotel), current work role, and amount of direct contact with service users.
- *Occupational Satisfaction*: The Job Satisfaction Survey (JSS; Spector, 1994) is a 36-item instrument that was used to measure employee attitudes about the job and aspects of the job. The JSS assesses satisfaction across nine facets of a job: [1] pay, [2] promotion opportunities, [3] supervision, [4] fringe benefits, [5] contingent rewards (i.e., rewards based on performance), [6] operating procedures, [7] coworkers, [8] nature of work, and [9] organizational communication. The JSS was developed for use in human service organizations and has been widely used in organizational psychology research. A score is computed for each subscale, in additional to a total score. Higher scores reflect greater job satisfaction. For this report, most analyses used the total score, though subscale scores are described descriptively where relevant.
- *Workplace-based Violence and Aggression Experiences and Perceptions*: The Violence Prevention Climate Survey-12 (VPCS; Kessler et al., 2008) was used to measure perceptions of the extent to which organizational management creates a climate that helps discourage employee exposure to physical violence and verbal aggression. The 12-item scale has three subscales: [1] Policies and Procedures, [2] Practices and Response, and [3] Pressure for Unsafe Practices. A score is computed for each subscale, with higher scores reflective of more responsive approaches for reducing workplace violence. Workplace exposure to critical events and stressors was measured using a modified list of items by Seto et al. (2020). Study participants were asked how often they experienced direct exposure in the workplace (i.e., "it happened to you or you responded to the event") to 16 different critical events and stressors in the past year (e.g., biohazards, constant screaming, self-injury, verbal abuse/threats, sexual assault, physical assault, overdose, suicide, and service restriction enforcement). The response options for each item were: never, annually (at least once/year but not monthly), monthly (at least once/month but not weekly), weekly (at least once/week but not daily), and daily. Items were analyzed individually.
- *Service Restriction Process and Outcome Perceptions*: Nine items were developed for this study to measure attitudes toward service restriction processes and outcomes. These included the extent to which service restriction reasons and processes were perceived as fair and just; agreement between staff on service restriction decisions; clarity of policies and procedures related to service restrictions; necessity of service restrictions for program safety; impacts of service restrictions on service users; and overall supportiveness of service restriction policies. For this study, the items were analyzed individually, as well as summed to create a total score, with higher scores reflective of more favourable perceptions of service restriction practices. The internal consistency of the nine items indicated good scale reliability (Cronbach's alpha = .81).
- *Behavioural Health Service Use*: Three items were used to assess perceived need for and use of services for mental health or substance use reasons in the past year (yes/no). An additional item also asked about barriers to accessing mental health and substance use treatment in the past year (e.g., concern about treatment effectiveness, lack of time, insufficient insurance coverage, affordability,

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uncertainty about where to get services). Items were analyzed individually.

- *Work Safety, Mental Health Status, and Impacts of the COVID-19 Pandemic*: Sense of safety in the workplace and mental health status were each assessed using a single item with a 5-point response scale. Higher scores on the two items reflected more positive assessments of safety and mental health, respectively. Two additional items asked about the impacts of the COVID-19 pandemic on work safety and frequency of service restrictions. Both items also used a 5-point response scale, with a "No Change" midpoint. Higher scores on the safety item were reflective of greater safety during the pandemic. Higher scores on the service restrictions item were reflective of a perceived increase in service restrictions at the study participant's shelter during the pandemic.

Qualitative Interviews with Shelter Staff

Qualitative interviews were held with 26 service providers working in shelters in Toronto. Recruitment of study participants occurred at the same six shelters as the online survey. Purposive sampling was used to recruit providers based on two primary factors: [1] service provider role (direct service, shift supervisor, or management) and [2] community agency (primary shelter program). The sampling objective was to obtain a sample that was diverse in terms of the role of service providers and the shelters where study participants worked. Interviews were completed from February-November 2022.

Of the 26 service providers, 11 worked in managerial roles, 9 were in direct service roles, and 5 were in shift supervisor roles. One other study participant was in a unique role that was not classifiable. The number of study participants per shelter program ranged from 2 to 7.

Interviews were semi-structured and included four parts. First, study participants were asked to identify their roles and the type of shelter program where they worked. In the second part, the causes and consequences of shelter-based violence were discussed. The interview then transitioned to discussing service restrictions in the third part. This included the reasons why service users are restricted and how this process occurs. This part of the interview also involved a discussion of the extent to which the design and environment of programs affect if and how restrictions occur. The fourth part of the interview focused on recommendations for reducing shelter-based violence; improving the process in which service restrictions are implemented, including mitigating associated harms; and improving overall safety in shelter settings for service users and staff.

Qualitative Interviews with Key Informants

Qualitative interviews were also held with 20 key informants. This was a diverse group of stakeholders involved in shelter system delivery, oversight, policy, and advocacy, as well as the provision of adjunct services to people experiencing homelessness (e.g., healthcare, community services, legal supports). Key informants were identified using the research team's connections, recommendations from TSSS staff, and chain referral sampling.

Of the 20 key informants, 7 were policymakers; 6 were healthcare, legal, or community service providers; 6 were shelter operators; and 1 worked in another type of role (description omitted to maintain confidentiality). Interviews were completed from April-December 2022.

Interviews focused on the needs and barriers to creating safer shelters and procedurally just service restriction processes (procedural justice focuses on the extent to which decision-making processes are perceived as fair, transparent,

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inclusive, and respectful; Evans, Rosen, & Nelson, 2014). The contents of the interview guide were similar to those used with service providers and applied flexibly given the area of expertise and knowledge of study participants.

Identification of Shelter Innovations and Promising Practices

A multifaceted approach was used to identify shelter innovations and promising practices focused on promoting safety and reducing service restriction-related harms. This included an internet search for literature and publicly available information on potentially relevant programs, consultation with over 25 subject matter experts on homelessness across Canada and the United States, and qualitative interviews with 4 shelter operators who were identified as having a potential promising practice. With regard to the latter, these interviews focused on understanding the service model or approach, including how and why it was developed, lessons learned in the implementation, and recommendations for replicating the promising practice elsewhere. A total of five shelter innovations and promising practices are profiled in this report. Representatives from the profiled programs were invited to review the written summaries for accuracy where applicable.

Qualitative Interviews with People Experiencing Homelessness

Two types of qualitative interviews were conducted with people experiencing homelessness. The first type focused on experiences of service restrictions and the other type on experiences of shelter-based violence. Study participants were not required to have had experienced violence or service restrictions from the shelters where they were currently staying, if applicable (i.e., they may have had these experiences elsewhere in the shelter system). Study participants experiencing homelessness were mostly recruited from the same six shelters as service providers. An additional 24 study participants who had experienced a past-year service restriction were interviewed in London, Ontario. Interviews were completed between October 2022 and June 2023.

Semi-structured interview guides were used for both types of qualitative interviews. For interviews focusing on service restrictions, interviews begin by examining how study participants' most recent service restriction unfolded. Questions explored the events, including experiences and perceptions, that preceded and succeeded the service restriction. Affective, cognitive, and behavioural impacts were explored sequentially (i.e., prior to the restriction, then when the restriction occurred, then immediately following the restriction and so on). The final part of the interview explored study participants' recommendations for creating safer shelter settings.

For interviews examining experiences of shelter-based violence, study participants were first asked to discuss their sense of safety when staying in emergency shelters. The interview guide then transitioned to focusing on an experience of violence in the shelter system of the study participant's choosing. The interview examined how this experience of violence unfolded. Affective, cognitive, and behavioural impacts were explored sequentially (i.e., prior to the violence, then when the violence occurred, then following the violence). The interview guide used the same prompts as the set of interviews examining service restrictions. The final part of the interview again involved a discussion of study participants' recommendations for creating safer shelter settings.

A short background survey to gather demographic and health information was completed prior to both sets of interviews.

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Secondary Analysis of Administrative Shelter Data

Administrative data from the incident report and service restriction modules of the City of Toronto's Shelter Management Information System (SMIS) were analyzed to identify trends and factors associated with shelter-based violence and service restrictions. Information available for each critical incident included: incident date and time, incident location, and type of incident. Data were available on 22 types of incidents:

1. Physical assault against staff
2. Physical assault against resident
3. Threats of death or harm
4. Self-harm
5. Property damage
6. Throwing objects
7. Verbal abuse against staff
8. Verbal abuse against resident
9. Harassment
10. Mischief
11. Theft
12. Criminal acts
13. Neglect or abandonment of a pet
14. Disruptive behaviour
15. Form 1 issued; hospital stay required
16. Fire
17. Death
18. Possible overdose
19. Neglect or abandonment of a child/children
20. Medical occurrence
21. Accident or illness
22. Other

Incidents can be registered in one or more categories in SMIS. Operational definitions do not exist for the incident categories. Complete SMIS data were available for incidents from January 1, 2011 to December 31, 2021.

Similar information were available for service restrictions: restriction start and end dates, program issuing restriction, restriction durations, and restriction reason. There were 15 reasons for restriction:

1. Assault of a client
2. Assault of residents, volunteers, or staff
3. Behaviours that compromise the health and safety of residents, volunteers, and staff
4. Disruptive behaviour
5. Not following case plan
6. Not participating in case planning
7. Possession of illegal substances/contraband within the shelter
8. Possession of firearms within the shelter
9. Property damage
10. Repeated rule violations
11. Theft
12. Trafficking in illegal drugs
13. Violent or threatening behaviour
14. Wielding weapons or dangerous objects
15. Other (see service restriction notes)

Only one reason for restriction can be registered in SMIS. Operational definitions do not exist for the restriction categories. Complete data were available for restrictions from August 1, 2014 to December 31, 2021.[4]

Additional SMIS data from service user intake forms and daily shelter system capacity were available and used for some analyses.[5] However, due to concerns about data quality and the infeasibility of comparing service users' sociodemographic characteristics to the full shelter population, data from service user intake forms were used sparingly. Similarly, SMIS data were primarily analyzed at the system and sectoral levels, with few analyses being conducted on individual programs.

[4] Aggregated SMIS data on service restrictions from 2022-2023 were made available to the research team in mid-January 2024. These data are presented separately in Appendix A and warrant further, future analysis at the individual restriction level.

[5] Mean number of daily service users was computed by summing daily service user counts for all programs with one or more operation days per year and then dividing by 365 (366 for leap years). These computations may not be identical to daily shelter and overnight service occupancy data in the City of Toronto's publicly available Shelter System Flow Data dashboard due to possible differing algorithms.

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Literature Review

A review of academic literature was conducted to examine the contributing factors to safety in shelter settings. A systematic search was performed in six electronic databases. Articles were considered if they were: research studies or program evaluations, published in peer-reviewed journals, and written in English. Over 170 articles were reviewed for eligibility in the review. A secondary search for additional resources, including grey literature, was completed on The Homeless Hub. Together, this report presents a narrative summary of the findings from over 30 publications. The full results of the systematic review are published elsewhere (Kerman et al., 2023).

Data Analysis

Quantitative data from the online survey were analyzed for several purposes. The first purpose was to determine how safe shelter staff felt at work and if some staff felt more safe than others. The relationships between job satisfaction and perceptions of workplace violence policies and practices were then explored. Finally, analyses were conducted to explore perceptions of service restrictions among shelter staff.

Quantitative data from the online survey were analyzed in SPSS using descriptive statistics (e.g., counts, means), simple bivariate correlations, independent-samples t-tests, and one-way analyses of variance (ANOVAs). For analyses involving inferential statistics, which are used to make comparisons between groups or variables to determine whether or not there are significant differences or correlations between them, the level of significance (p-value) was set at .05. This means that it was concluded that there were statistically significant differences or correlations between groups or variables when analyses yielded a p-value of ≤.05. In contrast, analyses with p-values of >.05 were assessed as being non-significant.

Quantitative data from SMIS was analyzed similarly to the online survey described above. Descriptive statistics (e.g., counts, means), one-way ANOVAs, and linear and logistic regression models were used to analyze changes in incident and restriction rates over time, as well as examine factors associated with these types of events. Some types of incidents and restrictions were grouped together in the analyses due to their similar nature.

Qualitative data from interviews with service providers, key informants, and people experiencing homelessness were transcribed verbatim. Different types of analyses, including matrix analysis and thematic analysis, were conducted with the qualitative data in order to most effectively address the different research questions for which these data were being used. The objective of all analyses was to identify common perceptions, experiences, and themes among study participants, as well as divergent ones. Some comparisons between groups of study participants were also completed (e.g., differences between youth and adults using the shelter system).

The presentation of the qualitative findings in this report rarely provides a number or percentage of study participants who held a discussed perspective (the only exception to this is some of the findings on service restriction consequences). This is because not every study participant was asked the exact same questions during their interviews. As a result, providing an exact number would produce unreliable estimates of the findings in some instances. Instead, nonspecific descriptors are often provided (e.g., “almost all,” “most,” “generally,” “some,” “few”). Divergent views held by study participants are also mentioned, where relevant.

Literature Review

This section presents findings from the review of academic literature on the contributing factors to safety in shelter settings. The findings are summarized in the table below and then subsequently described in more detail.

General Aspects of Shelter Safety

Several qualitative studies of service users' experiences in shelters identified violent and non-violent victimization, including theft, as being a key safety concern (Czechowski et al., 2022; Daiski, 2007; Neale & Stevenson, 2013; Sylvestre et al., 2018b). Shelter hotels were perceived to be safer than traditional shelters due to their provision of private spaces where service users felt less "on guard" (Nerad et al., 2021; Padgett et al., 2022; Robinson et al., 2022). Theft was also viewed to be less of a concern in shelter hotels, as service users could lock and store belongings securely in their rooms. A recent program evaluation of a shelter hotel in Toronto found similar findings, with service users reporting that the availability of private spaces contributed to fewer interpersonal conflicts, altercations, and thefts (Alabi et al., 2023).

Shelter structure and environment was another aspect that shaped safety experiences and perceptions. Congregate shelters with shared rooms can be experienced by service users as "constant stimulation and noise" that make it challenging for service users to relax and exacerbate stress (Lincoln et al., 2009; Nettleton et al., 2012; Pope et al., 2020; Salsi et al., 2017; Sylvestre et al., 2018b). Noise and the lack of private space are particular safety concerns for women and service users with Autism Spectrum Disorder (Garratt & Flaherty, 2023; Salsi et al., 2017). Overcrowding is a related issue in these settings that can also undermine privacy and increase the risk of spreading illness (Daiski, 2007). The exteriors of congregate shelters also affect safety perceptions. Loitering by shelter entrances can contribute to a perception that shelters are unsafe and be a barrier to people accessing shelter (Shier et al., 2007). Outdoor line-ups to access shelters have also been found to potentially damage relationships between service users and shelter staff, and contribute to negative perceptions related to homelessness within surrounding communities. The authors of this study recommend that shelter entrances be discrete, so that service users can retain privacy and dignity, while concurrently facilitating a greater perception of safety among community members. They also suggest that "large monolithic structures" be avoided and, instead, smaller shelters be developed, so that shelters can be more easily integrated into communities

Negative Impact on Safety	Positive Impact on Safety
	• Private rooms • Secure storage of belongings • Supportive shelter staff • Access to onsite drug use spaces [b] • Family-only shelters [c] • Safe play areas for children [c] • Environmental changes to facilitate sense of home and dignity [d]

[a] Factor specific/highly relevant to 2SLGBTQ+ individuals
[b] Factor specific/highly relevant to people who use drugs
[c] Factor specific/highly relevant to families experiencing homelessness
[d] Factor specific to an intervention tested with women and families experiencing homelessness (see Ajeen et al., 2023)

and more focused on specific groups within homeless populations (Shier et al., 2007).

Substance use and intoxication were also identified as a safety issue for people in sobriety (Czechowski et al., 2022; Shier et al., 2007; Sylvestre et al., 2018b). Spatial separation between service users who are intoxicated and those who are not may be beneficial given each group's vulnerabilities (Shier et al., 2007). Specific shelter safety considerations for people who use substances are described in the next subsection.

Two studies highlighted the role of health safety concerns in perceptions of shelter. Ha et al. (2015) found that bed bugs in shelters can lead young adult service users to see unsheltered homelessness as a safer option than shelters. Concerns about infection risk were also identified as a deterrence for homeless people who are pregnant. Similarly, the presence of cockroaches and mould, poor ventilation, spread of illness given close quarters, and unsafe heating systems were each identified as safety concerns within family shelter settings (Sylvestre et al., 2018a).

The role of shelter staff was discussed in one mixed-methods study of shelter needs among women experiencing homelessness in Montreal (Salsi et al., 2017). Findings showed that shelter staff could be a potential source of safety and stability during the instability of homelessness, but high workloads and staff turnover prevented the development of more supportive relationships.

A case study of Savard's, part of Strachan House, in Toronto, described program design considerations for women experiencing chronic homelessness, with an emphasis on safety (Bridgman, 2001). The program served chronically homeless women who had been "unable to live within the boundaries, rules, and regulations by which conventional shelters or other housing models operate" (Bridgman, 2001, p. 85). Key considerations identified in the article that were proposed or implemented included:

- Minimal rules, including no curfews or medication requirements
- No service restrictions, although women "may be asked to 'go for a walk' for periods of hours or days should this be necessary" (p. 81)
- No expectations related to behavioural change
- Lockers where material possessions could be safely stored even if women were not staying at Savard's on a nightly basis
- A pacing and screaming room (proposed and hypothesized to be beneficial, but not developed due to space restrictions and budgetary constraints).

In addition, the author described how the program design work focused on making the *inside* of the shelter safer; it also highlighted, however, that women who used the program could still experience concerns about their safety *outside* the shelter. The case study did not describe other program outcomes in detail.

Safety for People Who Use Drugs

Several studies examined shelter safety considerations among people who use drugs. These studies highlighted the importance of shelters with low-barrier, harm reduction-based approaches and supports for this subpopulation. The presence of shelter-based drug use rooms and regular checking of washrooms by staff were linked to a greater sense of safety related to reduced overdose risk (Bardwell et al., 2018).[6] The importance of comprehensive harm reduction policies was also emphasized (Briggs

[6] Staff checks of washrooms was perceived positively in harm reduction-based shelters where substance use was permitted. This is less likely to be the case, perhaps even a practice that facilitates drug-related harm, in shelters where there are penalties for substance use (e.g., service restriction).

et al., 2009). Wallace et al. (2018) described issues caused by "partial implementation of harm reduction" in which shelters may provide drug use supplies as part of a harm reduction approach, but discourage or prohibit substance use onsite. This creates inconsistencies for service users who use drugs, and may undermine safety in accessing the supplies and harm reduction supports offered in shelters. It also creates challenges for shelter staff who have to navigate situations of how to handle onsite substance use if this is against shelter policies ("recognizing that banning people for use could contribute increased harms associated with using in public spaces"; Wallace et al., 2018, p. 86).

Other notable safety-related issues included the unmitigable risk of thefts of money or drugs in low-barrier shelters (Bardwell et al., 2018; Briggs et al., 2009) and exposure to drug use and equipment of other service users (Neale & Stevenson, 2013). Lack of privacy in shelter spaces can also make it challenging to avoid drugs when desired, as well as hastens drug use to avoid detection, resulting in less hygienic and safe drug use practices (Neale & Stevenson, 2013). Taken together, these factors underscore the importance of having private spaces where service users can safely use drugs (with safeguards to prevent overdose) and discretely dispose of used equipment, as well as securely store belongings.

Safety for 2SLGBTQ+ Individuals

Five studies examined safety considerations in shelters for 2SLGBTQ+ service users. Overall, these studies identified shelters as being potentially unsafe environments for 2SLGBTQ+ people experiencing homelessness, especially for transgender and gender-diverse individuals. Primary factors that contributed to lack of safety included risk of victimization and mistreatment due to homophobia and transphobia (Abramovich, 2016; Bardwell, 2019), and gendered shelter programs where 2SLGBTQ+ service users have to adhere to a gender category that may not fit their identity or outs them (Bardwell, 2019; Coolhart & Brown, 2017). Shelter staff were also a source of harm when assumptions about gender and sexuality were made (e.g., using incorrect pronouns or preferred names), or in their handling of conflict (Bardwell, 2019; Coolhart & Brown, 2017; England, 2022). On the latter, a Welsh study by England (2022) found that staff tended to relocate transgender individuals to other shelter areas following interpersonal victimization and violence. This conveyed a perception that transphobic behaviour would be tolerated and the needs of non-transgender people are more important than transgender service users (England, 2022).

Safety concerns could affect if and how 2SLGBTQ+ people experiencing homelessness accessed shelters. Avoidance of shelters was one response to safety concerns, including fears that staff would not be sufficiently trained and competent to intervene in incidents involving homophobia and transphobia (Abramovich, 2016). In a large U.S. cross-sectional study, transgender and gender-diverse people experiencing homelessness who were less visually conforming were less likely to access shelter than visual conforming/passing individuals (Begun & Kattari, 2016). Other 2SLGBTQ+ service users hid their sexual and gender identities to avoid victimization in shelter settings (Bardwell, 2019).

Several key recommendations were identified for making shelters safer for 2SLGBTQ+ service users. These included: ensuring 2SLGBTQ+ individuals were represented among shelter staff; providing training on the causes of homophobia and transphobia, unique challenges faced by transgender service users in shelter settings, and staff interventions to address homophobia and transphobia; and developing 2SLGBTQ+ specific shelters (Abramovich, 2016; Coolhart & Brown, 2017). Providing separate

rooms or allowing 2SLGBTQ+ youth to access shelter rooms based on their identified gender was also discussed in one study (Coolhart & Brown, 2017). Although this was perceived as potentially beneficial, it could also lead to ostracization and isolation.

The experiences of 2SLGBTQ+ shelter staff have been minimally studied. However, a recent report by the Toronto Shelter Network (2020) asserted that gender diverse shelter staff are at heightened risk of gender-based violence in the workplace. Further, 2SLGBTQ+ shelter staff expressed concerns about management not adequately addressing workplace incidents of transphobia, which made their work more challenging and emotionally exhausting (Toronto Shelter Network, 2020).

Safety for Families and Women

Research has identified some key safety-related considerations for sheltering families experiencing homelessness, many of which focused on parents' concerns about their children's safety in shelters. Almost all families experiencing homelessness in a U.S. qualitative study reported some safety concerns with family shelters (Thompson et al., 2020). These included the lack of privacy and a "revolving door of strangers" in congregate shelters, which yielded parental concerns about how other residents and guests behaved in front of children. As a result of these concerns, families preferred shelters that were specific only for families, and where they had their own rooms and cooking facilities.

Two studies highlighted the importance of family shelters having safe play areas for children (Sylvestre et al., 2018a; Thompson et al., 2020). In a qualitative study of families experiencing homelessness in Ottawa, motel rooms, although small, facilitated a private family area and were perceived as safe places where children could play (Sylvestre et al., 2018a).

A recent pre-post study involved a trauma-informed design intervention that was implemented at two shelters for homeless women and families in North Carolina (Ajeen et al., 2023). Both shelters provided private rooms, with one shelter having 61 rooms and the other serving 21 families. The intervention involved changes to shelter style and room layout. This included painting the walls in blue-grey, yellow, and green, given that these colours can be experienced as calming, nurturing, and uplifting. Small pieces of furniture were added to facilitate a home-like environment, including: side tables; bathroom storage units; extra seating; and bedding, including sheets, comforters, bed and decorative pillows, and small blankets. Accessories were added to shelter rooms (e.g., rugs, new towels, mirrors, lamps, curtains, wall art, toys for infant children, small decorative items). Basic repairs and cleaning were also completed. The intervention yielded significant increases in sense of safety and hopefulness among study participants. Further, the intervention was experienced as dignifying by many study participants.

Evidence Gaps

There was a notable dearth of research in the literature on shelter safety for certain homeless subpopulations and other stakeholder groups. No study examined safety considerations in shelter settings for racialized groups, including Black and Indigenous service users, as well as newcomers and refugees. The experiences and perspectives of shelter staff were notably absent as well. There is a particular need to better understand experiences of racist violence among shelter staff, as such occurrences are perceived to be prevalent within shelter systems (Levesque et al., 2021). It is also important to acknowledge that few studies compared safety factors between shelters, which prevents the formation of conclusions about what works and for whom.

Safety in Shelters

Safety at Work for Shelter Staff

Concerns about safety at work were common among shelter staff. A total of 36.2% of the 157 survey respondents indicated that they felt very unsafe or somewhat unsafe in the workplace. For 56.1% of respondents, the COVID-19 pandemic had contributed to perceptions of a less safe work environment.

Analyses were conducted to determine the personal and occupational characteristics associated with sense of safety in the workplace. Sense of safety was significantly lower among direct service workers compared to management staff ($F = 3.79$; $p = .01$). Sense of safety among shift supervisors did not significantly differ from either of the other two work role groups (i.e., direct service workers and management).

Women reported feeling significantly less safe at work than men ($t = -2.03$, $p = .04$; see table below). Non-heterosexual study participants rated their sense of safety at work as lower than heterosexual study participants; however, this did not reach the level of statistical significance. It is important to note that lower statistical power due to the small number non-heterosexual study participants in the sample may have prevented the detection of a larger effect. Sense of safety was not significantly associated with age or length of time in the homeless service sector. In addition, sense of safety did not significantly differ between staff working primarily in shelters and those in shelter hotels.

Overall, the findings indicate that safety concerns are prevalent among shelter staff and greatest among direct service providers and women. Non-heterosexual shelter staff may also feel more unsafe at work than heterosexual staff, but a firmer conclusion cannot be made due to analyses being likely statistically underpowered.

Workplace Exposure to Critical Events and Stressors

Shelter staff reported frequently encountering various critical events and stressors in the workplace in the past year (see table on the next page). Of note, the majority of survey respondents reported direct exposure to constant screaming, verbal abuse/threats to physical safety, verbal abuse/threats involving racism, and overdose on a weekly or more frequent basis.

Verbal abuse/threats involving racism was experienced significantly more frequently by Black and Indigenous staff ($U = 2858.50$, $p = .03$). Among Black and Indigenous staff, 43.2% reported experiencing verbal abuse/threats involving racism on a daily basis.

No significant differences were found in exposure to the other types of verbal abuse/threats involving oppressive language based on corresponding service user characteristics (i.e., gender and misogyny, sexual orientation and homophobia/transphobia, migration status and xenophobia). Of note, there

Safety of Shelter Staff by Gender and Sexual Orientation

Demographic Characteristic		Very Unsafe	Somewhat Unsafe	Neither Safe Nor Unsafe	Somewhat Safe	Very Safe
Gender	Women	16.5%	24.2%	14.3%	36.3%	8.8%
	Men	5.8%	21.2%	15.4%	42.3%	15.4%
	Non-binary/transgender [a]	-	-	-	-	-
Sexual Orientation	Heterosexual	10.7%	24.0%	13.2%	42.1%	9.9%
	Non-heterosexual	28.6%	28.6%	14.3%	14.3%	14.3%

[a] Omitted to maintain study participants' confidentiality due to a small sample size

Safety in Shelters

Self-reported Frequency of Workplace Exposure to Critical Incidents and Stressors among Shelter Staff

Critical Incident/Stressor	Never	Less than Monthly	Monthly but Not Weekly	Weekly but Not Daily	Daily
Constant screaming	6.0%	7.9%	15.2%	29.8%	41.1%
Verbal abuse/threats to physical safety	4.5%	11.0%	16.2%	26.6%	41.6%
Verbal abuse/threats involving racism	6.6%	4.6%	23.0%	30.9%	34.9%
Overdose	5.8%	12.3%	20.8%	39.0%	22.1%
Verbal abuse/threats involving sexism/misogyny	14.5%	13.8%	24.3%	19.7%	27.6%
Verbal abuse/threats involving xenophobia	16.1%	16.8%	23.2%	21.3%	22.6%
Verbal abuse/threats involving homophobia/transphobia	15.5%	18.7%	22.6%	23.2%	20.0%
Biohazards	14.7%	20.0%	28.0%	16.7%	20.7%
Physical resistance of care/support	22.9%	10.5%	26.8%	25.5%	14.4%
Self-injury	17.5%	24.7%	32.5%	18.2%	7.1%
Physical assault without injury	21.9%	27.2%	29.8%	15.9%	5.3%
Physical assault causing injury/death	45.7%	29.1%	15.9%	6.6%	2.6%
Sexual assault	44.1%	40.1%	9.9%	3.3%	2.6%
Suicide (or near-fatal attempt)	35.3%	47.7%	13.7%	1.3%	2.0%

were few non-binary study participants in the sample, which prevented further analysis of this group's experiences of workplace-based verbal abuse/threats.

Job Satisfaction and Workplace Violence Policy and Practice Perceptions

The Job Satisfaction Survey (JSS) assesses various facets of job satisfaction, including salary and benefits, promotion opportunities, supervision, work conditions, colleagues, nature of the work, and organizational communication. The overall mean score on the JSS among survey respondents was 132.32 (standard deviation = 26.35). Statistical norms are available for the JSS, which can be used for interpretative purposes to compare the score from one group (i.e., this study sample) to a larger population. Compared to available norms for approximately 6,500 social service workers in the U.S., our study sample reported significantly lower job satisfaction ($t = -4.85$; $p < .001$). In contrast, our study sample was not significantly different from non-industry specific Canadian norms.[7] Of note, mean satisfaction with coworkers and supervision were lower among our study sample than in both the aforementioned norms.

Within our sample, job satisfaction did not significantly differ by gender, sexual orientation, or length of work history in the homeless service sector. Job satisfaction was also similar between staff working primarily in shelters and those in shelter hotels. However, survey respondents in managerial positions reported significantly higher job satisfaction than direct service workers ($p = .04$). This finding is consistent with survey research on the labour workforce that has demonstrated those in senior leadership positions report more positive perceptions of work and organizational cultures than frontline employees (American Psychological Association, 2015). No significant differences in job satisfaction were found between shift supervisors and direct service workers. Survey respondents who reported better mental health

[7] There are no available data for Canadian social service workers or another comparable workforce.

Safety in Shelters

also had higher job satisfaction ($r = .48$, $p < .001$).

Analyses were conducted to examine the correlations between job satisfaction and perceptions of employers' commitment to violence prevention in the workplace. Each of the three subscales of the Violence Prevention Climate Survey were positively correlated with job satisfaction (Practices: $r = .66$, $p < .001$; Policies: $r = .68$, $p < .001$; Pressure: $r = .49$, $p < .001$). These findings indicate that shelter staff who perceived that their organizations had effective and consistently implemented violence prevention policies and practices had higher levels of job satisfaction. These analyses were repeated with only respondents in direct service roles, which produced the same findings. Thus, effective and consistent violence prevention policies and practices are key to promoting job satisfaction among shelter staff.

Perspectives on Safety among Service Users

Most study participants described feeling fairly safe in the shelter where they were currently staying. However, many of these study participants described experiences at previous shelters where they felt unsafe. This was particularly common among women, some of whom described past experiences of shelter-based violence. Despite their sense of safety, study participants also emphasized that they still needed to be vigilant due to unpredictability in shelters.

> *"It's not that I don't feel unsafe, it's just you have to wary … you never know when someone's going to go off."*
>
> - adult man experiencing homelessness

Service users identified a range of factors that contributed to their sense of safety in shelters (see table below). Many of the positive and negative contributing factors align with those identified previously in the literature review. However, there were also several factors that had variable impacts on safety due to study participants' having differing perspectives or mixed experiences with the factors (i.e., variable effects on safety based on how the factor is implemented or used). In addition, it is important to note that there are some individual differences in shelter preferences that may contribute to safety being experienced differently by service users, as highlighted in the quote at the beginning of the next page.

Negative Impact on Safety	Variable Impact on Safety	Positive Impact on Safety
• Violent and non-violent victimization, including theft*,**	• Security guards	• Fewer service users*,**
• Visible presence of drugs (including second-hand smoke), onsite substance use and intoxication, and exposure to overdose**	• Secured access to the shelter building and floors	• Friendly and supportive staff*,**
• Dormitory sleeping arrangements and other large, open spaces**	• Security cameras	• Staff presence*
• Shelters located in neighbourhoods perceived to be less safe	• Access to lockers to store belongings***	• Shelter cleanliness and sanitariness**
• Presence of weapons		• Private and semi-private rooms**
• No daytime access to the shelter		• Access to onsite counselling services
• Poor quality food		• Onsite, private drug use spaces**

* Prominent contributor to safety among study participants
** Factor is congruent with literature review findings
*** Factor is partially incongruent with literature review findings

Safety in Shelters

> *They say this is the worst shelter out of them all when you say where you are staying and you say [name of shelter]. And, I find it to be the best.*
>
> - older adult man experiencing homelessness

With regard to factors that contributed positively to sense of safety, ones that were discussed most frequently or described as most important were shelters having fewer service users, and friendly and supportive staff. These findings underscore the importance of attending to the social environment of shelters wherein interpersonal interactions can either positively or negatively affect safety. Safe Haven shelters in the United States have many of the features that service users perceived as positive factors in safety (e.g., few service users, private and semi-private rooms, provision of mental health services). For more information on the Safe Haven shelter model, see the Promising Practice summary on the next page.

> *The support from my like case worker. She's really supportive and she's good at like talking to me if I do feel off on a day or whatever.*
>
> - female youth experiencing homelessness

> *There's not enough staff to watch everywhere at all times and everything like that, but the staff makes me feel pretty comfortable, usually.*
>
> - adult man experiencing homelessness

> *This one [shelter] used to have a real bad reputation but then when COVID came along, it cut the population down … it was mainly so many people crammed into a certain area … a fight going on just about every day, which you don't see much anymore.*
>
> - older adult man experiencing homelessness

In contrast, personal experiences, fears, and observations of violence and non-violent victimization in shelters were the most prominent factor in service users feeling unsafe. Relatedly, dormitory sleeping arrangements and other large, open spaces in shelters were locations where service users were concerned about the potential for violence.

> *A bunch of beds in the same room … you'll get things stolen. You watch people overdose.*
>
> - female youth experiencing homelessness

> *A man tried to steal my shoes while I was sleeping and he pulled a knife … it just showed that violence can erupt anywhere.*
>
> - adult man experiencing homelessness

Substance use in the shelter was most often described by study participants as a negative contributor to safety. However, this was largely the result of the visibility of substance use and unease around other service users who were intoxicated. Thus, it is important to also recognize that onsite drug use spaces, which can be discretely accessed by service users was identified positively by some study participants. Thus, the relationship between substance use and safety is a thorny one that requires a careful balance be struck between minimizing overdose risk and facilitating safety for people who do not use substances.

> *I know there's weapons here. There's drugs here, alcohol, at any time. There's never a safe feeling in shelters.*
>
> - adult man experiencing homelessness

The factors that were identified as having variable impacts focused on building security and surveillance. Service users held mixed views

Safety in Shelters

Promising Practice

Safe Haven Shelters

The Safe Haven shelter model was developed in the United States in 1992 as a low-barrier alternative to the traditional shelter system for people experiencing chronic unsheltered homelessness who have more complex needs (U.S. Department of Housing and Urban Development, 1999). Most Safe Havens serve people who have a serious mental illness, with or without comorbid substance use problems, and who are inadequately supported by health and social services due to their unsheltered homelessness. Individuals are typically referred to Safe Havens by street outreach teams.

Safe Havens are small, with space for up to 25 service users. Rooms are either private or semi-private, and service users are provided a key to their room. The shelters use an inclusive and trauma-informed approach, and offer a range of health and housing supports, including case management, primary care, psychiatric services, housing placement, and harm reduction supports. Service users are permitted to stay at the shelter during the day and access available services, if they choose.

As of 2005, it was estimated that there were 118 Safe Haven programs in the U.S. (Ward Family Foundation, 2005). There are no known Safe Haven shelters in Canada, though it is highly likely that there is model overlap with some existing programs.

What Is the Evidence on Safe Haven Shelters?

Safe Havens have not been widely studied or evaluated over the past three decades, but key findings from several studies are presented below.

In a 2009 program evaluation of a Safe Haven shelter in Boston, qualitative findings showed that service users described the program as feeling less institutional than traditional shelters, as they were able to access the program and their rooms without any mandated check-in processes (Lincoln et al., 2009). Service users also described the benefits of having their own rooms because it gave them privacy and a sense of safety that other shelters do not provide. Multiple residents reportedly became stably housed for the first time in decades after staying in the Safe Haven shelter, though additional information was not provided on this. Similar findings on the perceived benefits of Safe Havens have been described in other qualitative research as well (e.g., Wusinich et al., 2019).

A pan-American study of 79 Safe Haven shelters conducted in 2005 found that slightly over half of service users exited to permanent housing, whereas 14.4% returned to homelessness (other transition destinations: health institutions, criminal justice system, and unknown; Ward Family Foundation, 2005). Approximately one-third of staff respondents indicated that the low-barrier approach was the most important aspect for helping service users to permanently exit homelessness.

This summary on Safe Haven shelters partially relied on older resources, and policies and practices may have since changed. Program descriptions of two Safe Havens shelters in New York have been recently published elsewhere (Falvo, 2023).

about security guards and cameras. Some felt that these security features were necessary for the detection and verification of thefts and other incidents. Others felt that security guards and cameras were invasive or ineffective in preventing incidents. Some service users were simply indifferent to whether or not there were security guards and cameras in the building.

> *Like downstairs, there'd be a camera pointing in all directions, like it's kind weird. It feels a little invasive.*
>
> - male youth experiencing homelessness

> *You need fucking cameras everywhere … of course, it would [make things safer].*
>
> - adult man experiencing homelessness

> *Security [makes me feel safe] … they're on top of people. They don't let anybody get away with much as far as violence goes, they're pretty quick to react.*
>
> - adult man experiencing homelessness

> *They say security [makes shelters safer] but I don't see security doing anything about it. And, in terms of intervening, they intervene the wrong way.*
>
> - adult woman experiencing homelessness

Safety in Shelters

Some level of secured access to the shelter building and its floors was generally perceived positively; however, too many restricted spaces could leave service users to perceive the shelter as jail-like. It is likely that perceptions of secured access are further shaped by the extent to which service users have control over accessing personal spaces. For example, if service users are unable to access their room or belongings without staff permission or assistance, this could lead some study participants to view this level of security more negatively. In contrast, when service users had key cards for their own rooms and were able to come and go as they liked, this level of security was experienced more positively.

> *"There was a key card, so the only people that came in, they had housekeeping and the staff would come in and drop meals off, and that was it. Like nobody else could get in my room … [it protected from] theft, vandalism, random crazy assault, any potential harm, you know?"*
>
> - male youth experiencing homelessness

Access to lockers for storing belongings was a related factor that was also viewed positively by many study participants. However, some described the lockers in shelters where they stayed as insecure, resulting in their possessions being stolen. Thus, access to lockers are a positive contributor when shelters are able to minimize break-in risks.

> *"As good as the lockers are here inside the room, which is perfect, the lockers aren't strong enough because if a person wants in the locker, they're in the privacy of a room with resources available to get in there … I don't feel safe putting stuff in my locker."*
>
> - adult man experiencing homelessness

Safety in Shelters
Key Findings Summary

- 36.2% of shelter staff reported feeling very or somewhat unsafe in the workplace. Women reported feeling significantly less safe at work than men, as did direct service staff compared to managers.
- Shelter staff were exposed to a range of critical incidents and stressors in the workplace, with Black and Indigenous staff reporting significantly more frequent experiences of racist verbal abuse.
- A range of factors contributed to sense of safety among service users, many of which were consistent with findings from the literature review.
- Service users had mixed perspectives on building security and surveillance in their experiences of safety in shelters.

Shelter-based Violence

Rates and Types of Critical Incidents in the Shelter System

This section uses SMIS data to describe trends in critical incident rates in the shelter system over time, including differences by service sector and incident type.

All findings in this section were derived from data registered by shelter staff in SMIS. Because of this, changes in SMIS reporting requirements between January 1, 2011 to December 31, 2021 (the period for which data were analyzed) and other directives issued by the Toronto Shelter & Support Services (TSSS) Division during this time may have affected the number of reported incidents. For example, the Toronto Action Plan to Confront Anti-Black Racism was formally adopted at the end of 2017, which featured recommended actions for improving shelter conditions for Black families, adults, and youth (City of Toronto, 2017). This policy may have yielded increased reporting of critical incidents involving anti-Black racism in SMIS in the years that followed. Further, TSSS led a campaign to enhance awareness of its workplace violence program in 2018, which could have affected subsequent SMIS reporting, particularly in shelters directly operated by the City of Toronto. Similarly, other shelter agencies that use SMIS may have introduced other policies and initiatives over this decade, which could have affected their critical incident rates and reporting. Thus, it is important to recognize that the trends in critical incident rates presented here may be partially attributable to policy and practice changes throughout the shelter system that affected reporting frequency between 2011-2021.

Total Critical Incidents in the Shelter System

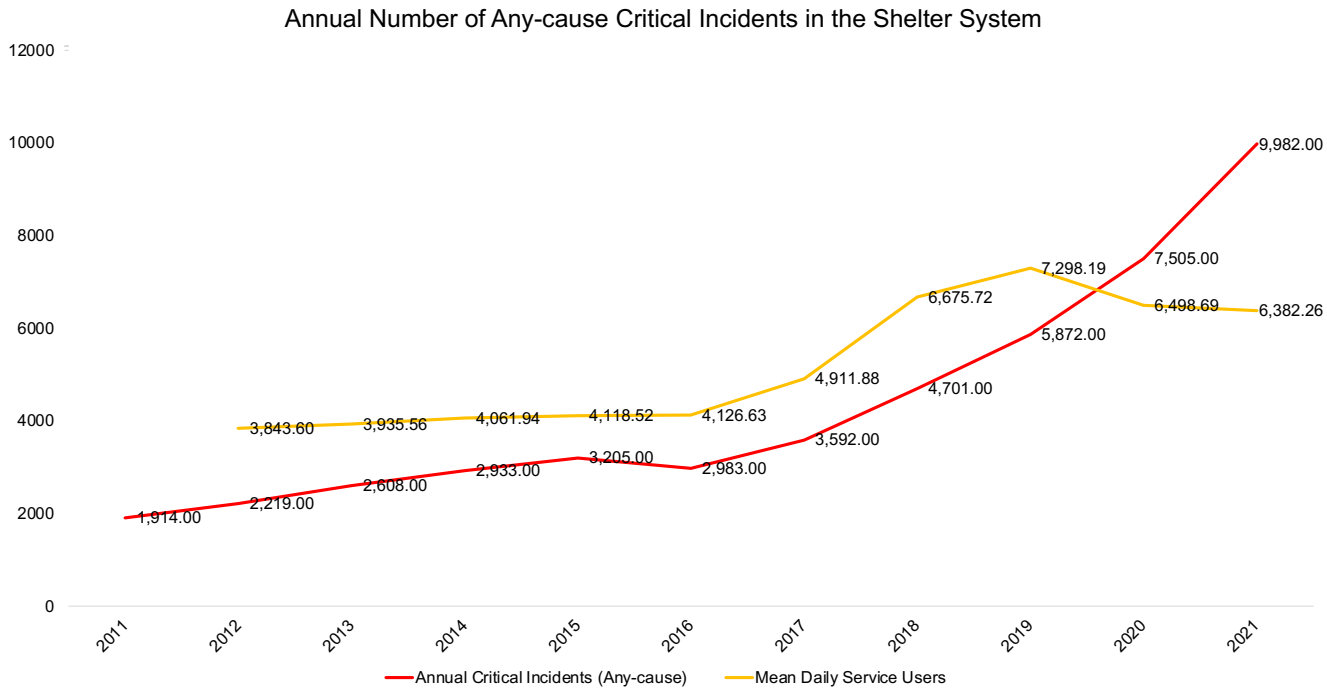
From 2011 to 2019, the annual number of any-cause critical incidents in the shelter system increased gradually at a rate that was similar to the rising number of daily service users in the shelter system (see top figure on the next page).[8] In 2020, the number of incidents increased 27.8% from the previous year, whereas the number of service users decreased 10.7%. In 2021, the number of critical incidents increased a further 33.0% over the previous year, whereas the number of service users remained fairly stable during this period.

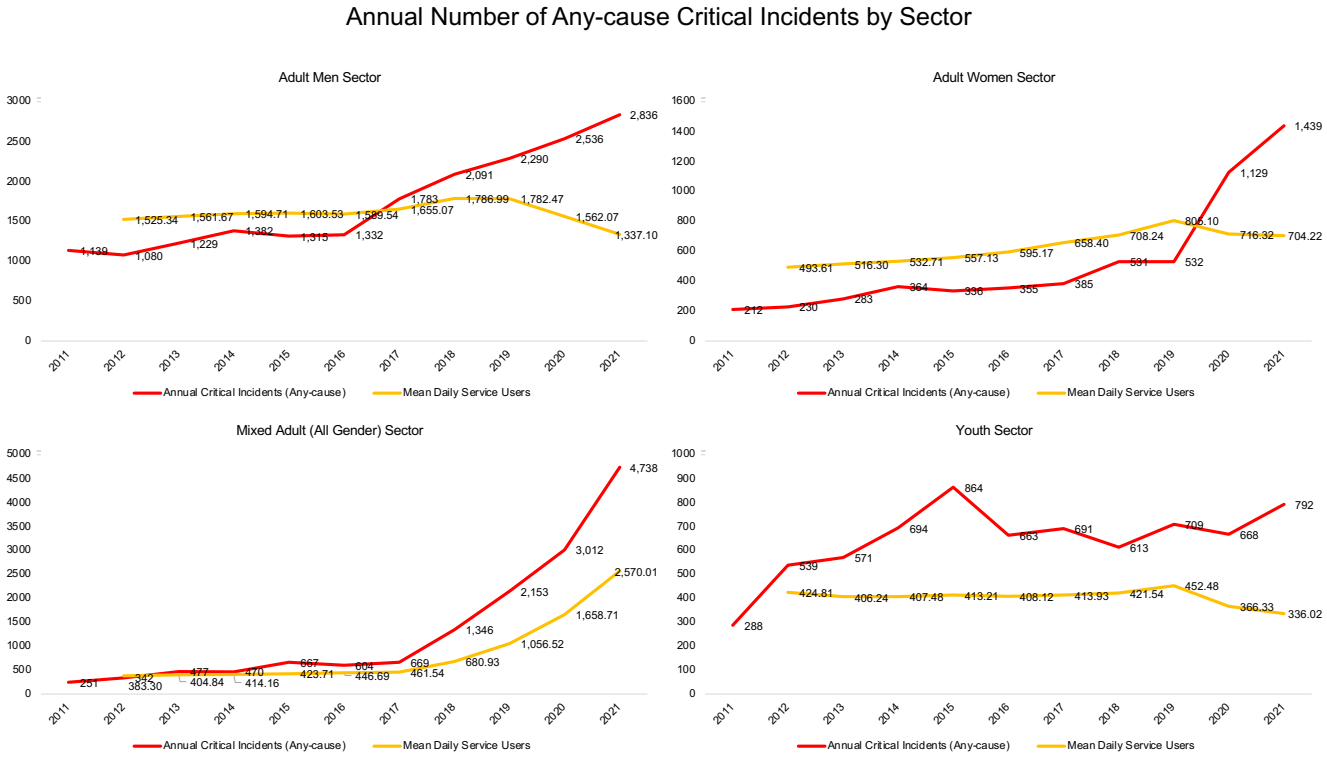
A linear regression model was conducted to examine whether the increased rate of any-cause critical incidents over time was statistically significant. The analysis controlled for the number of daily service users in the shelter system, season of the year, extreme weather alerts, and pandemic onset, which means that changes in the critical incident rate are not attributable to the number of daily service users in shelter system, season of the year, presence or absence of an extreme weather alert, or the pandemic. Findings showed a significant increase in the any-cause critical incident rate from 2011 to 2021 ($B = .25$; $p < .001$).[9]

There were considerable sectoral differences in critical incident rate patterns from 2011 to 2021. In the Adult Men sector, critical incidents increased 33.9% from 2016 to 2017, and continued to increase annually up until 2021.

[8] The number of daily service users in the shelter system is often used in data analysis and interpretation for the purpose of considering the extent to which changes in critical incident rates could be attributable primarily to changes in number of daily service users (i.e., the extent to which increases or decreases in incident rates could be largely explained by more or less people served in the shelter system, respectively).
[9] *B* is a standardized regression coefficient, which can be used to measure effect size. The larger the *B* statistic, the larger the magnitude of the effect of time on the critical incident rate. Effect sizes of .19 or smaller are considered small, .20-.49 are medium, and .50 or higher are large (Fey, Hu, & Delios, 2023).

Shelter-based Violence





Note: The Y-axes of the four graphs have differing scales.

Shelter-based Violence

This is a markedly different pattern from the number of daily service users in this sector, which changed fairly minimally between 2012-2019, before decreasing in 2020 and 2021.

A similar pattern was observed for critical incidents in the Mixed Adult (All Gender) sector, with substantial increases from 2017 onward. However, the number of service users in the Mixed Adult (All Gender) sector also increased each year from 2017 to 2021, albeit not at the same rate as critical incidents.

Critical incidents in the Adult Women sector showed gradual increases from 2011 to 2019, which largely paralleled the change in the number of daily service users in the sector over this period. In 2020, there was a 112.2% increase in the number of critical incidents in the Adult Women sector from the previous year, despite a reduction in the number of daily service users. Critical incidents increased further in the Adult Women sector in 2021, despite minimal change in the number of daily service users.

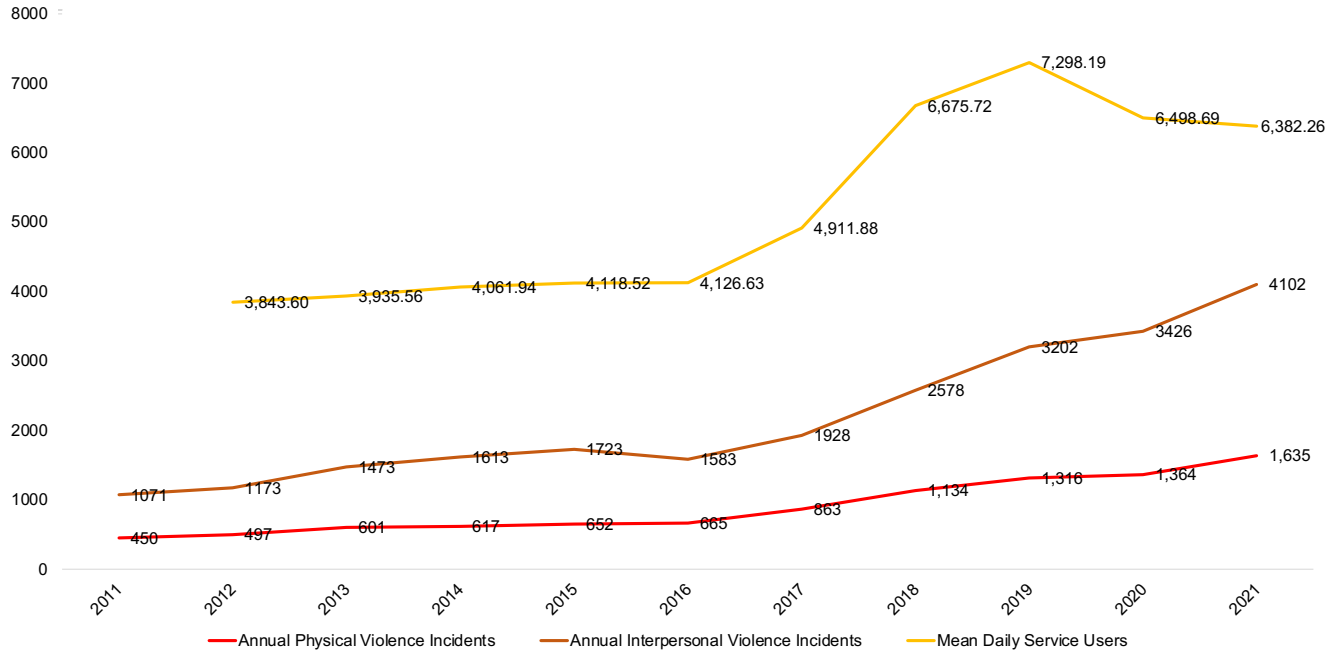
As for the Youth sector, critical incidents peaked in 2015, before gradually decreasing for three years. Incidents fluctuated from 2019-2021, though an overall upward trend was observed. The number of daily service users in the Youth sector remained stable from 2012 to 2019, before decreasing in 2020 and 2021.

Physical and Interpersonal Violence Incidents in the Shelter System

Two aggregate forms of shelter-based violence were computed by merging several SMIS critical incident categories: [1] physical violence (physical assault of shelter staff or service user) and [2] interpersonal violence (physical assault of shelter staff or service user, verbal abuse of shelter staff or service user, threats of death or harm, or harassment). Thus, interpersonal violence encompasses physical violence and other forms of verbal violence and aggression.

Both types of shelter-based violence increased across the shelter system as a whole from 2011 to 2021. There was a fairly gradual increase in

Annual Number of Incidents of Physical and Interpersonal Violence in the Shelter System



Shelter-based Violence

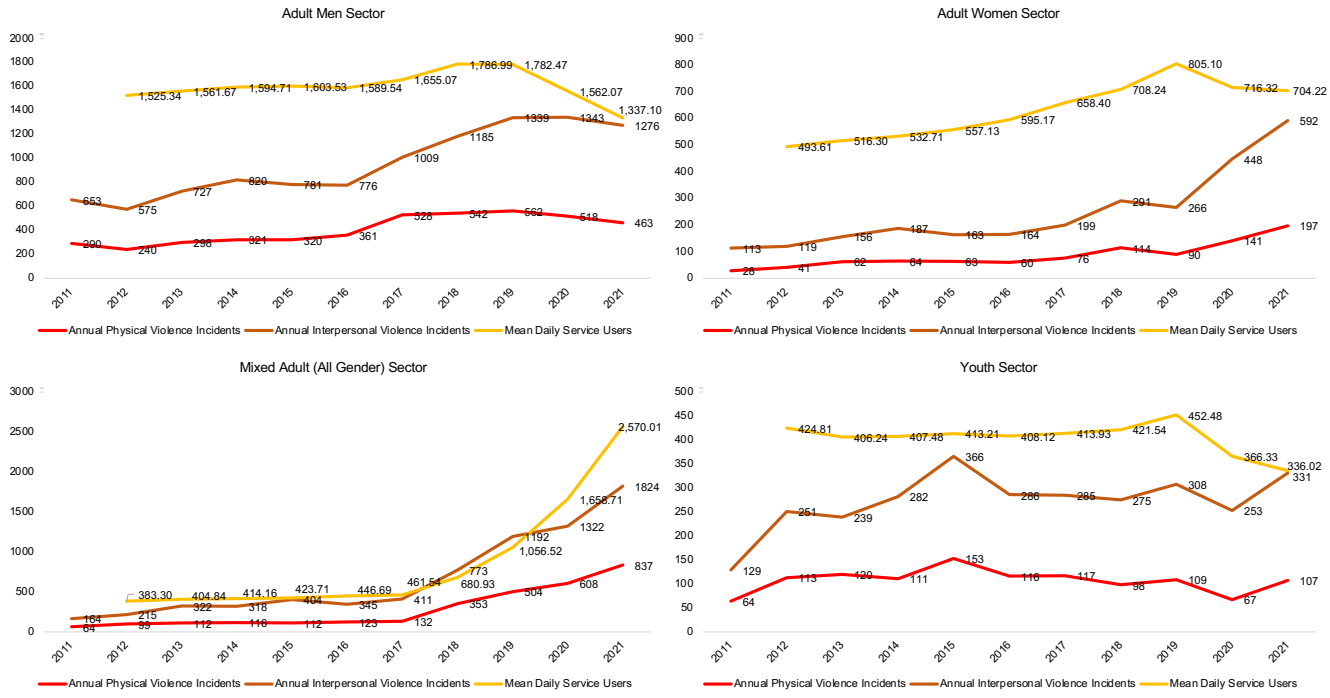
physical violence during this period, whereas there were larger annual increases in interpersonal violence from 2016 onward. Of note, neither the rate increases in physical or interpersonal violence were as steep as the any-cause critical incident rate, which suggests there has been more exponential increases in other types of critical incidents in the shelter system in recent years.[10]

An analysis of physical assault in its disaggregated forms showed that the number of assaults of shelter staff and service users both showed significant increases over time. Assault of shelter staff rose 423.5% from 132 in 2011 to 691 in 2021 ($B = .19$, $p < .001$), whereas assaults of service users significantly increased 208.3% from 336 to 1035 during the same period ($B = .10$, $p = .01$).

Like the any-cause critical incident trends, different patterns were observed in physical and interpersonal violence over time between sectors. In the Adult Men sector, physical and interpersonal violence increased gradually from 2012 to 2017 and 2012 to 2019, respectively. Both types of shelter-based violence decreased slightly from 2019 to 2021.

In the Mixed Adult (All Gender) sector, increases in physical and interpersonal violence from 2012 to 2019 paralleled the rise in daily service users in the sector. Although both types of shelter-

Annual Number of Incidents of Physical Violence and Interpersonal Violence by Sector



Note: The Y-axes of the four graphs have differing scales.

[10] It was not feasible to analyze whether the increases in the two aggregate forms of shelter-based violence over time were statistically significant given how the datasets were structured. However, each of the disaggregated forms of shelter-based violence significantly increased from 2011 to 2021 (assault of shelter staff: $B = .19$, $p < .001$; assault of service users: $B = .10$, $p = .01$; verbal abuse of shelter staff: $B = .19$, $p < .001$; verbal abuse of service users: $B = .12$, $p < .01$; threats of death or harm: $B = .18$, $p < .001$; harassment: $B = .17$, $p < .001$), making it near-certain that the increases observed in physical and interpersonal violence would have been statistically significant if these analyses were performable.

Shelter-based Violence

Rates of Physical and Interpersonal Violence Per 1,000 Service Users Between 2012-2021 by Sector

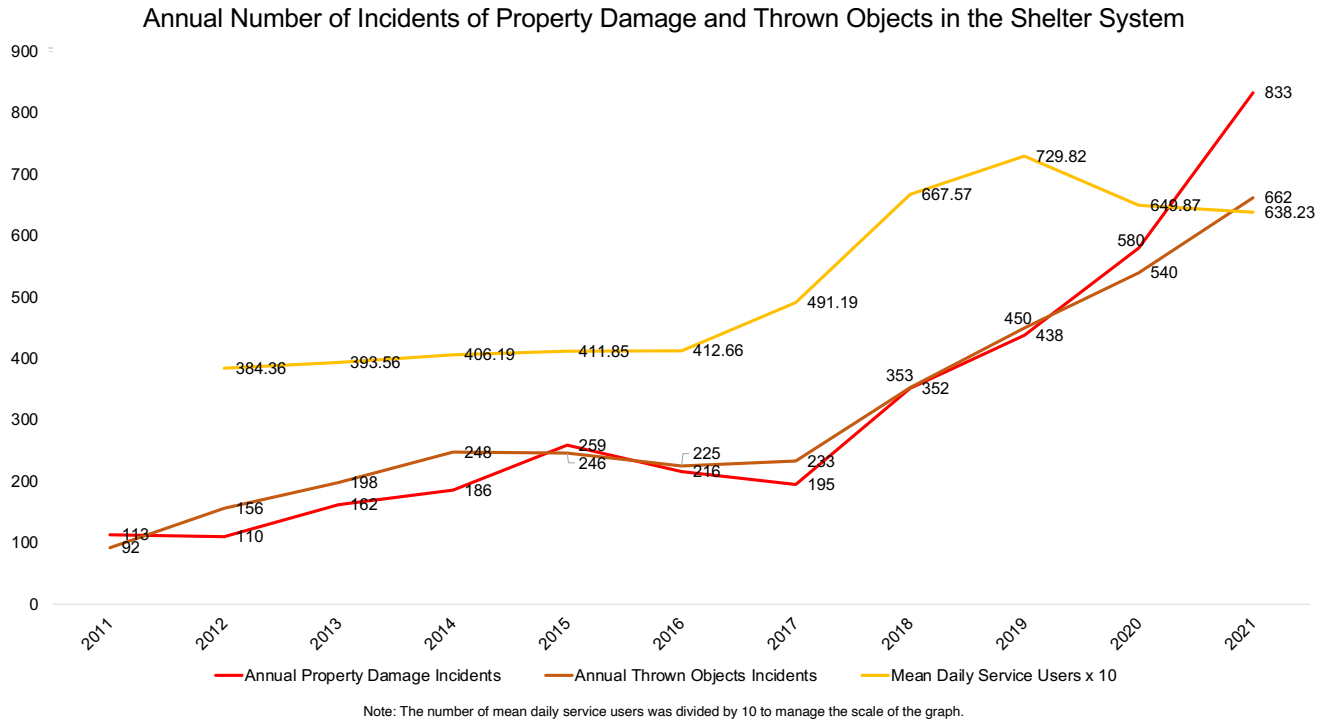
Sector	% of Total Program days (314,684)	Physical Violence		Interpersonal Violence	
		% of Incidents (9,344)	Rate per 1,000 Service Users	% of Incidents (22,801)	Rate per 1,000 Service Users
Adult Men	35.5	44.4	0.71	43.1	1.68
Adult Women	21.4	9.7	0.40	11.3	1.13
Mixed Adult (All Gender)	17.1	32.1	0.96	31.3	2.29
Youth	14.1	11.9	0.75	12.6	1.94

based violence continued to increase in 2020 and 2021, the rise was not as steep as the number of daily service users.

Both physical and interpersonal violence increased gradually in the Adult Women sector from 2011 to 2018. In 2020 and 2021, despite decreases in the number of daily service users, both types of shelter-based violence increased, with a sizeable 68.4% increase in interpersonal violence from 2019 to 2020.

Similar to the any-cause critical incident pattern in the Youth sector, physical and interpersonal violence increased from 2011 to 2015 and then declined from 2016 to 2020. In 2021, there was an uptick in both types of shelter-based violence, despite a continued reduction in the number of daily service users.

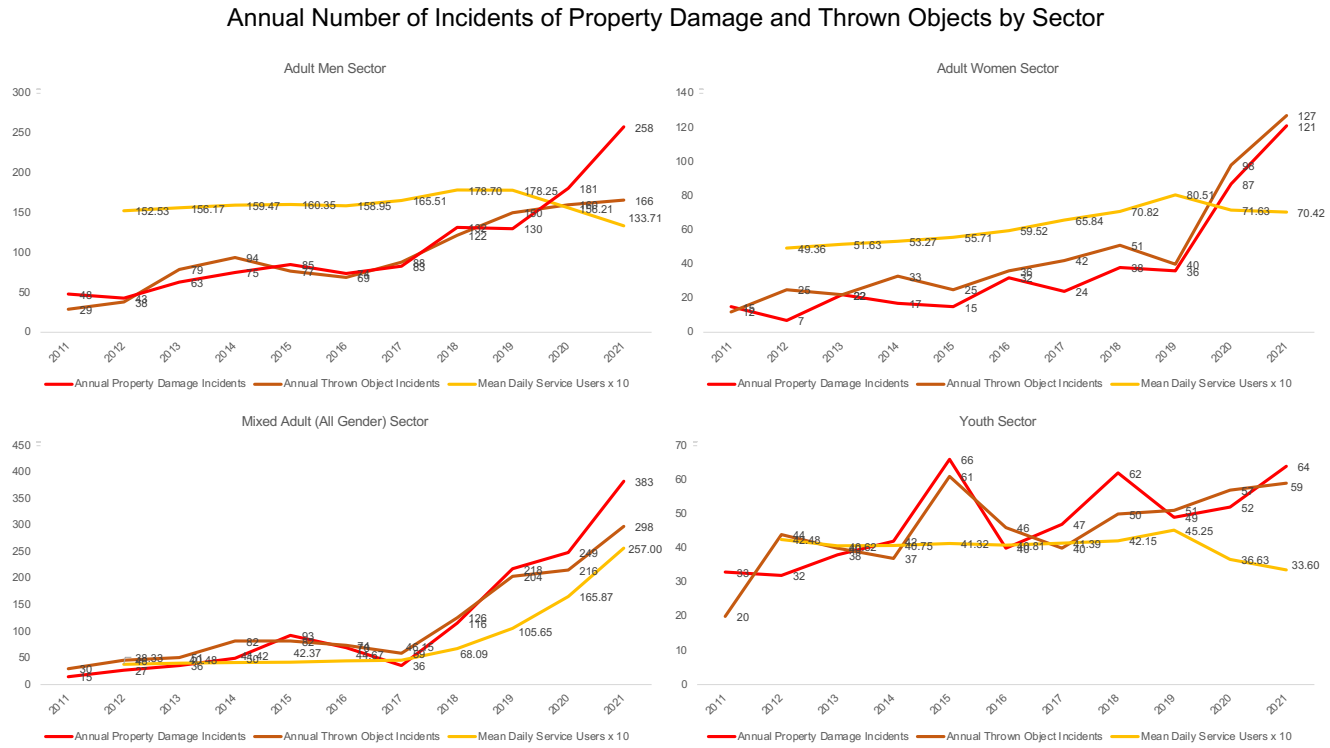
The number of violent incidents per 1,000 service users was also computed to examine rates between sectors.[11] As shown below, the rates of physical and interpersonal violence per



Note: The number of mean daily service users was divided by 10 to manage the scale of the graph.

[11] Critical incidents per 1,000 service users = [number of incidents ÷ (mean number of daily service users x number of operational program-days)] x 1,000.

Shelter-based Violence



Note: The Y-axes of the four graphs have differing scales and the number of mean daily service users was divided by 10 to manage the scale of the graph .

1,000 service users between January 1, 2012 and December 31, 2021 were highest in the Mixed Adult (All Gender) sector, followed by the Youth sector then the Adult Men sector. Rates were lowest in the Adult Women sector.[12]

Property Damage and Thrown Objects in the Shelter System

Similar trends were observed for two other types of shelter-based violence: [1] property damage and [2] thrown objects. As shown in the figure on the previous page, across the shelter system, there has been a steady increase in incidents from 2018 to 2021. Linear regression models revealed that both property damage ($B = .18$, $p < .001$) and thrown objects ($B = .11$, $p = .01$) significantly increased from 2011-2021.

The Adult Men and Mixed Adult (All Gender) sectors both had fairly similar patterns of property damage and thrown objects over time. The Adult Women sector also followed a similar trend, but showed a sharper increase in both types of critical incidents from 2019 to 2020 (145.0% increase in thrown objects and 141.7% increase in property damage). A divergent pattern was found for the Youth sector, with the number of property damage and thrown object incidents fluctuating up and down per year from 2014 onward.

The rates of property damage and thrown object incidents per 1,000 service users from January 1, 2012 to December 31, 2021 were similar to the other forms of shelter-based violence. As shown in the table on the next page, rates were highest in the Mixed Adult (All Gender) sector,

[12] It was not possible to analyze if the rates per 1,000 service users differed significantly between sectors in this and all subsequent analyses.

Shelter-based Violence

Rates of Property Damage and Thrown Objects Per 1,000 Service Users Between 2012-2021 by Sector

Sector	% of Total Program days (314,684)	Property Damage		Thrown Objects	
		% of Incidents (3,331)	Rate per 1,000 Service Users	% of Incidents (3,311)	Rate per 1,000 Service Users
Adult Men	35.5	33.7	0.19	35.5	0.18
Adult Women	21.4	12.00	0.17	21.4	0.22
Mixed Adult (All Gender)	17.1	38.4	0.41	17.1	0.40
Youth	14.1	14.8	0.33	14.1	0.33

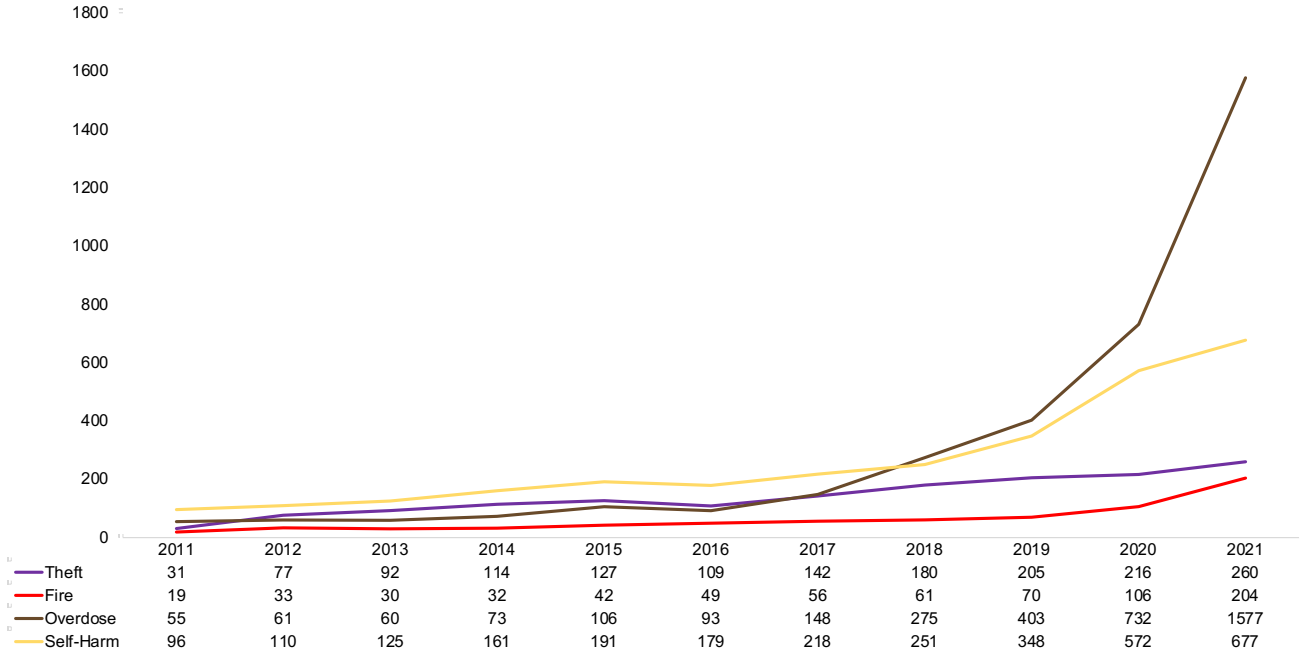
followed by the Youth sector. Rates were lower in the Adult Men and Adult Women sectors.

Other Types of Critical Incidents in the Shelter System

Changes over time in several other types of critical incidents across the shelter system are shown below. The number of suspected overdoses increased from 2017 onward, but rose substantially during 2020 and 2021 – increases of 81.6% and 115.4% from the previous year, respectively. Similarly, the number of self-harm incidents increased gradually from 2011 to 2019, with a sharper increase occurring in 2020. As for fire incidents, there was a 92.5% increase from 2020 to 2021, with a much more gradual trend of increases observed in previous years. Theft gradually increased from 2011 and 2021.[13]

Linear regression models that controlled for the number of daily service users in shelter system, season of the year, extreme weather alerts, and pandemic onset showed that the number of self-

Annual Number of Other Incident Types in the Shelter System



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Theft	31	77	92	114	127	109	142	180	205	216	260
Fire	19	33	30	32	42	49	56	61	70	106	204
Overdose	55	61	60	73	106	93	148	275	403	732	1577
Self-Harm	96	110	125	161	191	179	218	251	348	572	677

[13] SMIS categorizations for other types of critical incidents, including mischief, criminal acts, disruptive behaviour, medical occurrence, and accident or illness, among others, are not reported here. This is due to the ambiguity and potential overlap of these categories and their lack of definitions, which presents a risk for producing unreliable findings.

Shelter-based Violence

Rates of Suspected Overdose and Self-Harm Per 1,000 Service Users Between 2012-2021 by Sector

Sector	% of Total Program days (314,684)	Suspected Overdose		Self Harm	
		% of Incidents (3,528)	Rate per 1,000 Service Users	% of Incidents (2,832)	Rate per 1,000 Service Users
Adult Men	35.5	32.1	0.19	27.5	0.13
Adult Women	21.4	8.6	0.13	16.4	0.20
Mixed Adult (All Gender)	17.1	51.1	0.58	28.7	0.26
Youth	14.1	7.3	0.17	25.7	0.49

harm incidents ($B = .19$, $p < .001$), thefts ($B = .14$, $p < .001$), fires ($B = .13$, $p < .01$), and suspected overdoses ($B = .08$, $p = .02$) each significantly increased from 2011-2021.[14]

Further analyses were conducted to examine the rates of suspected overdose and self-harm incidents per 1,000 service users from January 1, 2012 to December 31, 2021. The suspected overdose rate was higher in the Mixed Adult (All Gender) sector than other sectors, whereas the self-harm incident rate was much higher in the Youth sector than other sectors.

Rates and Types of Critical Incidents in the Shelter System
Key Findings Summary

- The annual number of any-cause critical incidents increased from 2011 to 2019 at a rate that was similar to the rise in the number of daily service users in the shelter system; however, there was a marked increase in the number of critical incidents during 2020 and 2021, whereas the number of service users decreased during these years. Overall, critical incidents have significantly increased from 2011 to 2021, after controlling for the number of daily service users and other factors.
- The steep increases in critical incidents in the Adult Women sector in 2020 and 2021 suggest that women experiencing homelessness in the shelter system may have been disproportionally harmed by the COVID-19 pandemic.
- The number of incidents of physical and interpersonal violence in the shelter system have increased over the past decade for all sectors, though differing trends were observed over this period between sectors and in relation to the number of daily service users. The rates of physical and interpersonal violence per 1,000 service users from 2012 to 2021 were highest in the Mixed Adult (All Gender) sector. Overall, each type of violence (assault of shelter staff; assault of service users; verbal abuse of shelter staff; verbal abuse of service users; threats of death or harm; harassment; property damage; thrown objects) significantly increased from 2011 to 2021, after controlling for the number of daily service users and other factors.
- The number of suspected overdoses in the shelter system has increased substantially in recent years, with the Mixed Adult (All Gender) sector having the highest rate per 1,000 service users.
- It is important to recognize that the observed trends in critical incident rates may be partially attributable to policy and practice changes that occurred throughout the shelter system during the same period.

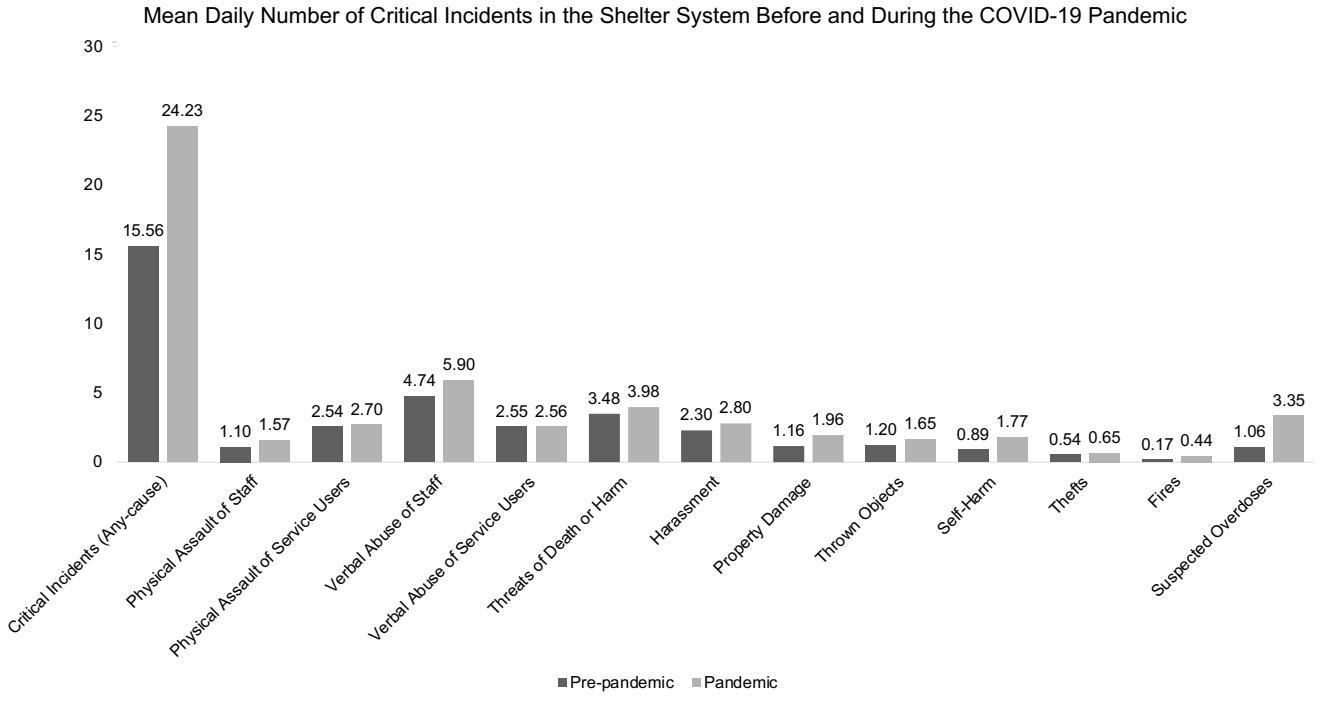
[14] Of note, the reason for the smaller effect size for suspected overdoses despite its substantial increase in recent years is due to the regression model controlling for the effects of the pandemic, which was found to have a much more sizeable impact on suspected overdose rates than time. This means that, although overdose rates significantly increased over time from 2011 to 2021, the onset of the pandemic was the larger contributor to this rise.

Shelter-based Violence

Effects of the COVID-19 Pandemic on Critical Incidents

Linear regression analyses were conducted to examine the mean number of critical incidents in the 661 days before the onset of the pandemic (May 20, 2018-March 10, 2020) compared to the first 661 days of the pandemic (March 11, 2020-December 31, 2021). The range of 661 days was selected, as data were available until December 31, 2021. Analyses controlled for the daily number of service users in the shelter system and the season of the year, which means that differences found in incident and restriction rates pre- and post-pandemic are not attributable to changes in the number of service users in the shelter system or season of the year. It was not possible to explore or adjust for differences between sectors in this set of analyses.

All types of critical incidents, with the exception of verbal abuse toward service users and theft, significantly increased during the pandemic (physical assaults of staff: $B = .16$, $p < .001$; physical assaults of service users: $B = .14$, $p < .001$; verbal abuse toward staff: $B = .22$, $p < .001$; threats: $B = .12$, $p < .01$; harassment: $B = .23$, $p < .001$; property damage: $B = .31$, $p < .001$; thrown objects: $B = .18$, $p < .001$; self-harm: $B = .29$, $p < .001$; fires: $B = .24$, $p < .001$; overdoses: $B = .70$, $p < .001$).[15] The number of physical assaults on shelter staff and service users increased 42.7% and 6.3%, respectively. Verbal abuse toward shelter staff, which was the most common type of critical incident, also increased 24.5%. However, the most sizable increase was observed in suspected overdose rates (216.0% increase from pre-pandemic to pandemic). The increases in self-harm incidents also suggest the likelihood of worsening unmet



Critical incidents (any cause) are fewer than the sum of all critical incident categories, as some incidents were coded in multiple categories and this is adjusted for in the any cause variable.

[15] Physical and interpersonal violence are presented in their disaggregate forms (i.e., each type of SMIS critical incident category), as it was not feasible to analyze these data in the same way as previous analyses.

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mental health needs among service users of the shelter system during the pandemic.

As for any-cause critical incidents, this also significantly increased by 55.7% from pre-pandemic to the pandemic ($B = .63$, $p < .001$). During the first 661 days of the pandemic, an average of 24.23 incidents were registered in SMIS on a daily basis, compared to 15.56 daily incidents during the pre-pandemic period of the same duration.

Effects of the COVID-19 Pandemic on Critical Incidents

Key Findings Summary

- Rates of almost every type of critical incident significantly increased during the first 661 days of the pandemic. These increases are not explained by changes in the daily number of service users in the shelter system, nor season of the year.
- The findings indicate greater exposure to workplace violence among shelter staff during the pandemic.
- There has been an alarming rise in suspected overdoses in the shelter system following the onset of the pandemic and

Correlates of Shelter-based Violence

This section uses SMIS data to examine two types of correlates of shelter-based violence: [1] shelter size and [2] environmental and temporal factors.

Shelter Size

Analyses were conducted to examine whether larger shelters had higher rates of critical incidents than shelters of a smaller size. All shelters were categorized as being one of the following sizes:

1. Small (≤25 beds/rooms and ≤50 service users)[16]
2. Medium (≤99 beds/rooms and 51-99 service users)
3. Large (≥100 beds/rooms and/or ≥100 service users)

Like the previous analysis, the same period of 1,322 days (661 days pre-pandemic and 661 days post-pandemic) was selected. For this period, the number of incidents per 1,000 service users was computed. Due to the need to integrate data from multiple datasets with differing structures, only descriptive statistics were conducted (i.e., it is not possible to conclude whether differences between groups or changes over time are statistically significant).[17]

All-cause Critical Incident Rates Before and During the COVID-19 Pandemic by Shelter Size

Shelter Size	Combined (05/20/2018 12/31/2021)			Pandemic (03/11/2020 12/31/2021)			Pre pandemic (05/20/2018 03/10/2020)		
	Mean number of daily service users	% of total program days (135,379)	Rate per 1,000 service users	Mean number of daily service users	% of total program days (76,874)	Rate per 1,000 service users	Mean number of daily service users	% of total program days (58,505)	Rate per 1,000 service users
Small	13.62	33.4	4.85	14.43	39.4	6.01	12.25	25.4	1.96
Medium	49.85	53.2	3.91	46.93	49.8	5.05	53.12	57.7	2.78
Large	166.21	13.4	2.42	166.38	10.8	2.80	166.07	16.9	2.10

[16] This operational definition was selected to align with the Safe Haven shelter model that typically supports ≤25 service users.
[17] These analyses did not control for shelter model (i.e., shelter hotel vs. traditional congregate shelter model; see Appendix B).

Shelter-based Violence

Rates of Physical Violence Per 1,000 Service Users Before and During the COVID-19 Pandemic by Sector and Shelter Size

Sector	Shelter Size	Combined (05/20/2018 12/31/2021)			Pandemic (03/11/2020 12/31/2021)			Pre pandemic (05/20/2018 03/10/2020)		
		Mean number of daily service users	% of total program days (43,843)	Rate per 1,000 service users	Mean number of daily service users	% of total program days (22,898)	Rate per 1,000 service users	Mean number of daily service users	% of total program days (20,945)	Rate per 1,000 service users

Rates of Interpersonal Violence Per 1,000 Service Users Before and During the COVID-19 Pandemic by Sector and Shelter Size

Sector	Shelter Size	Combined (05/20/2018 12/31/2021)			Pandemic (03/11/2020 12/31/2021)			Pre pandemic (05/20/2018 03/10/2020)		
		Mean number of daily service users	% of total program days (43,843)	Rate per 1,000 service users	Mean number of daily service users	% of total program days (22,898)	Rate per 1,000 service users	Mean number of daily service users	% of total program days (20,945)	Rate per 1,000 service users
Adult Men	Small	15.26	35.8	2.19	15.86	43.1	2.87	14.25	27.7	0.92
	Medium	49.94	56.0	2.44	44.89	50.7	2.90	54.46	61.8	2.10
	Large	172.57	8.3	1.87	149.69	6.2	1.37	187.36	10.5	2.13
Adult Women	Small	12.26	38.1	0.76	15.26	43.3	0.70	7.96	32.5	0.92
	Medium	44.45	59.5	1.32	42.04	56.5	2.39	46.79	62.7	0.39
	Large	106.12	2.4	3.92	103.00	0.2	5.30	106.27	4.8	3.89
Mixed Adult (All Gender)	Small	16.53	21.1	1.56	17.24	17.8	2.28	15.57	28.3	0.46
	Medium	55.48	59.1	1.79	50.07	62.9	2.13	70.04	51.0	1.14
	Large	153.8	19.8	1.85	115.13	19.3	2.27	172.89	20.8	1.93
Youth	Small	14.55	48.0	3.63	15.16	70.0	3.91	11.54	18.9	1.79
	Medium	42.24	52.0	1.50	37.74	30.0	0.74	44.45	81.1	1.81
	Large	-	0	-	-	0	-	-	0	-

As shown in the table on the previous page, small shelters had the lowest rates of critical incidents in the shelter system in the 661 days before the onset of the pandemic. However, the pandemic transformed the shelter system, with fewer large and medium sized shelters, and more beds available in small programs (according to the given operational definition of

Shelter-based Violence

shelter size).[18] Further, the mean number of service users in small shelter programs increased, whereas medium programs had fewer mean service users and large programs remained fairly stable. The rates of critical incidents also changed substantially, with small shelters have the highest rates per 1,000 service users during the pandemic. Although incident rates increased for shelters of all sizes from pre-pandemic to pandemic, smaller programs had the largest increases.

Further analyses were conducted by sector on two types of shelter-based violence: [1] physical violence (physical assault of shelter staff or service user) and [2] interpersonal violence (physical assault of shelter staff or service user, verbal abuse of shelter staff or service user, threats of death or harm, or harassment).

In the Adult Men sector, pre-pandemic rates of physical and interpersonal violence per 1,000 service users were both lowest in small shelter programs, but rose sharply during the pandemic. In contrast, large programs had higher rates prior to the pandemic, but this declined during the pandemic, as did the mean number of daily service users per program.

A similar pattern was observed in the Mixed Adult (All Gender) sector, with small and large shelter programs having the lowest and highest rates of both physical and interpersonal violence, respectively, prior to the pandemic. Although rates increased for shelter programs of all sizes during the pandemic, small programs had the highest rate increases.

A somewhat different pattern was observed in the Adult Women sector. Similar to other sectors, physical and interpersonal violence rates were highest in large programs prior to the pandemic. However, medium-sized shelters had lower rates of violence than small programs. During the pandemic, increases in rates of violence were highest among medium-sized shelters, whereas the rate decreased in smaller shelters. The violence rates also increased slightly in large shelters; however, large programs comprised only 0.2% of all beds in the sector during the pandemic. Of note, large shelters in the Adult Women sector also had the highest rates of physical and interpersonal violence per 1,000 service users compared to programs of any size in all other sectors.

The Youth sector did not have any programs that were classified as large. The physical violence rate per 1,000 service users was higher in medium-sized shelters than small programs prior to the pandemic, whereas the rate of interpersonal violence was similar between the two. Like the Adult Men and Mixed Adult (All Gender) sectors, during the pandemic, violence rates increased in small programs, as did the number of daily service users. Violence rates and the number of service users in medium-sized programs decreased during the pandemic.

Although some sectoral differences were found in changes in violence by shelter size from May 2018-December 2021, a key trend was that rates per 1,000 service users decreased in larger shelters during the pandemic and increased in smaller programs. The changes in violence rates often occurred alongside more service users residing daily in smaller programs. Thus, the findings suggest that crowdedness is likely a key factor in shelter-based violence rates.

[18] It is important to note that shelters in each category were not necessarily the same in analyses conducted prior to and during the pandemic. In particular, shelters categorized as medium or large in analyses prior to the pandemic may have been re-categorized as small during the pandemic due to physical distancing measures and other factors. This would explain small shelters having higher mean daily service users during the pandemic than prior to it, though it is also possible that new shelters with operating and other programs had closed during the pandemic, which could also have affected the changes in mean daily service users.

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Environmental and Temporal Correlates of Shelter-based Violence

Linear regression models were conducted to examine how environmental and temporal factors affected shelter-based violence rates. Six factors were examined: [1] season of the year, [2] maximum daily temperature, [3] minimum daily temperature, [4] total daily precipitation, [5] cold weather alert issued by Toronto Public Health, and [6] heat warning alert by Toronto Public Health/Environment & Climate Change Canada.[19] All analyses controlled for date, daily number of service users in the shelter system, and pandemic onset. Critical incidents were examined in their disaggregate forms (i.e., each type of SMIS incident category).

Only season of the year significantly affected critical incident rates, with all analyses producing small effect sizes. Physical assaults of service users, threats, and property damage were all significantly higher in the winter compared to the other seasons (see footnote for statistics).[20] Physical assaults of shelter staff were also significantly lower in the summer compared to the winter ($B = .09$, $p < .01$). Verbal abuse was also higher in the winter compared to some other seasons (see footnote for statistics).[21]

Logistic regression models were also conducted to examine how time of a day affected the likelihood of shelter-based violence. Four times of day were examined: [1] morning (6:00 am-11:59 am), [2] afternoon (12:00 am-5:59 pm), [3] evening (6:00 pm-11:59 pm), and [4] nighttime (12:00 am-5:59 am). The analyses controlled for date, daily number of service users in the shelter system, program size, pandemic onset, and season of the year.[22]

Violent incidents significantly differed by time of day. Physical violence was more likely to occur in the evening than the afternoon ($B = .18$, $p < .001$). In contrast, interpersonal violence was more likely in the morning than afternoon ($B = .20$, $p < .001$). Both were less likely during the nighttime (physical violence: $B = .10$, $p < .01$; interpersonal violence: $B = .10$; $p = .001$).

Correlates of Shelter-based Violence Key Findings Summary

- Although larger shelters typically had higher rates of violence per 1,000 service users prior to the pandemic, increases in violence rates were highest in small programs in many sectors during the pandemic. The findings suggest that crowdedness in shelters may be a highly important factor in violence rates.
- Higher rates of shelter-based violence generally occur during the winter season.
- Physical violence was more likely to occur in the evening, whereas interpersonal violence was more likely to occur in the morning. These findings suggest possible temporal differences in manifestations of interpersonal conflict and expressions of anger that have implications for service delivery. Minimizing the imposition of inflexible program rules and expectations during the morning may be beneficial for reducing violence. In the evening, managing crowding through the use of private spaces and removal of bottlenecks within the shelter is recommended.

[19] Data were unavailable on income support payment schedules at the time of analysis (see Appendix B).
[20] Summer (assaults of service users: $B = .08$, $p = .01$; threats: $B = .10$, $p = .001$; property damage: $B = .07$, $p = .03$), spring (assaults of service users: $B = .06$, $p = .02$; threats: $B = .06$, $p < .01$; property damage: $B = .08$, $p < .01$), fall (assaults of service users: $B = .08$, $p < .001$; threats: $B = .08$, $p < .001$; property damage: $B = .05$, $p = .02$).
[21] Fall (verbal abuse of staff: $B = .04$, $p = .05$; verbal abuse of service users: $B = .05$, $p = .02$) and summer (verbal abuse of service users: $B = .07$, $p = .04$).
[22] It was not possible to control for shelter policies on curfew times, and whether or not daytime access was permitted.

Shelter-based Violence

High-Incident Service Users

A small group of service users accounts for a sizeable number of critical incidents in the shelter system. For example, in 2021, there were 24 service users who had ≥20 incidents documented in SMIS for that year. These individuals were involved in a total of 638 incidents in 2021, accounting for 6.6% of all critical incidents that year (9,657). The characteristics of this group were examined to better understand who they were and the types of incidents in which they were involved.

Of the 24 service users, 14 identified as male and 10 were female or transgender/non-binary.[23] There was an overrepresentation of younger persons in this group, with 9 service users under the age of 25 years, 13 aged 25-50 years (3 of whom were 25-29 years), and 2 who were 51 years or older. However, these individuals were involved in incidents that were fairly distributed across sectors, with 164 incidents (25.7%) occurring in the Adult Men sector, 164 incidents (25.7%) occurring in the Adult Women sector, 164 incidents (25.7%) occurring in the Youth sector, and 120 incidents (18.8%) occurring in the Mixed Adult (All Gender) sector.

The types of incidents these 24 service users were involved in varied, with frequent interpersonal violence and personal health crises:

- 129 incidents (20.2%) involved verbal abuse or harassment toward shelter staff or other service users without any physical assault or other violence
- 82 incidents (12.9%) involved self-harm without any physical violence or verbal abuse toward others
- 73 incidents (11.4%) involved physical assault
- 70 incidents (11.0%) involve other forms of violence (i.e., threats of death or harm, property damage, or thrown objects) without any physical assault
- 62 incidents (9.7%) involved a suspected overdose without any physical assault or verbal abuse toward others
- 54 incidents (8.5%) involved a non-overdose medical event (i.e., medical occurrence or accident/injury) without any physical assault or verbal abuse toward others
- 99 incidents (15.5%) involved “disruptive behaviour” without any form of violence and minimal overlap with other incident categories

Of note, almost all service users had critical incidents across many of the categories listed, suggesting that this group’s difficulties in shelter may manifest in different ways during their stays. Suspected overdose appeared to be the exception to this, as four service users had a total of 65 overdoses (85.5% of all overdoses among this group in 2021).

This group of 24 service users also had a total of 466 service restrictions in 2021, which represented 5.8% of all service restrictions registered in SMIS for that year. The most common reasons for restriction were: behaviours that compromise the health and safety of service users, volunteers, or staff (172 restrictions; 36.9%); violent or threatening behaviour (80 restrictions; 17.2%); disruptive behaviour (70 restrictions; 15.0%); and assault (61 restrictions; 13.1%).[24] The mean duration of the 466 service restrictions received by this group was 32.66 days (standard deviation: 31.49 days).

[23] Female and transgender/non-binary study participants are grouped together to protect service user confidentiality in this analysis.
[24] Unlike the other disaggregated reasons for service restriction, assault included two SMIS categories: [1] “assault of client” and [2] “assault of residents, volunteers or staff.”

Shelter-based Violence

Data from available intake forms were incomplete on the 24 service users' histories of homelessness. However, examining incidents in prior years indicates that many of these individuals had multi-year histories in the shelter system. A total of 19 individuals (79.2%) were involved in at least one critical incident between 2017 and 2020. Further, 12 (50.0%) had ≥5 incidents in one of the two years prior to 2021 and 8 (33.3%) had ≥10 incidents in 2020 alone.

These findings suggest that SMIS data could be leveraged to identify service users who are at-risk of escalating critical incidents in the future. Coupling this information with a system-wide intervention to support high-incident service users could be beneficial for preventing further critical incidents, as New York City's Department of Homelessness Services has been doing (see promising practice description below).

High-Incident Service Users

Key Findings Summary

- A small number of service users are involved in a sizable amount of total critical incidents across the shelter system. In 2021, 24 service users accounted for 6.6% of all critical incidents and 5.8% of all service restrictions that year. Critical incidents in prior years were common among this group as well.
- High-incident service users were involved in a range of critical incident types, suggesting that this group's difficulties in shelter may manifest in different ways during their stays.
- SMIS data can be routinely used to identify recent high-incident service users for subsequent support and intervention.

Promising Practice

Central Care Coordination Program, New York City Department of Homeless Services

Critical incidents in the shelter system in New York City (NYC) are reported electronically by shelter staff to the Department of Homeless Services (DHS). Types of incidents are classified into three priority groups: priority one, which is the most serious (e.g., death; homicide and suicide attempt; overdose; assault; firearm use; sexual assault; child abuse; fire, disaster, or other environmental concern causing life-threatening injury or site evacuation); priority two (e.g., physical or sexual assault not resulting in arrest; arrest for offsite criminal activity; theft or property damage; firearm possession; onsite substance possession, use, or sale); and priority three, which is the least serious (i.e., more minor onsite and offsite incidents not categorized as priority one or two events).

NYC DHS launched a pilot program, the Centralized Care Coordination Program, in August 2021 to identify and improve shelter and support outcomes for "complex or high-risk" service users. The Centralized Care Coordination Program is a series of frequent interdisciplinary case conferences focused on more effectively addressing individuals' housing and support needs. The Centralized Care Coordination Program involves cross-sectoral and cross-agency participation and collaboration between shelter, outreach, hospital, supportive housing, and income support providers. One service user is discussed per meeting and a service provider or advocate who has a close connection to that individual initially presents them to the group.

The purpose of this is to understand service users' histories, including strengths, beyond recent events (i.e., the critical incidents that led to their discussion in the Centralized Care Coordination Program). The Centralized Care Coordination Program then works to advocate for service users' needs and connect them to existing community resources. At the end of each initial meeting, attendees are challenged to identify three actions for follow-up within the next two weeks. The pilot program emphasizes the importance of long-term follow-up, as there is the expectation that many service users will require support beyond one year.

The pilot program involves a total of 50 single adult service users who were assessed as "complex or high-risk" by the following criteria: [1] 14 or more total incidents in the past 6 months, [2] at least one priority one incident, and [3] resided in the DHS shelter system between January-June 2021. Administrative shelter data was leveraged to identify the service users with the highest incident rates, which minimizes availability and information biases. Among the 50 service users in the pilot program, they had used the shelter system for 10.9 years and had 5 priority one incidents, on average.

In the past year, with 1.5 FTE staff members, over 100 service users have been served in the pilot program. Preliminary outcome data show pre-post intervention reductions in shelter-based incidents among 30 service users who continued to remain in shelter. A total of 17 service users (34%) also obtained supportive housing or assisted living (Schwartz et al., 2023).

Shelter-based Violence

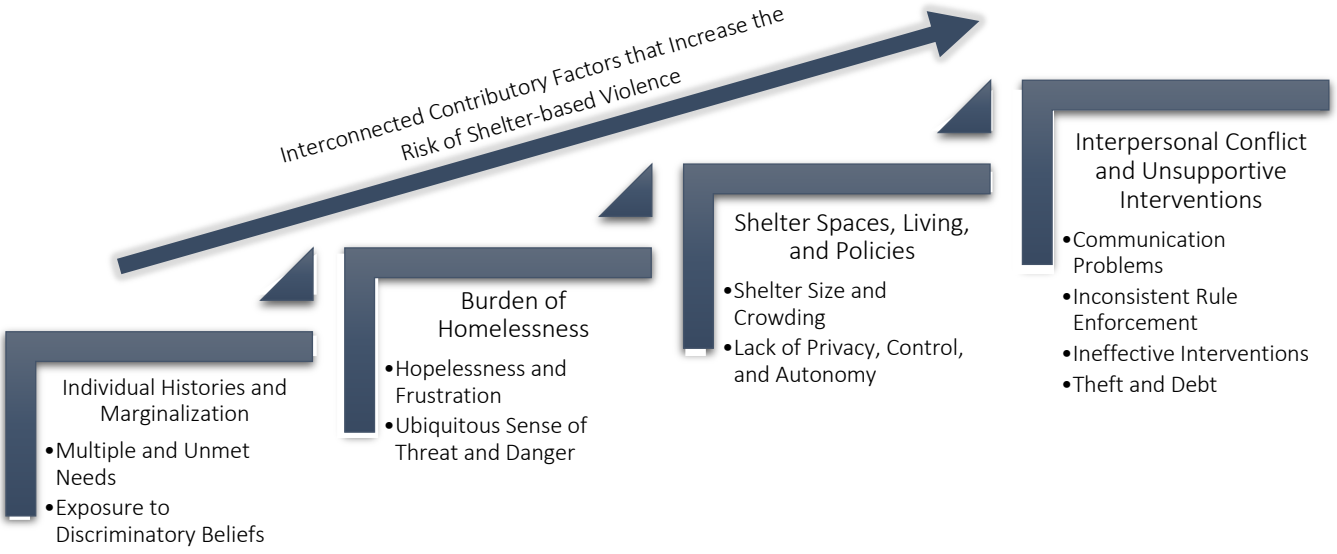
Perspectives on the Contributory Factors to Shelter-based Violence

Shelter-based violence is a complex phenomenon that is shaped by a range of interconnected factors. Using data from the qualitative interviews with shelter staff, key informants, and people experiencing homelessness, this section details the perceived key factors in shelter-based violence. It is important to note that these findings are subjective, as is the case with qualitative research, and represent the views of the individuals who were interviewed. Where appropriate, perspectives that converge and diverge with the quantitative findings from the previous section, as well as other research literature, will be discussed.

The perceived factors in shelter-based violence are summarized in the figure below and then subsequently described in detail. Of note, the factors were seen as interconnected, meaning that each one could interact with others to further amplify risk of violence. For example, frustrations of being homeless could be intensified by shelter policies that limit control and autonomy, leading to violence when rules are inconsistently applied.

Individual Histories and Marginalization

The identities, needs, and past experiences of service users are diverse. These characteristics were described as having the potential to interact with people's experiences of homelessness and shelter environments, possibly affecting violence risk. Service users were often seen as having multiple and unmet needs that could be worsened by chaotic and stressful shelter environments. Further, there was a strong belief among many shelter staff and key informants that service users' behavioural health needs were inadequately supported by community services, leading to unmet needs in the shelter system. In particular, study participants had concerns about the risks associated with methamphetamine use in shelters: "The type of street drugs that are more accessible will also have an impact on violence … with crystal meth, you're going to see more incidents of violence in the shelter." The lack of community-based supervised consumption services that allow drug



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inhalation was perceived as one contributory factor to the current state of methamphetamine use in the shelter system.[25] One key informant also underscored the importance of understanding the functionality of methamphetamine use among service users, which may be a response to safety concerns in shelter environments, as described in the quote below.

> *"That's the thing, it's never just the drug and it's so easy to demonize it and be like, 'That's it. We know what the problem is and let's just stamp out methamphetamine.' Well, remember when we tried to stamp out heroin and then we got fentanyl? … But it's also realizing the value of crystal meth to people who are in the system. Like why is someone on a run of crystal meth when they're using a shelter system? Because they need to stay up and watch their stuff."*
>
> - key informant (healthcare provider)

Alcohol was another substance that shelter staff identified as producing disinhibition, leading to violence: "Alcohol is an interesting substance because people often have other things going on, they may be dwelling on it when they get intoxicated. The inhibition is that 'I'm not just going to punch this person because he's annoying me.' [Then it becomes] 'I'll just punch him anyway.' So, those inhibitions disappear." In contrast, opioid use was perceived to increase risk of theft-based victimization, but decrease risk of violence during intoxication.

Finally, study participants described how shelters were environments with a diversity of individuals, including some who held discriminatory beliefs (e.g., homophobia, transphobia, misogyny, racism). This presented a potential risk for conflict between people who held those discriminatory beliefs and others who had those identities. Said one service user of a recent conflict in the shelter: "He came in and, when he was opening the door to come in, he screamed the "N" word and then I looked at him. I just kind of ignored it the first time and then he started screaming it again. And, I said, 'Hey, can you please stop?' And then he's like, 'What are you going to do? It's my body, it's my mouth, I'll say whatever I want.' And then he just started going off on me."

Burden of Homelessness

The burden of homelessness was perceived as another predisposing factor in shelter-based violence. The lack of affordable housing in the city and beyond was thought to undermine service users' prospects of exiting homelessness, yielding a sense of hopelessness and frustration.

> *"In big places like this, you know, people are going to be frustrated and upset where they're at and are having a bad day. So, there might be a confrontation or whatever."*
>
> - adult man experiencing homelessness

> *"Poverty has become so much more entrenched [in the world], and I feel like there's hopelessness, and like that culture of homelessness isn't about a season of your life, it is your whole life now … there's just a hopelessness, there's no options for folks and I feel like that hopelessness is resulting in more violence."*
>
> - key informant (healthcare provider)

Similarly, the shelter system in Toronto was identified as often being near maximum capacity on a regular basis. This could yield similar frustrations and be a source of conflict among those looking to access a bed: "Maybe they've

[25] Data were collected prior to changes at one supervised consumption site in Toronto that now permits drug inhalation.

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been up for three days, they're just looking to crash, they need a place to crash, and you're telling them, there's no bed available for you right now. I mean, that can be obviously very triggering, and lead to issues of violence." Given the unique role of the Assessment and Referral Centre in Toronto's shelter system, this site was identified as one where frustrations related to capacity limits could culminate, in particular.

The experience of homelessness was also identified as producing a ubiquitous sense of threat and danger. Assault, theft, and debts were commonly identified sources of potential harm for people experiencing homelessness – a view that is consistent with past research (Kerman et al., 2023). Violence could serve as a survival tool in the midst of this harsh reality: "Violence is a coping mechanism … it's about people fighting for their survival … it's very biological in a way. It's our neurological systems coming out in a socially prescribed way."

Shelter Spaces, Living, and Policies

One of the most frequently identified factors in shelter-based violence was the shelter size and potential for crowding. Large, congregate shelters were consistently perceived by shelter staff and key informants as settings where violence was more likely to occur due to there being more service users onsite and typically shared accommodations (e.g., bedrooms and bathrooms). These built environments were seen as increasing the risk of overcrowding and interpersonal conflict that could lead to violence. Further, these shelter settings were identified as having institutional atmospheres, which were unwelcoming, offered minimal privacy, and used surveillance. Said one shift supervisor at a large shelter, "I think people just feel watched – policed – that this isn't their home. That this isn't a place where there's particularly much investment in them. And it's more just like a people management system – shuffle through, get your food, get your token, and get out." A key informant in a senior leadership role at a homeless service organization explained how large shelters led management to enact such an approach:

> *"You know, it's just hard to [provide individualized support] once you reach a certain size of shelter. You have a huge amount of clients, have an army of staff, and job number one becomes security and keeping order. And, because of that, you need a lot of rules. It just is not an environment, in my opinion, conducive to addressing individual needs, to treating people with respect and dignity. Because of that, I believe it can inflame and causes violence."*
>
> - key informant (shelter operator)

The effects of the COVID-19 pandemic were also described in relation to service delivery in the shelter system. The reduced number of service users in large, congregate shelters was perceived by some shelter staff to have had positive effects on the rates of violence in these settings, as they were more able to meaningfully engage with service users due to lower caseloads. These views generally align with the previously described quantitative findings that found shelter-based violence rates increased to a greater extent in smaller shelters during the pandemic compared to large ones, which were likely the result of crowdedness changes in these programs.

Shelter policies and service approaches were also identified as having a role in shelter-based violence. In particular, policies that limited a sense of privacy, control, and autonomy were perceived to exacerbate the frustration of some service users. Examples of such policies included: service users having to ask shelter staff to access their rooms, designated meal times, and curfews. Relatedly, one shelter staff

identified waiting queues and identification checks for entry into shelters as another source of potential conflict where violence could ensue: "We have a waiting list sometimes of 8 to 10 people. Some people are restricted who come and they see the lineup and then it just exacerbates their current situation. They start kicking the doors, breaking the glass, assaulting other people in lineup, which adds to the restriction." This perspective is consistent with previously described research that found waiting queues for shelter can undermine a sense of safety for prospective service users (Shier et al., 2007).

Shelter hotels were also discussed in relation to service users' privacy. Shelter staff and key informants generally perceived shelter hotels to have lower rates of violence due to their provision of private rooms and bathrooms, and fewer common spaces. Said one health professional who worked with people experiencing homelessness across the shelter system: "I do think that the shelter hotels and everybody having their own bedroom, their own bathroom, like all of those things are very, very, very helpful and important … in these big congregate settings, there are many, many, many more interpersonal actions that come up … the more you have interpersonal encounters, the more there's risk that those will escalate." However, in contrast, one key informant in a senior leadership role at a homeless service organization noted that their agency had seen higher rates of violence at the hotels they operated than their traditional shelters. Overall, study participants' perspectives suggest that shelter hotels may have the potential to reduce shelter-based violence rates in comparison to traditional shelter models; however, a variety of factors would undoubtedly contribute to this (e.g., support models, populations served, the built environment in shelter hotels) and the formation of any conclusions at this time would be premature. Further, shelter hotels present other unique safety issues that must be carefully considered and addressed (e.g., overdose risk, building access).

Interpersonal Conflict and Unsupportive Interventions

The most proximal factor in violence involved interpersonal interactions and exposures that took place in shelter. Much of this focused on the interactions between service users and with shelter staff.

The provision of unsupportive interventions, including poor communication, inconsistent rule enforcement, and ineffective supports, was described as increasing the risk of violence. Ineffective de-escalation skills were one contributing factor to violence identified by study participants: "At times, I've seen my coworkers or some site leads emotionally react and then they flip out, and then that causes clients to further escalate." The unavailability of in-person training during the COVID-19 pandemic was identified as exacerbating this issue in recent years, as some staff had reportedly not received training related to Crisis Prevention and Verbal De-escalation – a mandatory training requirement of the Toronto Shelter Standards that all staff (excluding board members) must fulfill within six months of employment appointments. Security guards were another employee group that some shelter staff and key informants felt did not have sufficient knowledge and training on mental health and addiction, or related areas, to effectively de-escalate situations with shelter populations.

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> *I think the question of security also needs to be revisited. Who are we contracting to stand at the door and provide security services? Security officers often are not trained in de-escalation and it can go from 0 to 100 pretty fast.*
>
> - key informant (law)

> *I've often thought, if I was staying here, and somebody talks to me like that … I could see how somebody would want to punch somebody who talked like that. If I'm around a rude person, I can remove myself because I have my own housing, or I get to leave an environment … people who are homeless, especially those who, maybe, you can tell are homeless by certain visual cues, are treated like pieces of crap all day long. And, by the time they come back, they don't want to have to bug you for an extra pillow. They just want the freaking pillow … and you're just talking to them like they're two. And, these are adults who have had lives and families and experience.*
>
> - shelter staff (management)

A related issue was the use of poor or inconsiderate communication approaches by shelter staff. This included descriptions of rude and patronizing comments by staff, as well gatekeeping and scrutiny. Gatekeeping was referenced by multiple shelter staff in the context of how staff respond to simple and fulfillable requests, such as a request for a sandwich outside of designated meal times. Said one shelter staff in a managerial role about how this unfolds, "A client asks for a sandwich and staff says, 'No.' And, then the client freaks out, understandably, and then staff can't come back from it. They'll kick somebody out over an entirely preventable situation."

Inconsistent rule enforcement by staff was another factor that could precipitate shelter-based violence. Several shelter staff discussed differences in how colleagues approached rule enforcement, which could lead service users to feel discriminated against when their request is denied, yet they have observed different outcomes with other staff and service users. In some instances, shelter staff followed clear organizational rules that led to gatekeeping-like responses. One shelter staff described following organizational rules that their colleagues did not and how this led to perceptions that they were "the enemy": "We have regulations and policies put in place that day. This is what you can do in a certain time and then our staff will come in and allow the client to do that. And then you come back down to tell them, 'I'm sorry, you're not allowed to do that,' and then you're the enemy. 'No, you know, everybody else wants me do it, why don't you allow me to do it? You're the only person who doesn't let me do these things.' And, they want to attack you and you're like, 'No, sir, this is the policy and I'm following.'" The lack of consistency in service restrictions was also discussed in relation to rule enforcement inconsistencies and perceived to contribute to violence risk.

Poor service navigation by shelter staff was another perceived catalyst for violence. This reportedly occurs when staff are supporting service users to access community services; however, they provide information that is incorrect or misleading, which then causes inconvenience and anger for service users. This issue was reportedly heightened at the Assessment and Referral Centre. Staff at this location described prospective service users arriving to the site with a misinformed expectation that they would receive a shelter bed: "People being dropped off, dumped or directed to Peter Street without communication to us, with the promise of all of the beds and services, when they show up and they can't get

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that, then our windows are completely broken often."

> *"There's nothing worse than sending a client somewhere that's not open and then people wonder why clients come back to yell and scream at us … I've seen staff who are like, 'Why are you giving all this attitude with me?' and I'm like, 'Because this person does not have $20 to stop and get a Starbucks and something to eat or take the TTC. They just walked 10 blocks there and 10 blocks back because it wasn't open and you sent them there.'"*
>
> - shelter staff (shift supervisor)

Use of wellness/bed check practices were described by shelter staff as having the potential for violence, especially in shelter hotel contexts. Some staff identified how wellness/bed checks could be intrusive and interfered with a sense of privacy. Poor lighting and visibility in hotel rooms made for more intrusive, closer-contact wellness/bed checks: "There's not proper lighting in the rooms. There's a light that you flick on right in front of the door; the other light in the room [is] like a table lamp that you have to flick on, which means you're getting quite close to people, you're potentially leaning over them. Or, at times, you're flashing like a flashlight in their face, which, I don't know, like I feel like that's pretty traumatic, maybe." In contrast, only a few service users discussed wellness/bed checks and, those who did, were fairly indifferent about this practice in relation to safety.

Service restrictions were described as having a bidirectional relationship with shelter-based violence. Use of service restrictions could lead to violent or aggressive reactions by service users toward the staff or shelter property where the restriction occurred: "'They're kicking me out to the street, now what's going to happen?' So, they'll put up that kind of like last fight." Alternatively, the restriction could cause the perpetuation of violence at another service location, such as the shelter to which the individual is subsequently referred (described in more detail in the service restrictions section of this report).

Poor staff wellness in the forms of high stress and low sense of safety among shelter staff was identified as shaping the relationship between staff interventions and shelter-based violence. Stressed shelter staff were perceived as being more likely to respond to service users in a way that worsened interpersonal conflict: "The staff's reaction, right? It's been a trying day, they have something going on in their life, they have dealt with a client so many times … they take one look at them and they're like, 'No,' and [the service user is] like, 'Me? Why me?' and then it just causes them to ramp up." Further, as found in the online survey, 36.2% of staff felt somewhat or very unsafe in the workplace. One shelter staff in a managerial role highlighted how feeling unsafe in the shelter could shape interactions between staff and service users in an unsupportive way: "If staff are feeling unsafe, sometimes their behavior is going to inadvertently cause people to escalate, because the way that they're treating clients might … be more dehumanizing, because their working conditions aren't good."

Lastly, interpersonal conflict could also arise due to theft and debts. This was discussed in relation to service users who were accessing the same shelter, as well as with drug sellers who visited or were in the vicinity of shelters, but did not use them.

> *"You owe a drug dealer money and they know where you live."*
>
> - nonbinary adult experiencing homelessness

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Perspectives on the Contributory Factors to Shelter-based Violence

Key Findings Summary

- Shelter-based violence is a complex problem that is perceived to result from an interaction between systemic, environmental, programmatic, interpersonal, and individual factors. The most proximal factor in shelter-based violence was interpersonal conflict and unsupportive staff interventions, but these can be exacerbated by other factors, including the hopelessness and frustration associated with homelessness, restrictive shelter rules and crowded environments, and unmet needs.
- Enhancing safety for both service users and shelter staff is key to reducing shelter-based violence.

Individuals and Groups At-risk of Shelter-based Violence

There were several types of individuals and groups that were identified as being at higher risk of experiencing shelter-based violence, including people with mental illness and cognitive impairment; people who use substances; transgender and non-binary individuals; Black, Indigenous, and People of Colour; and women. However, it was also noted that service users with other identities may also be at-risk of victimization beyond these groups: "I think straight White men do really well within the shelter system and anybody who is not does poorly, or anyone who can't pretend to fit that category."[26]

People with Mental Illness and Cognitive Impairment

Mental illness and cognitive impairment were most frequently identified as being risk factors for victimization, including violence. This was often the result of perceived vulnerability that could be exploited by others for personal gain or interpersonal conflict related to behaviours that disturbed other service users, leading to violence. Older adults with serious mental illness and cognitive impairment were identified as being particularly at-risk of exploitation: "There's a number of elderly individuals who are in the hotel who are quite vulnerable, especially with early signs of dementia, and a lot of older individuals in the hotels also have a significant amount of like negative symptoms of schizophrenia." Said one key informant in a healthcare provider role, "There's a surprising amount of folks with learning disabilities and developmental delays who are enticed by this like new community and friends who are then led astray with substance use and sex trafficking, and all the things that come with that."

People Who Use Substances

People who use substances were also identified as being at-risk of shelter-based violence due to intoxication, drug debts, and problems arising during drug purchases. This included violence and exploitation within or around shelters by

[26] Of note, the literature review for this study did not identify any studies examining shelter-based violence among newcomers and refugees, and few study participants discussed newcomers and refugees in relation to shelter-based violence risk. It is important to note that data collection with shelter staff and key informants was mostly completed in the first six months of 2022, which coincided with the early stages of a large increase in the number of newcomers and refugees in the shelter system, following the reopening of Canada's borders in September 2021. This may have been a factor in their potential non-identification in this study. Nevertheless, exposure to shelter-based violence may increase this group's risk of mental health problems, including major depression and posttraumatic stress disorder, as had been found in research on Cambodian refugees' post-settlement exposure to violence in the United States (Marshall et al., 2005). Thus, it is critically important to consider the safety needs of newcomers and refugees who are using the shelter system and the potential harms that shelter-based violence exposure may have for this group.

individuals who were not homeless or members of the surrounding community.

> *People who use substances are at huge risk because there's dealers within these places, too. They're doing all sorts of things to get drugs that they need in that moment and, depending on what people are asking for and needing and what you have to leverage, that could be a huge risk.*
>
> - key informant (healthcare provider)

Transgender and Non-binary Individuals

The shelter system in Toronto is partially structured around binary gender categories (i.e., shelters for Adult Men and shelters for Adult Women). Although the Toronto Shelter Standards requires that shelter operators support the choices of transgender individuals to access sites that correspond with their gender identity (8.1.e.i.), there are few non-binary gender shelter options.[27] As a result, transgender individuals were described as an "invisible population" that lived in perpetual fear in the shelter system due to prevalent transphobia: "People who are trans experience much more violence, I think, just in the world and, definitely, in the shelter system."

Several non-binary service users who were interviewed described frequent experiences of verbal violence due to their genders and gender identities: "Well, being LGBT is kind of hard being in the shelter, honestly … just a lot more use of the word faggot in the shelter … I can't let myself be free, I don't want to be stabbed in the middle of the night."

Black, Indigenous, and People of Colour

Black, Indigenous, and People of Colour (BIPOC) service users and staff, especially Black and Indigenous individuals, were identified as being at high risk of shelter-based violence. This was perceived to be the result of pervasive racism in the shelter system, as well as a long-standing tolerance of racist behaviour and language.

> *I have talked also to clients who are Indigenous who are like, 'I would never go in the shelter system, like the level of racism is so high' and somebody makes a racist remark, the other person is upset about that, and then that can escalate.*
>
> - key informant (healthcare provider)

> *They need to talk about the issues that are relevant for myself, as a Black woman, issues around violence against Black women is very relevant to me and that happens a lot in here … those things should be talked about because we, as Black women, we experience more violence than any other race, you know what I mean? It's just terrible. We go through depression and all these things because of that.*
>
> - shelter staff (direct service)

For BIPOC shelter staff, racism was described as having deleterious and emotional impacts: "The way [a service user] spoke to myself and this other girl, we are both Black, he was just so rude. And then the shift leader came over there and the shift leader was Black, too, and the way he talked to us was like we were worse than animals … and he really triggered me. Honestly, I felt that I could jump on the bed and just choke him." The normalization of racism in the shelter system was identified as a continued barrier to bringing these issues forward that forced shelter staff to be "brave," as opposed to feeling safe. Lack of consistent guidelines between shelters and confusion among shelter staff about how to

[27] Data were collected prior to the opening of the first transitional shelter for LGBTQ+ adults in Toronto.

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respond to racial violence were also identified as yielding silence and inaction as responses that could reinforce racism in the shelter system.

> *I can't imagine being a woman of colour and continually hearing racist, sexist comments being made to me, and thank God, we are finally addressing that within our Division, within shelters, because for too long – and, we should have known better – people have been getting passes for that kind of language and behaviour, and it should have never been tolerated.*
>
> - shelter staff (management)

Numerous shelter staff and key informants described that the shelter system was undergoing a policy shift toward confronting anti-Black racism. However, the implementation of new policies and practices to address racial violence had been slowed by the COVID-19 pandemic. Overall, there was a general sense among study participants that the shelter system was in the early phases of its work to understand and respond to the scope of anti-Black racism in shelter settings.

Women

Women were another group identified as being at-risk of shelter-based violence. Study participants noted that female service users were at-risk of physical and sexual assault, as well as sex trafficking. Further, female shelter staff could also be subjected to gender-based violence in the workplace.

> *Verbal abuse of women in the shelter is the order of the day. You know, it's you getting called bitches and whores and all kinds of names. I remember doing bed check with somebody who kept saying [misogynistic comments] and I remember getting very upset … and getting really scared.*
>
> - shelter staff (direct service)

> *He started picking on me, verbally abusing me, using very discriminatory names toward me, derogatory names, like just very disgruntled towards women. So, he picked on the way I look or the clothes that I'm wearing and he'd be like, 'You know what? You look like a prostitute. You're a whore. Why don't you go back to your whore house?'*
>
> - adult woman experiencing homelessness

Individuals and Groups At-risk of Shelter-based Violence

Key Findings Summary

Five types of individuals and groups were perceived to be at heightened risk of shelter-based violence:

- People with mental illness and cognitive impairment
- People who use substances
- Transgender and non-binary individuals
- Black, Indigenous, and People of Colour
- Women

Consequences of Shelter-based Violence

Shelter-based violence was described by study participants as having three types of consequences: [1] injury, [2] avoidance, and [3] procedural enforcement. These are summarized in the figure below and then subsequently described in more detail. The arrows in the figure denote that injury from shelter-based violence increases the likelihood of subsequent avoidant behaviours and programmatic responses (i.e., service restriction or police/legal involvement).

Injury occurred primarily in the forms of physical or psychological injuries for both service users and shelter staff. Physical injuries referred to the various types of bodily harm, whereas

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psychological injuries included shock, fear, hypervigilance, and other related trauma symptoms. Property damage was discussed less frequently, though shelter staff and key informants recognized that property damage could have associated financial impacts for shelters. Injuries increased the risk of avoidant behaviours, which were another consequence of shelter-based violence.

> *I had a situation where one of my staff was grabbed by the throat and then brought to the floor. And it took like 10 police officers and the clients helped the staff, but it was really violent.*
>
> - key informant (shelter operator)

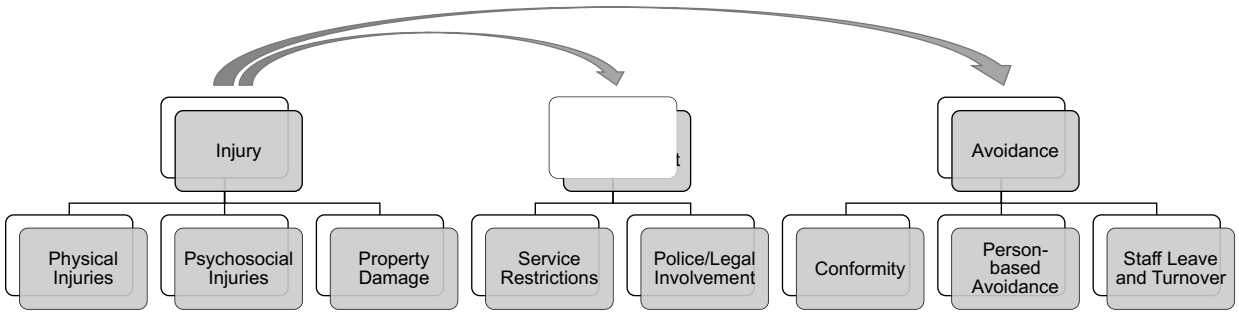
> *I was just in shock. I didn't call anybody and tell anybody about it, just because I was, like, this isn't my life. I'm not the girl that gets into fights with people .*
>
> - adult woman experiencing homelessness

Avoidant behaviours occurred in several forms: conformity (avoidance of one's identity to reduce risk of further victimization), person- and place-based avoidance (avoidance of individuals or locations associated with past violence), and staff leave and turnover (occupational avoidance by shelter staff). With regard to conformity, this was principally reported by 2SLGBTQ+ service users who had experienced gender- or gender-identity based violence. This finding is consistent with a robust body of past research (Kerman et al., 2023). Person- and place-based avoidance, when experienced by service users, could involve their avoidance of specific shelters or the shelter system altogether due to safety concerns. Relatedly, shelter-based violence could lead staff to take leaves of absence or leave their job altogether.

> *It made me paranoid because I wouldn't know where he is. Like, I knew he would access the other drop-in, which is why I didn't go, and I knew which shelter he was staying at, so I wouldn't go to that part of the city, in case I did see him.*
>
> - female youth experiencing homelessness

> *I'm not at the shelter anymore because of that, so – yes, I come in at weird hours now, just to make sure he doesn't see me coming and going out, which is honestly not fair.*
>
> - nonbinary youth experiencing homelessness

> *We've had some very serious incidents and staff have been off on WSIB for an extended period of time.*
>
> - shelter staff (direct service)



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Procedural enforcement referred to the actions taken by shelter staff and agencies following shelter-based violence. Injury was described as increasing the likelihood of procedural enforcement consequences, though these could also occur in the absence of injuries. Procedural justice primarily involved the administration of a service restriction to the service users involved in the violent incident. The involvement of police or legal action was reported to occur less often. Police involvement was reportedly more likely in shelters with workplace policies that prohibited or discouraged direct intervention by shelter staff, leading the police to be called in response to violent incidents.

Consequences of Shelter-based Violence[28]

Key Findings Summary

- Shelter-based violence can cause physical and psychological injuries, as well as avoidant behaviours for both service users and staff.
- 2SLGBTQ+ individuals may also hide their gender and sexual orientation identities in shelters to avoid further victimization.
- Shelter agencies were described as primarily responding to violence through the use of service restrictions.

Key Components of Violence Prevention in Shelters

This section describes violence prevention policies and practices as discussed in the qualitative interviews with shelter staff, key informants, and service users, with a focus on those that were perceived to be most important. The extent to which these approaches were used in shelters varied, with many barriers to implementation being described. As such, the violence prevention policies and practices identified here reflect a more idealistic set of approaches for which shelters can strive.

Embedding all of the policies and practices outlined below within trauma-informed, anti-oppressive, and anti-racist frameworks was underscored. Although these frameworks were not described in detail, study participants generally noted that this work was ongoing and were supportive of its continued implementation.

> *"The research around trauma-informed care is that it can reduce incident reports in a huge way and so we're working hard to integrate that into our approach."*
>
> - key informant (policymaker)

> *"In the past, a lot of brutal racism was expressed. We now have a confronting anti-Black racism initiative, which I believe has been a long time in coming."*
>
> - shelter staff (shift supervisor)

Staff training and engagement of service users were identified as being fundamental for the prevention of shelter-based violence. This included ensuring that shelter staff receive timely

[28] It should be noted that the identified consequences of shelter-based violence were principally limited to individual-level impacts. However, shelter-based violence may also have broader social implications in the forms of homelessness-related stigma perpetuation and community resistance to new housing and shelter builds. These warrant some consideration in relation to shelter-based violence.

and in-person training on violence prevention, including de-escalation skills. In contrast, online training options in this area were often criticized by shelter staff as being inadequate. For one key informant whose agency operated a purchase of service shelter, wage inequality in the shelter system was a barrier to staff retention following training completion, making it more difficult to consistently have well-trained direct service staff: "The city shelters take all our staff. We train them, they hire them. We lose them weekly."

> *I feel like any training I've ever really done, other than Naloxone training, it's all online based, which you have to do from work, and like you have like an external ear set, you can't hear out of the work computer. So, you're kind of just like reading the captions while watching the screen, while dealing with clients popping in and out, so you're not really concentrating. I think, when it comes to like a first aid, or like a WHMIS, fine, but when you're dealing with like how to like de-escalate people, [it's important for training to be] hands-on.*
>
> - shelter staff (direct service)

The role of staff in violence prevention was also discussed in the context of how they engaged service users. Staff presence and availability throughout the shelter was described as important for detecting early issues. This included checking-in with service users and building the working relationship, so that service users felt comfortable approaching staff when in need. Further, given that shelters could be frenetic environments at times, the importance of maintaining a consistent staff presence to foster a sense of stability and certainty was also highlighted.

> *We also make sure that we have regular engagements with our clients to give them the sense that we're there to support them.*
>
> - shelter staff (direct service)

> *Be on the floor, and monitor, and just keep an eye on individuals … we do 20-minute walks, so you're getting out and seeing most people every 20 minutes, just looking for those shifts in behaviour. And then, again, if you're a good staff, you would maybe take that person aside and say, 'Is everything okay? Take a little walk to the dining room, or maybe go out for a smoke, or let's do something that gets you out of the situation that's causing whatever behaviour since the last time I've seen you,' that would be the best preventative measure. It's just to try and see the signs before that happens, and then see what you can do to de-escalate a person.*
>
> - shelter staff (management)

> *When you see staff come checking-up on the clients, that's a very comforting feeling … it's reassuring when you just see staff run around, 'Hey, how are you?' 'Are you good today?'*
>
> - adult man experiencing homelessness

> *I can see some staff will walk around here every hour and I really appreciate that.*
>
> - older adult man experiencing homelessness

Supporting service users to engage in social and recreational activities, or participate in their communities was discussed as beneficial for preventing violence resulting out of boredom, especially among youth: "Engagement is having things for people to do. When people have nothing to do, then that in itself can build up opportunities for violence. So, if it's programming, discussions, meetings with clients, like having them engaged in things other than, 'I'm stuck in this shelter, I have no money and nothing to do.'"

Other important approaches for preventing shelter-based violence included: transparent shelter rules, policies, and expectations; critical

incident documentation, debriefing, and use of safety plans; and access to mental health supports. With regard to shelter policies on violence prevention, the importance of communicating this to service users upon intake was emphasized, as was ensuring that staff are well-familiar with these policies. However, the latter was identified as a barrier to their use due to staff shortages and quiz-based online trainings that could be completed without learning relevant materials.

> *Like any policy, it only is effective if people are aware of it and are doing what they're supposed to be doing. So, I'm quite aware of the workplace violence policy and the workplace violence prevention initiatives that we use here … with these policies, this is mainly a shift leader duty. So, how often are shift leaders aware of this and use it in practice? I would say probably not as often as they should … [because], generally, there's a lot of things going on. Oftentimes, there's staff shortages, shift leaders are taking on a lot more work now. So, being aware of everything can be taxing.*
>
> - shelter staff (shift supervisor)

> *I would get to the questionnaire, and I would answer the questions because I know the answers before properly reading through the [violence prevention policy] document again … it's basically a paper exercise. There's no real benefit to doing that, unless you're gonna sit down with someone and do a one-on-one, and with the size of our organization, that's impossible.*
>
> - shelter staff (management)

Critical incident documentation, debriefing, and use of safety plans were described by many shelter staff as other important components of their agency's practices for understanding how past violent incidents occurred, and identifying alternative approaches and support needs to prevent future ones. Use of safety plans was most frequently discussed in relation to service users returning to the same shelter often following violent incidents and service restrictions. However, consistent implementation of these practices was again identified as an issue by some study participants.

> *Like somebody was discharged for violence, some process, now they come back, that would be flagged and there would be a particular sort of service plan, interaction plan drawn up for them … trying to understand what was the trigger, what had happened, what commitments they'll make, what we're going to make, and have a sort of agreement to go forward like that.*
>
> - key informant (shelter operator)

> *You have different things like you document the incident, you're supposed to have a debrief … they're supposed to do all that. So I mean, on paper, it looks great but, in practicality, it's just it's not there, you know what I mean? Nobody follows it.*
>
> - shelter staff (direct service)

The importance of access to mental health supports for service users was also raised in the context of violence prevention, with many study participants calling for more services to be embedded onsite in the shelter system. Improving access to psychiatric services, especially in smaller shelters, was noted as an important need. Without sufficient access to mental health supports, shelter staff sometimes felt like they were de facto counsellors, despite a lack of sufficient training. Shelter staff also described predicaments where they were unable to support service users in accessing mental health services, resulting in difficult situations to problem-solve: "There's an individual on the floor where my office is who screams maybe like 4-5 hours a day, roams the halls, and is incredibly unwell. There's nothing that we can do because

he doesn't hit any threshold for a Form, he doesn't want to engage with the medical support, but, were psychiatrists onsite, you know, we could work on that engagement process slowly, introducing them and just developing some trust."

Shelter staff and key informants also discussed other policies and practices, such as service user belonging searches and the presence of security guards, in relation to violence prevention. However, study participants had mixed views on their effectiveness or concerns about their use. With regard to service user belonging searches, many study participants reported that their programs did not use this practice or did so selectively. Some study participants expressed skepticism about whether the potential harms (e.g., mistrust, shelter avoidance, intrusiveness) outweighed the benefit (weapon and other contraband detection). The importance of identifying service users with a history of firearm possession in the shelter system was discussed, but other methods for achieving this without searching the belongings of all service users upon entry were noted as well: "If you're a client that has been found to have a gun in a previous shelter, then I think you need a flag on SMIS. We should know that. I wouldn't want to see us going through every person's bag at admission."

> *"[There is risk in] this concept of checking things. Whether you're checking-in weapons, or checking-in prohibited items, or checking-in alcohol or drugs, that we want to encourage people to come indoors. Of course, people do not want to part with their possessions, their protection for being street-involved and on the street. So how do you manage that risk … [with] creating a low-barrier service that people feel safe to come into?"*
>
> - key informant (policymaker)

Mixed views were also expressed with the presence of security guards in shelters. In general, security guards were not perceived to have a key role in preventing violence, but had a more impactful role when intervening in violent incidents. However, the lack of gender diversity in security teams was also described as a barrier for women accessing support following gender-based violence: "The security is almost entirely male and there is a significant amount of sexual assaults that are being taken place against women, primarily, and as a result, the women who are assaulted don't have many allies that they can identify with to go to for support." Some staff working in shelters with security reported that they do not intervene in ongoing violence and instead call security. As such, perspectives on the utility of security may vary based on how shelter staff see their own roles in violence prevention and intervention. As previously mentioned, some shelter staff and key informants also had concerns about security guards' training and sensitivity with a population that has high rates of trauma.

On security guards:

> *"Not well prepared, not well trained. Can't really interview. I mean if you just need somebody to station at the door, I guess, to check IDs and 'Are you on the list?' 'Yes.' 'OK, you can come in.' Like that's what security can do, but I don't think they're at all effective in violence prevention."*
>
> - key informant (shelter operator)

> *"We also have security onsite … they step in if a fight is breaking out … as far as I'm concerned, if a fight is breaking out, you call 9-1-1 and you call security. You don't need to be a hero."*
>
> - shelter staff (management)

Service users also had mixed experiences with security, though few were adamantly opposed to

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their presence in shelters.[29] However, service users stressed the importance of security having adequate training, and being accessible to and familiar with service users. Thus, service users had similar expectations for security as they did for shelter staff. Overall, some service users felt security was beneficial for feeling safe in shelters, whereas others perceived them as having limited impacts on this. These findings likely underscore the diversity of people experiencing homelessness who use the shelter system and some differing needs for achieving a sense of safety.

> *"You can't get in the building past security. That's the best that they do. They're at the front. They monitor who's coming in. That's all, but I actually like the security a lot. I respect them a lot. I really got to be very friendly with all of them."*
>
> - adult man experiencing homelessness

On security guards being in shelters:

> *"It would be more antagonistic."*
>
> - older adult man experiencing homelessness

On security guards being in a previous shelter:

> *"It was okay. It was sometimes a little weird because I don't usually see that."*
>
> - adult woman experiencing homelessness

Key Components of Violence Prevention in Shelters

Key Findings Summary

- Staff training and engagement of service users were perceived as fundamental for the prevention of shelter-based violence. This included ensuring that staff: have adequate training and make use of de-escalation skills, are focused on building relationships with service users, are visible and accessible to service users in the shelter, and support service users to engage in social and recreational activities.
- Other important approaches for preventing shelter-based violence included: transparent shelter rules, policies, and expectations; critical incident documentation, debriefing, and use of safety plans; and access to mental health supports.
- Service user belonging searches and the presence of security guards were seen as less beneficial for violence prevention.
- It is essential for violence prevention policies and practices to be embedded within trauma-informed, anti-oppressive, and anti-racist frameworks.

[29] As many of the service users who participated in this study were staying in shelters that had security, these findings may be biased toward more positive perceptions of this role. Thus, some caution is warranted in the interpretation of these findings.

Service Restrictions

Rates, Causes, and Durations of Service Restrictions in the Shelter System

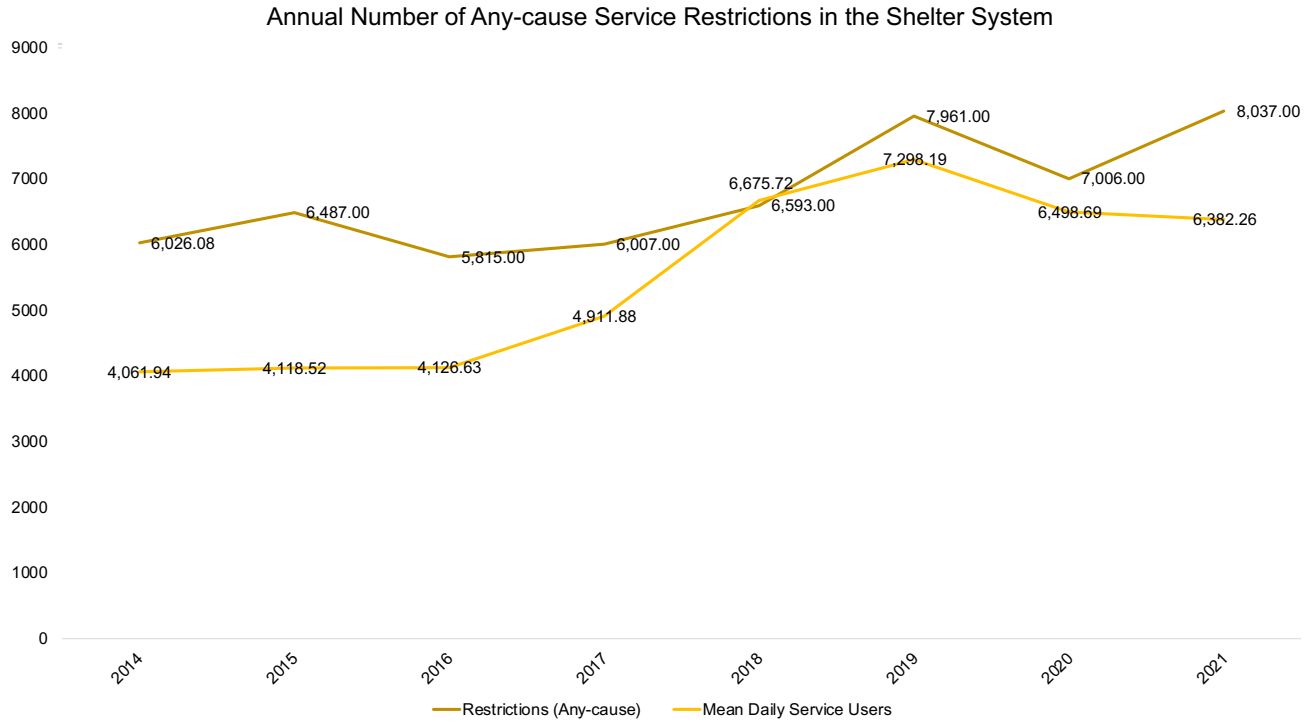
This section uses SMIS data to describe trends in service restriction rates, causes, and durations, in the shelter system over time, including differences by sector and restriction causes.

Service restriction data from August 1, 2014 to December 31, 2021 were analyzed.[30] For annual service restriction rates in 2014, an estimate for the full year was computed from the partial data, hence the rates for this year being decimalized.[31] Seasonal effects on service restrictions were not controlled for in this computation.

Total Service Restrictions in the Shelter System

From 2014 to 2021, the annual number of any-cause service restrictions increased by 33.4% across the shelter system. The trend in service restrictions generally mirrored the number of mean daily service users over this period, with the exception of 2021.[32] There was a 14.7% increase in service restrictions in 2021 from the previous year, whereas the number of service users decreased slightly.

A linear regression model was conducted to examine whether the increased rate of any-cause service restrictions was statistically significant. The analysis controlled for the number of daily service users in the shelter system, season of the year, extreme weather



[30] Aggregated SMIS data on service restrictions from 2022-2023 were made available to the research team in mid-January 2024. These data are presented separately in Appendix A and warrant further, future analysis at the individual restriction level.
[31] Number of annual service restrictions in 2014 = (number of service restrictions from August 1-December 31 2014 ÷ 153) x 365.
[32] The number of daily service users in the shelter system is often used in data analyses and interpretation for the purpose of considering the extent to which changes in service restriction rates could be attributable to changes in the number of daily service users (i.e., the extent to which increases or decreases in restriction rates could be explained by more or less people served in the shelter system, respectively).

Service Restrictions

alerts, and pandemic onset, which means that changes in the service restriction rate over time are not attributable to the number of daily service users in the shelter system, season of the year, presence or absence of an extreme weather alert, or pandemic. Findings showed a significant increase in the any-cause service restriction rate between August 1, 2014 and December 31, 2021 ($B = .17$; $p < .01$).[33,34]

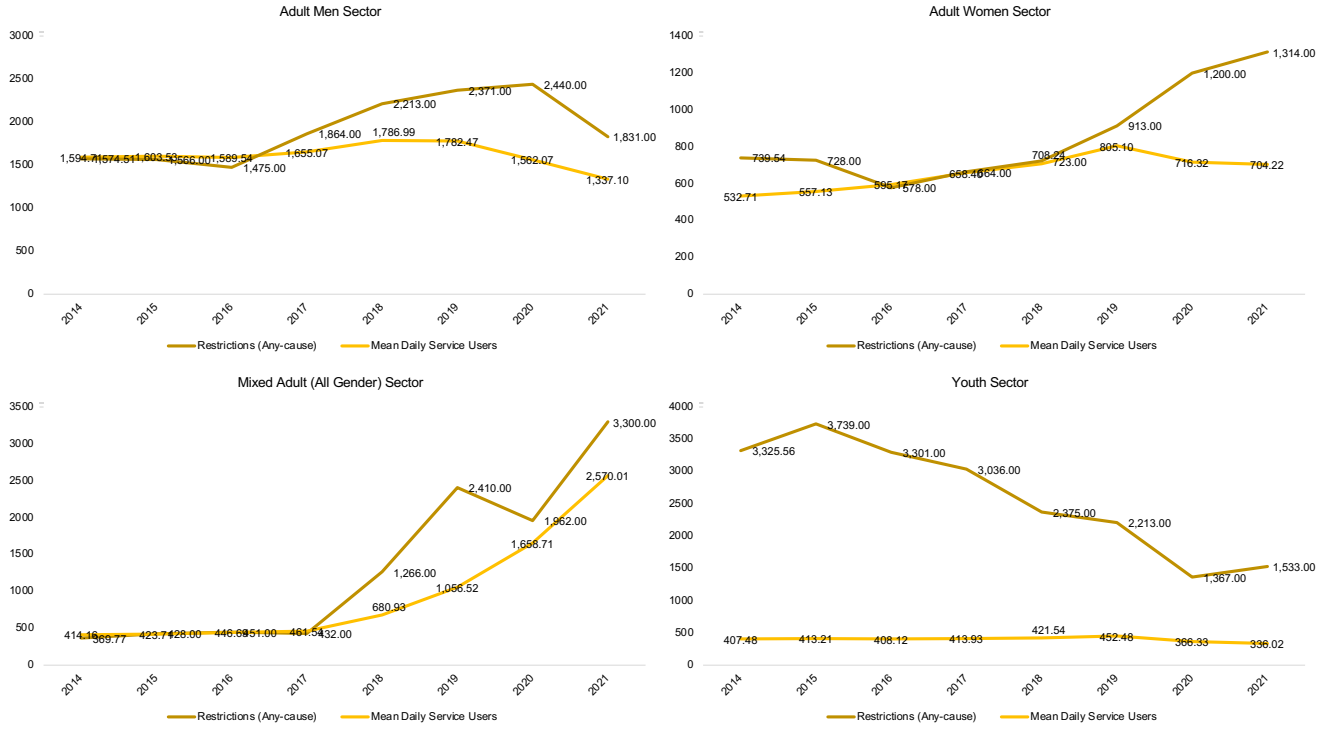
The number of service restrictions per 1,000 service users was also computed to examine rates between sectors.[35] As shown in the table on the right, the rate of service restrictions in the Youth sector between 2014-2021 was many times higher than the three adult sectors.

Rate of Any-cause Service Restrictions Per 1,000 Service Users Between 2014-2021

Sector	% of Total Service Restrictions (50,432)	% of Total Program days (248,557)	Rate per 1,000 Service Users
Adult Men	28.6	28.7	3.29
Adult Women	12.7	18.1	3.54
Mixed Adult (All Gender)	20.6	15.3	3.81
Youth	37.6	11.3	17.40

However, use of service restrictions in the Youth sector over this period was trending downward. As shown in the figure below, there was a 63.4% reduction in the annual number of service

Annual Number of Any-cause Service Restrictions by Sector



Note: The Y-axes of the four graphs have differing scales.

[33] As shown in Appendix A, there was a sharp decrease in the number of any-cause service restrictions in 2022 and 2023, which would likely nullify the significant increase reported here if these data were analyzed in greater depth at the individual restriction level.
[34] *B* is a standardized regression coefficient, which can be used to measure effect size. The larger the B statistic, the larger the magnitude of the effect of time on the restriction rate. Effect sizes of .19 or smaller are considered small, .20-.49 are medium, and .50 or higher are large (Fey, Hu, & Delios, 2023).
[35] Service restriction rate per 1,000 service users = [number of service restrictions ÷ (mean number of daily service users x number of operational program-days)] x 1,000.

Service Restrictions

restrictions in the Youth sector from 2015 to 2020, followed by an increase of 12.1% in 2021 from the previous year. In contrast, the number of daily service users remained fairly stable over this period, indicating that the sector's large reduction in service restrictions over most of the past decade is not attributable to there being fewer youth service users.

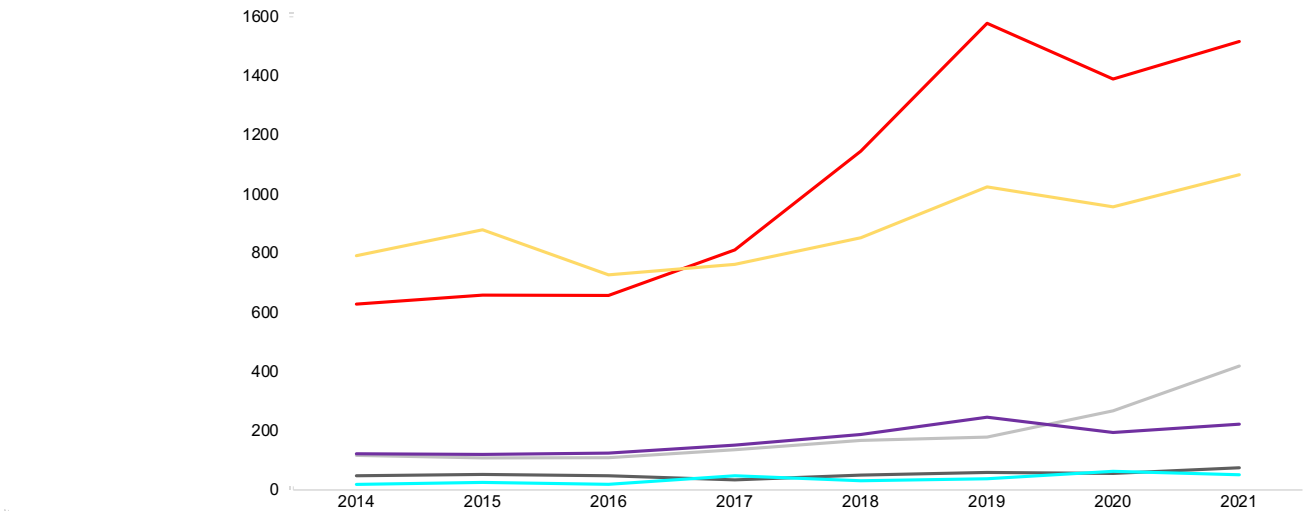
Divergent patterns were found in the adult sectors. In the Adult Men sector, there was 65.4% increase in service restrictions from 2016 to 2020, followed by a decrease of 25.0% in 2021 from the previous year. Restrictions also increased in the Mixed Adult (All Gender) sector from 2018 onward, with the exception of a brief decline in 2020. Although the daily number of service users in the Mixed Adult (All Gender) sector also increased substantially over this period, there was a sharper rise in the number of service restrictions.

In the Adult Women sector, the number of service restrictions and daily service users increased at a very similar rate in 2017 and 2018; however, service restrictions have continued to rise at a much greater rate from 2019 to 2021. Overall, service restrictions in the Adult Women sector increased 77.7% from 2014 to 2021, whereas the number of daily service users increased 32.2% over the same period.

Causes for Service Restrictions

Fifteen reasons for service restriction are presented in SMIS. Some of these categories were similar or overlapped with others, allowing several to be merged (e.g., "assault of client" and "assault of residents, volunteers, or staff" were merged to create a measurement of "assault"). Reasons for service restriction are discussed in three groups: [1] violence and potential victimization (i.e., assault; violent or threatening behaviour; weapon use or firearm possession; property damage; theft; drug trafficking); [2] non-violent causes (i.e., case plan non-adherence or non-engagement; repeated rule violations; contraband or illicit substance possession); and

Annual Number of Service Restrictions for Violence and Potential Victimization Reasons in the Shelter System



	2014	2015	2016	2017	2018	2019	2020	2021
Assault	627.42	658	657	811	1145	1578	1389	1516
Violent or Threatening Behaviour	792.03	880	727	763	852	1025	957	1066
Property Damage	116.89	108	109	136	167	178	267	419
Weapon Use/Firearm Possession	47.71	52	48	34	50	59	56	75
Theft	121.67	120	125	151	187	246	194	222
Drug Trafficking	19.08	25	19	48	31	38	63	51

Service Restrictions

Rate of Service Restrictions Per 1,000 Service Users Between 2014-2021 by Cause and Sector

Sector	% of Total Program days (248,557)	Assault		Violent or Threatening Behaviour		Weapon Use or Firearm Possession	
		% of Total Service Restrictions (8,017)	Rate per 1,000 Service Users	% of Total Service Restrictions (6,602)	Rate per 1,000 Service Users	% of Total Service Restrictions (394)	Rate per 1,000 Service Users

Sector	% of Total Program days (248,557)	Property Damage		Theft		Drug Trafficking	
		% of Total Service Restrictions (1,433)	Rate per 1,000 Service Users	% of Total Service Restrictions (1,296)	Rate per 1,000 Service Users	% of Total Service Restrictions (283)	Rate per 1,000 Service Users
Adult Men	28.7	32.4	0.11	24.9	0.07	52.3	0.03
Adult Women	18.1	15.8	0.12	16.1	0.12	2.8	<0.01
Mixed Adult (All Gender)	15.3	31.3	0.16	26.1	0.12	30.0	0.03
Youth	11.3	19.1	0.25	32.7	0.39	14.8	0.04

[3] ambiguous or unknown causes (i.e., behaviours that compromise the health and safety of service users, volunteers, or staff; disruptive behaviour; "other" reason).[36]

Violence and Potential Victimization

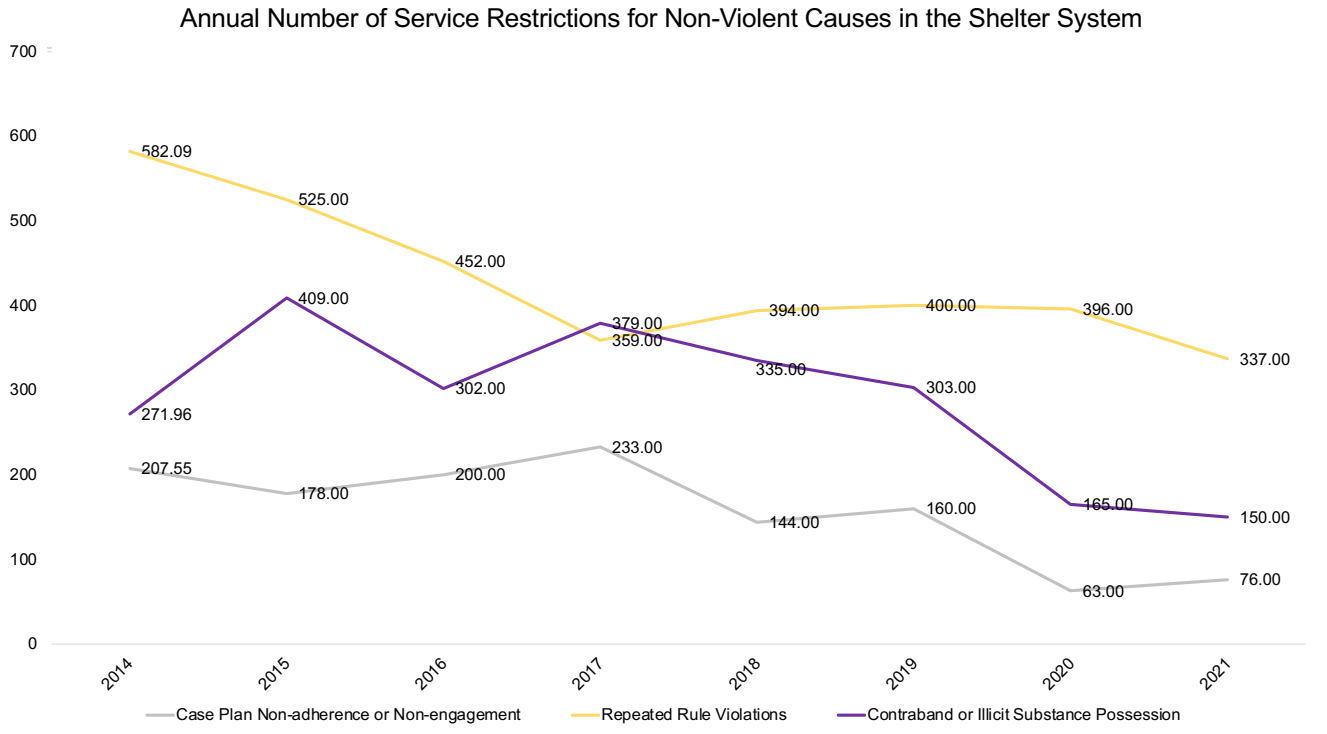
Service restriction rates for reasons related to violence and potential victimization generally showed an upward trend from 2014 to 2021. Service restrictions for assault (141.5% increase from 2014-2021; $B = .46$; $p < .001$), theft (82.5% increase from 2014-2021; $B = .23$, $p < .001$), property damage (258.5% increase from 2014-2021; $B = .16$, $p < .001$), violent or threatening behaviour (34.6% increase from 2014-2021; $B = .12$, $p < .001$), and drug trafficking (167.3% increase from 2014-2021; $B = .08$, $p < .01$) each significantly increased over this period.[37]

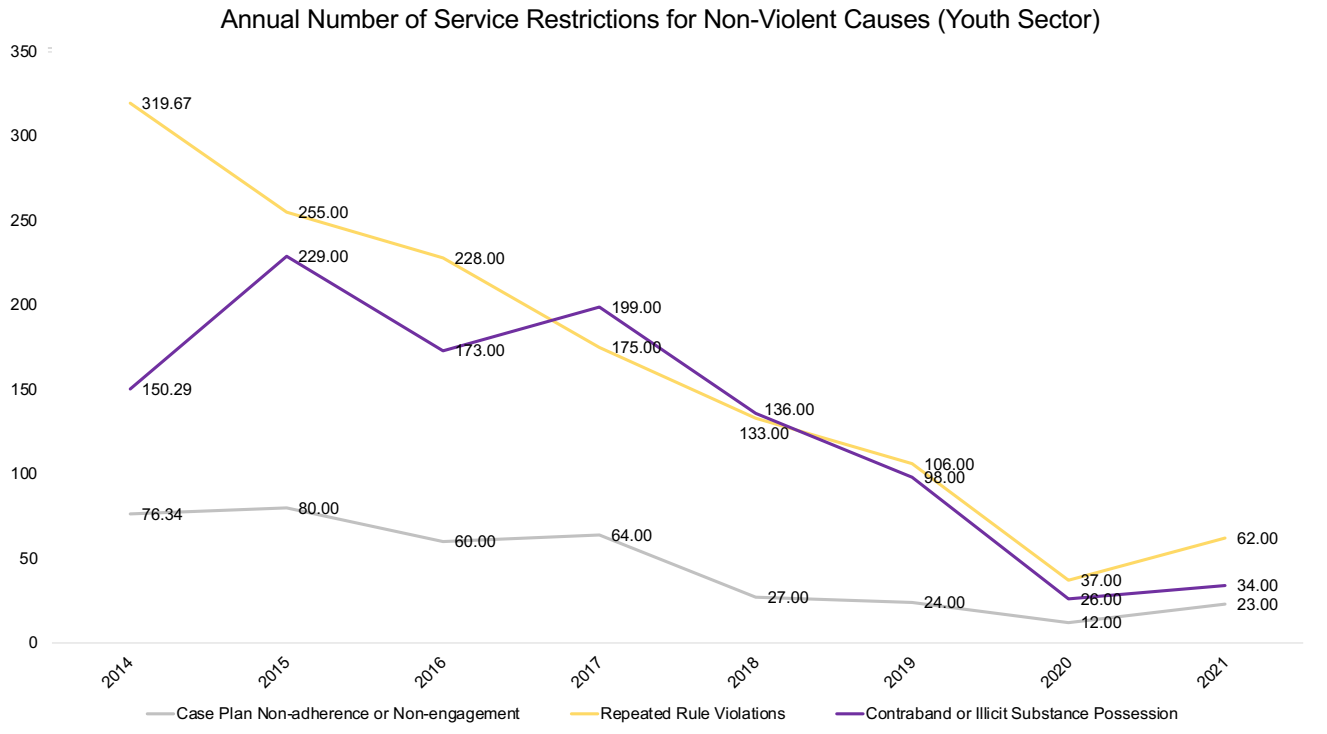
Restrictions for weapon use/firearm possession did not significantly change over time.

The rate of service restrictions for violence and potential victimization per 1,000 service users was also computed to examine similarities and differences between sectors. As shown in the table above, rates per 1,000 service users from August 1, 2014 to December 31, 2021 were highest in the Youth sector for each restriction reason. Rates were generally similar between the three adult sectors, with the exception of assault, which was higher in the Mixed Adult (All Gender) sector than the Adult Men and Adult Women sectors.

[36] The delineation between violence and potential victimization, and non-violent causes is imperfect, as some incidents in the former category may not always include victimization, whereas some incidents in the latter category may include victimization.
[37] As shown in Appendix A, the number of service restrictions for many of these violence and potential violence reasons decreased in 2022 and 2023, which would likely nullify some (but not all) of the significant increases reported here if these data were analyzed in greater depth at the individual restriction level.

Service Restrictions





Service Restrictions

Not-Violent Causes

In contrast to restrictions involving violence and potential victimization, restriction rates for non-violent causes showed a downward trend from 2014 to 2021. Service restrictions for repeated rule violations (42.1% decrease from 2014-2021; $B = .12$, $p < .001$) and case plan non-adherence or non-engagement (63.38% decrease from 2014-2021; $B = .06$; $p = .05$) both significantly decreased. Restrictions for contraband or illicit substance possession also decreased, though the change was non-significant.[38]

Similar to service restrictions for reasons involving violence and potential victimization, the service restriction rate for non-violent causes per 1,000 service users was higher in the Youth sector. Between the three adult sectors, rates were lowest in the Mixed Adult (All Gender) sector for each type of non-violent restriction.

Although the Youth sector had the highest restriction rate per 1,000 service users for non-violent causes, there was again a downward trend in these restrictions over time. Thus, the Youth sector has historically had greater use of service restrictions for non-violent causes, but this has begun to change in recent years.

Ambiguous or Unknown Causes

Of the 50,432 service restrictions between 2014 and 2021, 24,006 (47.6%) had ambiguous or unknown causes. The ambiguity is partially attributable to the lack of operational definitions for the service restriction categories. Further, "behaviours that compromise the health and safety of service users, volunteers, or staff" and "disruptive behaviour" are broad, yielding the potential for these SMIS categories to be used for a wide range of service restrictions.

A random selection of 25 anonymized service restriction descriptions categorized as "behaviours that compromise the health and safety of service users, volunteers, or staff" from 2021 were analyzed to determine if the reasons for restriction qualitatively differed from other categories. Almost all 25 restrictions were for behaviours coverable by other categories:

- Onsite substance use (7 restrictions)
- Threatening behaviour (5 restrictions)
- Sexual harassment (3 restrictions)
- Property damage (2 restrictions)

Rate of Service Restrictions Per 1,000 Service Users Between 2014-2021 by Cause and Sector

Sector	% of Total Program days (248,557)	Repeated Rule Violations		Case Plan Non Adherence or Non Engagement		Contraband or Illicit Substance Possession	
		% of Service Restrictions (3,107)	Rate per 1,000 Service Users	% of Service Restrictions (1,141)	Rate per 1,000 Service Users	% of Service Restrictions (2,157)	Rate per 1,000 Service Users
Adult Men	28.7	35.0	0.25	44.9	0.12	45	0.22
Adult Women	18.1	15.1	0.26	19.1	0.12	5.9	0.07
Mixed Adult (All Gender)	15.3	13.3	0.15	4.1	0.02	4.7	0.03
Youth	11.3	36.4	1.04	28.2	0.30	44.4	0.88

[38] As shown in Appendix A, service restrictions for contraband or illicit substance possession continued to decrease in 2022 and 2023, and it is possible that this may be approaching the threshold for a significant decrease if these data were analyzed in greater depth at the individual restriction level.

Service Restrictions

- Verbal abuse (2 restrictions)
- Disruptive/inappropriate behaviour (2 restrictions)
- Legal conditions (1 restriction)
- Human trafficking (1 restriction)
- Public urination (1 restriction)
- Weapon use (1 restriction)

A total of 23.0% of all service restrictions between 2014 and 2021 were categorized as "other" – more than any other reason for restriction. However, use of this category greatly varied across the shelter system, with two shelter programs accounting for 8,026 (69.3%) of all "other" restrictions. A random selection of 100 anonymized service restriction descriptions categorized as "other" from these two programs in 2021 were analyzed to determine if the restriction reasons differed from other categories. Almost half of the 100 descriptions involved short service restrictions, often 1-3 days in length, for failing to return to the shelter, leaving unexpectedly, or acquiring housing/shelter elsewhere. Other commonly given reasons overlapped with other categories (e.g., threatening behaviour; disruptive/inappropriate behaviour; substance intoxication or possession; onsite substance use; rule non-adherence; property damage; and verbal abuse).

Additional analyses were not performed on the ambiguous or unknown cause service restrictions due to the high risk of generating equivocal and unreliable findings. Further, the use of these categories undermines confidence in some other observed trends. For example, although there was a non-significant decrease in the use of service restrictions for contraband and illicit substance possession, it is possible that such restrictions are being categorized by some shelter staff using one of the ambiguous or unknown cause categories. This would mean that the size of the reduction described previously could be an overestimation.

Service Restriction Durations

Analyses were conducted to explore the duration of service restrictions, including differences by service restriction reason, between sectors, and over time.

As shown in the table on the next page, service restrictions for reasons related violence and potential victimization, on average, ranged from slightly over one month to over two months. Restrictions for non-violent causes were shorter in duration, averaging approximately one month or less. However, as evidenced by the large standard deviation statistics, which measure data dispersion, there was considerable variation in service restriction durations. This was the case for all sectors and reasons for service restriction.

One-way analyses of variance (ANOVAs) were performed to examine whether the differences in service restriction durations by sector, as seen in the table on the next page, were statistically significant. Each ANOVA revealed significant differences between sectors, suggesting variability in service restriction decision-making. Restrictions involving violence and potential victimization tended to be significantly shorter in the Mixed Adult (All Gender) sector and longer in the Adult Men sector compared to other sectors. Drug trafficking was an exception to this trend, as restrictions for this reason were significantly longer in the Youth sector compared to the Mixed Adult (All Gender) and Adult Men sectors.

As for restrictions for non-violent causes, a different pattern was observed. Restrictions for repeated rule violations, contraband or illicit substance possession, and case plan non-adherence or non-engagement were shortest in the Youth sector compared to the other sectors.

Service Restrictions

Mean Service Restriction Durations in Days by Reason and Sector

Service Restriction Reason	All Sectors		Adult Men		Adult Women		Mixed Adult (All Gender)		Youth	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Weapon use/firearm possession	67.98	76.52	99.28	92.17	65.05	48.09	53.07	58.99	55.29	71.43
Assault	52.27	60.68	61.06	66.50	58.95	59.16	38.48	51.74	56.52	61.87
Violent/ threatening behaviour	50.00	53.59	63.54	64.01	49.01	43.39	36.93	47.04	45.23	45.78
Drug trafficking*	49.58	60.29	51.26	47.48	-	-	31.54	39.96	78.43	108.92
Property damage	44.08	45.69	54.91	51.45	46.08	35.86	37.40	44.59	33.41	40.74
Theft	32.91	40.65	51.65	51.55	30.18	36.59	19.86	25.94	30.26	37.72
Case plan non-adherence/non-engagement	30.96	36.26	37.24	38.17	40.66	34.55	34.38	34.01	9.99	22.41
Contraband/ illicit substance possession	30.37	38.97	43.90	47.32	32.30	26.19	12.86	25.18	18.19	25.02
Repeated rule violation	20.48	35.66	33.73	49.77	21.67	23.26	13.89	19.57	8.90	14.50

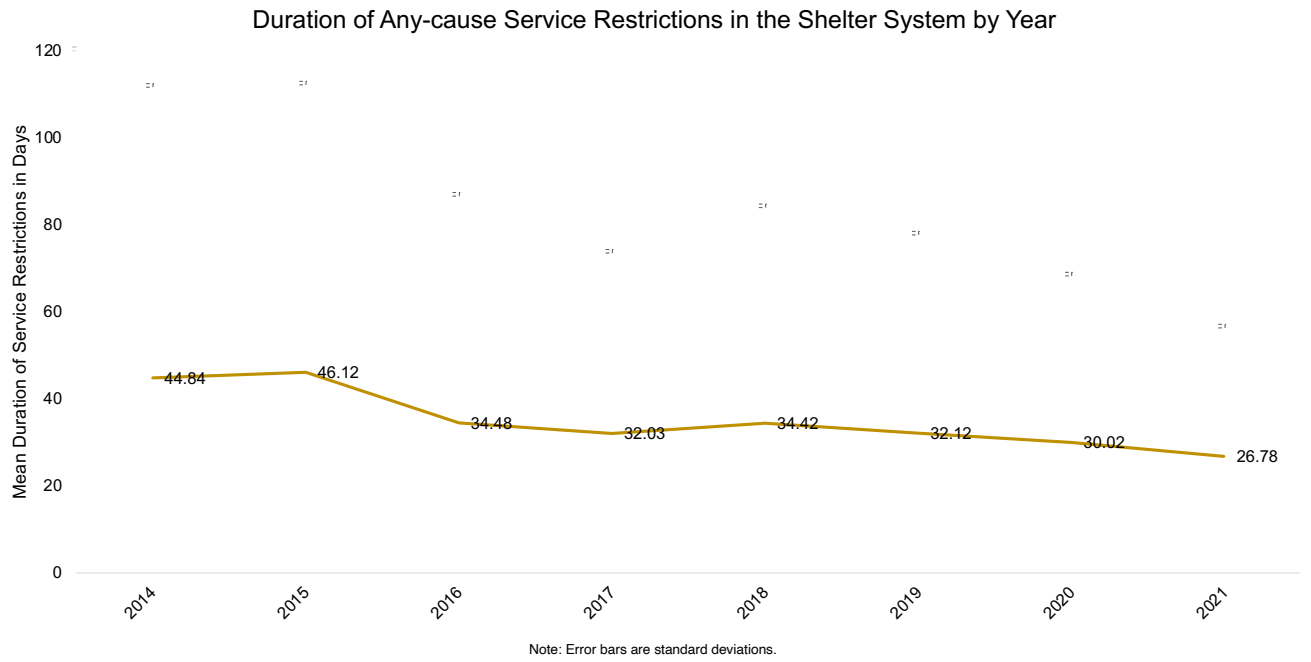
The Adult Men sector also had significantly longer restrictions for repeated rule violations, and contraband or illicit substance possession than the Mixed Adult (All Gender) and Adult Women sectors.

The mean length of service restrictions has changed over time. As shown in the figure on the next page, restrictions averaged approximately 45 days in length during 2014 and 2015, and then decreased to an average of slightly more than one month in duration during 2016-2019. The decrease observed in 2016 is likely attributable to an update of the Toronto Shelter Standards, which occurred in September 2015. In that update, a new standard was added that required service restrictions lasting longer than three months to be reviewed and approved by the Toronto Shelter & Support Services (TSSS) Division.[39] In 2020 and 2021, service restriction durations decreased further, reaching an average of less than 30 days in the most recent year for which data were available.[40]

A linear regression model was conducted to examine whether the changes in service restriction duration between August 1, 2014-December 31, 2021 were statistically significant. The analysis controlled for the season of the year and pandemic onset, which means that changes in mean service restriction duration over time are not attributable to changes in season of the year or the pandemic. The linear regression model showed that the duration of service restrictions has significantly decreased over time (mean duration decreased by 18.06 days from 2014-2021; $B = .13$, $p < .001$).

[39] Per information provided by TSSS staff directly to the research team, around 2016, TSSS also began engaging in active follow-up with shelter agencies in response to lengthier service restrictions that appeared to misalign with the severity of the critical incidents, as assessed in documented information. These actions may have also contributed to a reduction in the duration of service restrictions around this time.
[40] As shown in Appendix A, any-cause service restriction durations increased slightly in 2022 and 2023, averaging approximately one month in length during these two years.

Service Restrictions



Overall, the findings suggest that there is considerable variation in service restriction durations, including between the sectors of the shelter system. Service restrictions for reasons related to violence and potential victimization tend to be longer in duration, averaging over 1-2 months for these incidents, whereas service restrictions for non-violent causes typically last one month or less, on average. Despite the variation, service restriction durations have significantly decreased over time.

89-Day Service Restrictions

In the qualitative interviews with shelter staff and key informants, a number of study participants discussed the use of service restrictions that were 89 days in length due to the Toronto Shelter Standards requirement that all service restrictions "lasting three (3) months or longer may only be issued with the approval of SSHA" (8.6.2.m.; City of Toronto, 2023). Analyses were subsequently performed to explore whether study participants' perceptions aligned with service restriction durations registered in SMIS. A total of 440 service restrictions had an initial duration of 89 days, accounting for 0.9% of all restrictions issued between August 1, 2014-December 31, 2021.[41] As shown in the figure on the next page, there was a notable spike in service restriction durations at 89 days, though this was considerably smaller than the 4,784 restrictions given for the more well-rounded 90-day duration.

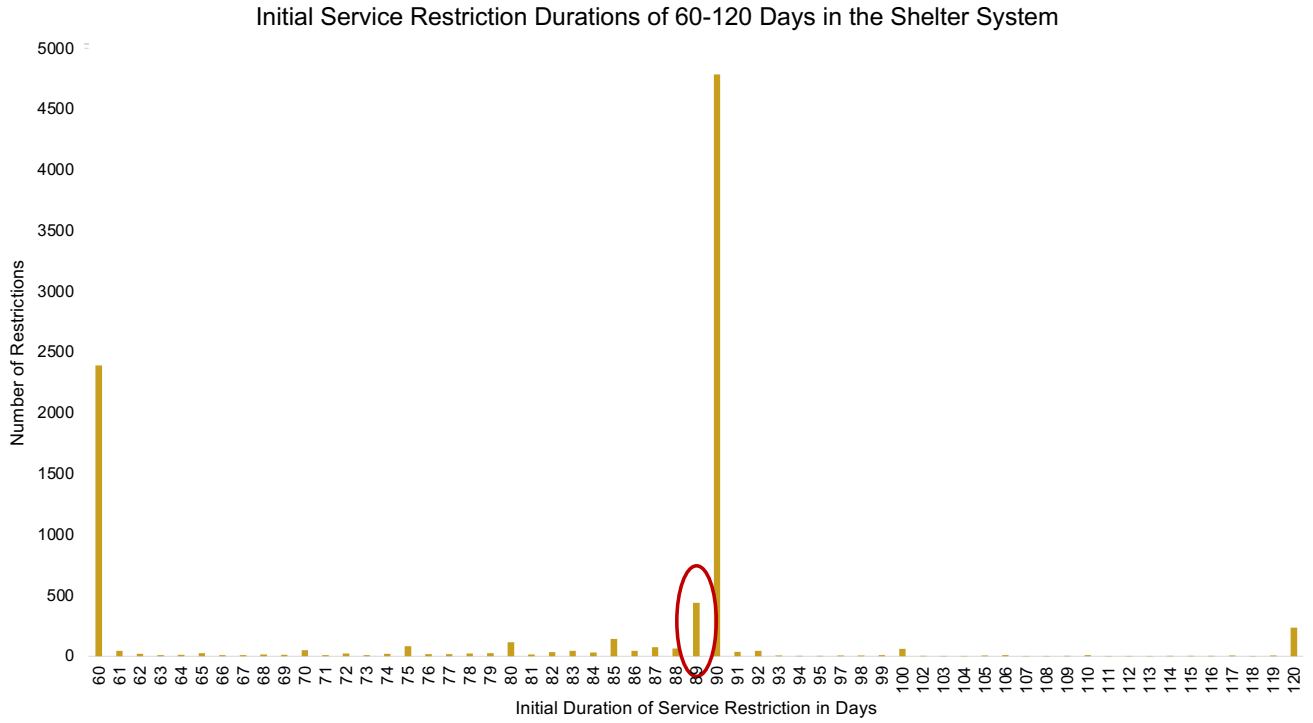
Use of 89-day service restrictions has increased in recent years. Of the 440 restrictions for 89 days, only 93 (20.2%) were given between 2015-2018; however, 64 (14.5%) were issued in 2019, 129 (29.3%) in 2020, and 154 (35.0%) in 2021.

As for the reasons for 89-day service restrictions, behaviours that compromise health and safety were most common (113 restrictions; 25.7%), followed by assault (99 restrictions; 22.5%), and violent or threatening behaviour (67 restrictions;

[41] Initial service restriction duration refers to the length of time for which a restriction is first issued, prior to any adjustments to its length (e.g., following an appeal process).

Service Restrictions

15.2%). A comparison of 89- and 90-day service restriction durations since 2019 showed that significantly more service restrictions for 89 days (8.1%) were given for disruptive behaviours than 90 days (3.7%; $\chi^2 = 13.63$, $p < .001$). Few other notable differences were found.



Rates, Causes, and Durations of Service Restrictions in the Shelter System

Key Findings Summary

- The number of any-cause service restrictions has significantly increased by 33.4% from 2014 to 2021 across the shelter system. The service restriction rate per 1,000 service users is higher in the Youth sector than the adult sectors; however, there has also been a downward trend in the use of service restrictions in the Youth sector over time.
- Whereas many service restrictions for reasons involving violence and potential victimization have significantly increased over time, service restrictions for non-violent causes have decreased.
- Frequent use of ambiguous categories for recording service restriction reasons in SMIS, such as "behaviours that compromise the health and safety of service users, volunteers, or staff" and "disruptive behaviour," as well as the overuse of the "other" category, limits a more reliable understanding of service restriction trends in the shelter system.
- Service restriction durations vary widely across the shelter system, including between sectors. Nevertheless, there has been a significant decrease in the mean duration of service restrictions between 2014 and 2021, with a marked decrease in 2016 following an update to the Toronto Shelter Standards.
- Use of 89-day service restrictions increased in 2020 and 2021, compared to previous years.

Service Restrictions

Effects of the COVID-19 Pandemic on Service Restrictions

Linear regression models were conducted on SMIS data to examine the mean number of service restrictions in the 661 days before the onset of the pandemic (May 20, 2018-March 10, 2020) compared to the first 661 days of the pandemic (March 11, 2020-December 31, 2021). The range of 661 days was selected, as data were available until December 31, 2021. Analyses controlled for the total nightly number of service users in the shelter system and the season of the year, which means that any differences found in restriction rates pre- and post-pandemic are not attributable to changes in the number of service users in the shelter system or season of the year. It was not possible to explore or adjust for differences between sectors in this set of analyses.

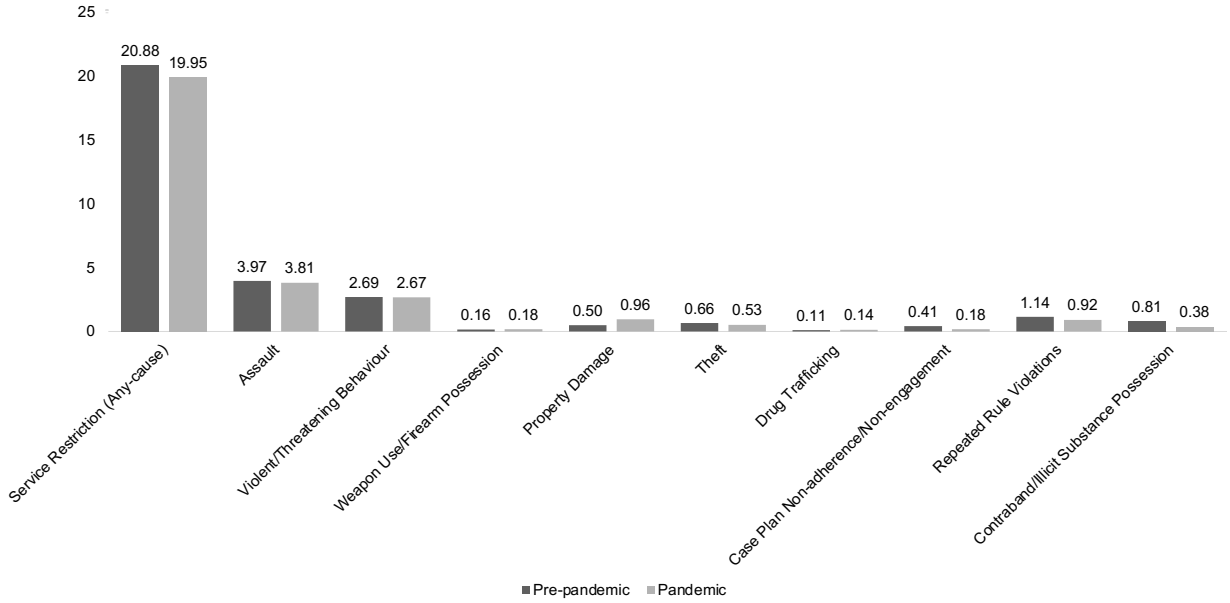
As shown in the figure below, the pandemic had varying effects on service restriction rates. The service restriction rates for reasons involving violence and potential victimization did not significantly change, with the exception of property damage, which significantly increased ($B = .13$; $p < .01$). In contrast, service restrictions for non-violent causes, including case plan non-adherence and non-engagement ($B = .19$; $p < .001$), contraband/illicit substance possession ($B = .22$; $p < .001$), and repeated rule violations ($B = .13$; $p < .01$), each significantly decreased. Overall, the any-cause service restriction rate did not significantly change during the first 661 days of the pandemic compared to the 661 days before it.

Effects of the COVID-19 Pandemic on Service Restrictions

Key Findings Summary

The pandemic had varying effects on service restrictions, with rates not significantly changing for most service restrictions involving violence and potential victimization. In contrast, restrictions for non-violent causes significantly decreased.

Mean Daily Number of Service Restrictions in the Shelter System Before and During the COVID-19 Pandemic



Service restriction (any cause) are greater than the sum of the individual service restriction categories, as restrictions that had ambiguous or unknown causes are not shown.

Service Restrictions

Frequently Restricted Service Users

Like critical incidents, a small group of service users accounts for a sizeable number of service restrictions in the shelter system. For example, in 2021, there were 17 service users who had ≥20 service restrictions documented in SMIS for that year. These individuals were restricted a total of 522 times in 2021, accounting for 6.5% of all service restrictions that year (8,037). The mean duration of the 522 service restrictions received by this group was 33.46 days (standard deviation: 31.74 days).

The characteristics of this group were examined to better understand who they were and the types of incidents for which they were restricted. Of the 17 service users, 10 identified as male and 7 were female or transgender/non-binary.[42] There was an overrepresentation of younger persons in this group, with 9 service users under the age of 25 years and 8 aged 25 years or older (of whom 2 were 25-29 years).[43] A total of 210 restrictions (40.2%) were issued in the Youth sector, with 135 (25.9%) in the Adult Women sector, 117 (22.7%) in the Mixed Adult (All Gender) sector, and 60 (11.5%) in the Adult Men sector.

The reasons for service restriction among these 17 service users varied, with frequent use of ambiguous or unknown cause categories:

- 210 restrictions (40.2%) for behaviours that compromise health and safety of residents, volunteers, or staff
- 78 restrictions (14.9%) for violent or threatening behaviour
- 63 restrictions (12.1%) for disruptive behaviour
- 62 restrictions (11.9%) for assault
- 47 restrictions (9.0%) for “other” reason
- 32 restrictions (6.1%) for property damage
- 17 restrictions (3.3%) for repeated rule violations
- 8 restrictions (1.5%) for contraband or illicit substance possession
- 5 restrictions (1.0%) for one of: weapon use/firearm possession, theft, or drug trafficking

Of the categories above, all 17 service users had been restricted at least once for both behaviours that compromise health and safety of residents, volunteers, or staff, and disruptive behaviour. Further, 16 service users had been restricted at least once for assault, and violent or threatening behaviour.

Frequently Restricted Service Users

Key Findings Summary

- Like critical incidents, a small number of service users receive a sizable number of service restrictions in the shelter system. In 2021, 17 service users accounted for 6.5% of all service restrictions, the majority of whom were youth.
- SMIS data could be used to identify frequently restricted service users for subsequent support and intervention. However, due to many of their restrictions having ambiguous or unknown cause categories in SMIS, it is difficult to interpret what are their support needs, thus requiring additional information be gathered for potential intervention.

[42] Female and transgender/non-binary study participants are grouped together to protect service user confidentiality.
[43] Adults and older adults are grouped together to protect service user confidentiality.

Service Restrictions

Perceptions of Service Restrictions among Service Users

Interviews with people experiencing homelessness explored their perceptions on the use of service restrictions in the shelter system. This section presents findings on how this group viewed use of service restrictions generally and not in relation to any personal experiences of being restricted.

Many people experiencing homelessness expressed conditional support for the use of service restrictions, particularly in response to shelter-based violence. In this context, service restrictions were perceived as a necessity for creating safe shelter settings, especially for other service users at-risk of victimization.

> *"They shouldn't keep someone in the shelter if they are, I feel like a safety concern to other residents."*
>
> - nonbinary youth experiencing homelessness

> *"If there's someone that's harassing or attacking anyone, then, yeah, they should be discharged, absolutely. There should be no one in here having to worry about getting harassed or attacked or any reason."*
>
> - adult man experiencing homelessness

However, concerns were often raised with the use of service restrictions. Some people experiencing homelessness felt that service restrictions were used too readily and a more graded approach was warranted for non-violent issues: "I think they restrict way too easily." One study participant also recommended the use of restrictions lasting less than 24 hours: "Maybe there should be little restrictions – like here, you know, when something happens here, they kick them out for couple of hours, not ban them, you know." Avenue 15 is a shelter operated by Trellis in Calgary, Alberta, which uses a similar approach wherein youth may be required to be away from the shelter during the day following violent incidents, but they do not receive a service restriction (see Promising Practice summary on the next page).

> *"If a service is going to restrict people for, like … because they're on drugs? That's probably when they need the service most."*
>
> - nonbinary adult experiencing homelessness

Others wanted to see more empathy from shelter staff related to the use of service restrictions and greater consideration of service users' situations during decision-making. The need for more oversight on service restriction decisions was also raised by several study participants. This included having appeal processes wherein decision-making did not involve the shelter staff member(s) who were involved in the initial service restriction decision. The Ombudsperson role at Covenant House Toronto is one example of an appeal process that is undertaken by a more neutral party (see Promising Practice summary on page 75).

On how she feels about service restrictions:

> *"Good and bad. Good for safety reasons, but bad because we're trying our best."*
>
> - female youth experiencing homelessness

> *"I don't know. Like I can see why it would be needed in certain instances, but to have one person be able to make a say like that without any other oversight or a second opinion is pretty ridiculous. Especially, when it's like a non-physical or threatening issue."*
>
> - adult man experiencing homelessness

Service Restrictions

Promising Practice

Avenue 15, Trellis

Avenue 15 is a shelter in Calgary, Alberta, for youth aged 12-17 years. It serves up to 25 youth on any given night. Trellis made a policy change in 2009 to remove the use of service restrictions at the Avenue 15 shelter. The Avenue 15 shelter now addresses violence and other risk issues using approaches that do not involve service restrictions.

How Did the Policy Change Toward Non-use of Service Restrictions Occur?

- Trellis was becoming involved in a Housing First for Youth program, which made use of low-barrier and human rights approach principles. Involvement in the Housing First for Youth program facilitated an opportunity to consider how that approach aligned with other services within the organization.
- The organization critically reflected on the impacts of shelter rule and restriction policies in relation to organizational mission, which embraced a support philosophy that asks: "What do we need to do to make this a person's last episode of homelessness?"

What Have Been the Perceived Impacts of the Policy Change?

- Internal data indicated that 85% of youth do not return to Avenue 15 following their shelter exit.
- Substantial reductions in "shelter hopping" (i.e., youth transitioning from shelter-to-shelter following service restrictions or completion of maximum shelter stays).
- Youth reported that they felt more trusted and supported by shelter staff.

What Made the Policy Change Successful?

- Managers were onsite at the shelter with direct service staff during the policy change process to support them, and used reflective practice to capture the learnings and support change management.
- Mechanisms were in-place to capture learnings and feedback related to the policy change.
- Use of alternative approaches to addressing conflict and violence (e.g., one-to-one meetings between staff and youth; mediation following incidents involving conflict and property damage).
- Use of "relentless engagement" to support youth to exit homelessness and a trauma-informed approach to understand what underlies behavioural issues (e.g., youth verbally lashing out at staff in response to anger or a trauma history).
- Following some incidents of violence, access to the shelter may be limited to create a sense of safety; however, youth are not restricted from sleeping or using other services at the shelter (e.g., a youth may be required to be off-site during the day due to ongoing conflict with other another service user at the shelter).
- All staff are trained in Therapeutic Crisis Intervention.

What is Recommended to Other Organizations Interested in Making a Similar Change?

- Support is needed at the level of senior leadership, including Board of Directors, to accept risk related to policy change.
- Identification and support of champions at the direct service level are beneficial during the transition away from use of service restrictions.
- Creation of a positive error culture wherein staff can openly share and discuss difficulties and missteps, and identify lessons learned.
- Recognition that risk management, including risk to others, will continue to be a challenge after the policy shift.

The potential harms of service restrictions, including reduced access to shelter-based healthcare and being unsheltered during winter months, were also highlighted by study participants. This was a perceived source of unfairness in service restriction outcomes. These individuals asserted that actions were needed to ensure that service restrictions did not impede healthcare access or cause people to experience unsheltered homelessness. One recommendation for preventing the latter was the development of programs for restricted service users. Few suggestions were made about what such a program could look like, though ensuring service users were provided with access to beds and food was noted.

> *"I guess I'm OK with them moving people, but being thrown out on the street in the winter, it's not acceptable."*
>
> - nonbinary adult experiencing homelessness

It should be noted that almost all study participants were staying in the shelter system at the time of their interviews. Because of this, there may be a bias among study participants to accept or approve of service restrictions given

Service Restrictions

Promising Practice

Ombudsperson, Covenant House Toronto

Covenant House Toronto employs an ombudsperson at its emergency shelter who undertakes the appeals process following service restriction issuances. The ombudsperson is not a youth worker, shift supervisor, or manager. Thus, the ombudsperson provides a third-party perspective on most service restriction decisions. The ombudsperson does provide supervision services to one team of community liaison workers. If an appeal is related to this team, the ombudsperson is recused and a third-party manager undertakes the appeal.

The appeals process involves several steps. Following a service restriction decision, youth can contact the ombudsperson to raise any questions or initiate an appeal. The ombudsperson will first meet with the youth to hear more about their concerns. The ombudsperson then independently gathers information from other involved youth and staff, and reviews any relevant documentation or video footage of the incident. A decision on the appeal is then made and communicated to the youth and staff. Due to the need for the ombudsperson to gather and review information, appeal decisions are not made on the same day as the service restriction.

The ombudsperson and their role is known to youth. The ombudsperson's role is explained to youth at the points of intake and discharge. The ombudsperson also holds a residence council meeting every month where youth can share feedback about the organization and the services they receive. Thus, despite being a third-party, the ombudsperson is not an unknown person whom youth are told to contact following service restrictions.

Written contact information for the ombudsperson is also easily accessible to youth; the business card for the ombudsperson is located at the front desk of the shelter and visible to guests. Service restriction incidents and decisions can be stressful and emotionally arousing events that cause attentional narrowing. For example, a youth may not attend to verbal information related to the appeal process because they are focused on other information that is more central to the service restriction that has just occurred. Because of this, the availability of written contact information for the ombudsperson is key to facilitating an accessible appeal process following service restrictions.

Overall, the ombudsperson role at Covenant House Toronto is an accessible, person-centred exemplification of the Toronto Shelter Standards' requirement that shelter providers establish an appeals process following restrictions.

that they were accessing shelters that permitted this practice. People experiencing unsheltered homelessness or who avoid using shelters may have more divergent perspectives on the use of service restrictions.

Perceptions of Service Restrictions among Service Users

Key Findings Summary

- People experiencing homelessness were generally supportive of the use of service restrictions for shelter-based violence. However, the importance of preventing unsheltered homelessness following service restriction implementation was underscored. People experiencing homelessness were less supportive of service restrictions for non-violent incidents. Here, they wanted there to be more discretion in the use of service restrictions and greater consideration of how restrictions might affect the individuals who receive them.
- Many of the concerns identified by people experiencing homelessness in regard to service restrictions were similar to those raised by shelter staff and key informants.
- Unbeknown to study participants, several of their recommendations were aligned with existing policies on service restrictions in the Toronto Shelter Standards (e.g., referral to another shelter following service restriction, use of service restrictions as "a last resort," suspension of service restrictions during weather alerts; City of Toronto, 2023). Thus, ensuring that the Toronto Shelter Standards are being consistently followed with regard to service restrictions would likely appease some (but not all) of the concerns raised by people experiencing homelessness.

Service Restrictions

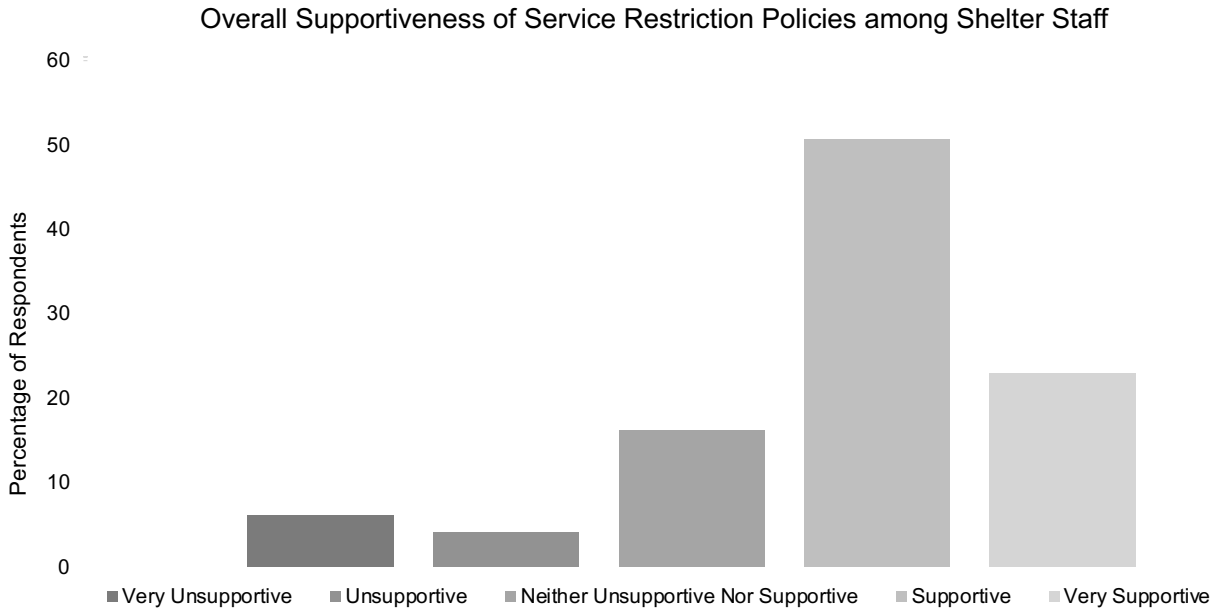
Perceptions of Service Restrictions among Shelter Staff

This section uses data from the online survey of 157 shelter staff, as well as qualitative interviews with shelter staff and key informants to describe how this group perceives service restrictions, including their supportiveness of the practice and perceptions on how they are applied.

On the online survey, shelter staff were asked about their perceptions of service restriction processes and decisions. Overall, most staff were supportive of the use of service restrictions, which were perceived to be fair and just, and necessary for ensuring safety (see figure below and table on the next page). There were more mixed perceptions of the extent to which shelter staff agreed on the need for service restrictions in individual cases.

Analyses were also conducted to examine the factors that are associated with service restriction supportiveness among shelter staff. Job satisfaction ($r = .42$, $p < .001$), effective and consistently implemented violence prevention policies and practices (Practices: $r = .50$, $p < .001$; Policies: $r = .45$, $p < .001$; Pressure: $r = .32$, $p < .001$), and better personal mental health status ($r = .33$, $p < .001$) were each significantly, positively associated with service restriction supportiveness. No significant differences were found by work role, length of employment in the homeless service sector, or sense of safety at work. Thus, shelter staff who are more supportive of service restrictions may perceive this practice to be beneficial for violence prevention, whereas service restrictions may be a source of job dissatisfaction, as well as potentially a mental health burden, among those who disagree with their use. Service restrictions likely contribute positively to job satisfaction among shelter staff who agree with this practice, but not their sense of safety in the workplace.

In the qualitative interviews with shelter staff and key informants, service restrictions were discussed in relation to the types of incidents from which they precipitated. These conversations yielded more nuanced perspectives of service restriction practices.



Service Restrictions

Supportiveness of Service Restrictions among Shelter Staff

Survey Item	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Service restriction reasons are fair and just	4.1%	6.1%	19.6%	43.9%	26.4%
Service restriction processes are fair and just	4.1%	13.5%	23.6%	37.8%	20.9%
Staff agree on service restriction decisions	6.8%	17.0%	19.7%	40.1%	16.3%
There are clear policies and procedures on service restrictions	12.1%	13.4%	20.1%	33.6%	20.8%
Service restriction decisions are clearly communicated to service users	7.5%	10.2%	15.6%	41.5%	25.2%
Restricted service users are supported to access other community services	4.1%	6.8%	10.8%	46.6%	31.8%
Service restrictions are necessary for ensuring safety in the shelter	2.7%	1.3%	8.7%	34.2%	53.0%
Service restrictions leave people without needed supports	22.3%	26.4%	20.9%	23.6%	6.8%

Almost all study participants identified violence and other types of incidents involving victimization, such as theft, property damage, human trafficking, fire-setting, and weapon possession and use, as being grounds for service restriction. These causes were discussed in fairly definite terms (i.e., shelter staff described a cause-and-effect relationship between the behaviour and the service restriction). In contrast, shelter staff held more varied views with regard to substance use and verbal abuse; the latter also being described as more open to subjective interpretation. A further contributing factor was a changing culture in the shelter system with regard to harm reduction policies and the enforcement of zero tolerance policies on racism and oppressive language.

With regard to substance use, this was discussed as a cause for service restriction in some shelters and not others. In shelters where substance use was a cause for restriction, some shelter staff noted that this occurred gradually, beginning with warnings and then later restrictions. Of note, this practice may conflict with Directive 2021-01 issued by TSSS in response to the overdose crisis in Toronto, which stipulated that service restrictions cannot be imposed “on the basis of substance use on or off site” (City of Toronto, 2021). However, given that qualitative interviews for this study were held in 2022 – less than one year after this Directive’s issuance – its implementation may have been ongoing at the time when data were collected.

Further, some methods of substance use were identified as yielding additional risks, which could precipitate service restrictions. In particular, smoking substances indoors was discussed as a potential fire risk for which service restrictions were more likely: “If I walk into your room and you’re smoking, you are leaving … you can smoke anywhere else but in the building. It is a fire hazard. And, if you are caught smoking, you will be discharged immediately and your restriction will be longer.”

Service Restrictions

> *For us, you can't use in our shelters … we understand harm reduction, so we usually will have a conversation and place them on a warning. So, with [substance] use, we'll use the warning system a lot, just because whatever is happening for them at this time. So, it's like first warning, second warning, final warning, then their discharge – which would be a service restriction – because it took four times and you still haven't understood what we've said to you.*
>
> - shelter staff (management)

Shelters were described as having differing policies on whether or not service restrictions were warranted for verbal abuse, including racist and oppressive language. Some study participants partially attributed this to a long-standing history of shelters being settings where verbal abuse was tolerated and perceived by some to be "a part of the job" – a culture that was also often described as now changing. Similar to the handling of substance use, some shelter staff indicated that use of intentionally racist language yielded an automatic service restriction, whereas other shelters reportedly took a more gradual warning-based approach. The importance of considering situational factors on a case-by-case basis was also highlighted by some study participants. This included considering mental capacity in incidents of verbal abuse involving racism and oppressive language.

> *Racism, we're not going to tolerate that here anymore. 'Let's have a conversation about it, because if it should happen, again, you're going to get a warning letter and you're going to get a time-out. And, as we move forward, another warning letter will equal a greater restriction. Eventually, you could end up with a substantial service restriction.' I've got four guys going through that right now.*
>
> - shelter staff (shift supervisor)

> *I think it's all about the receiver … I've been on the frontlines and, for example, a client would be discriminatory towards me, obviously because I'm Black. If that client says something discriminatory or racist, or whatever, but I know this person has compromised mental capacity, I will say, 'No, give the person a pass.' … This person that I'm looking at that can hardly stand because they probably haven't eaten for days, they haven't slept anywhere, and he called me the N word. And, am I affected to the point where now you can't even give him food or water, he has to leave? Because, yeah, there's something to me, that's a little bit off … I'm saying, 'No, they should not be [restricted].'*
>
> - shelter staff

> *Racism here is an automatic discharge. Automatic. And, that is a big conversation in the sector right now, and there's no consistency around it. Some people want to give chances and educate. We base it on, 'Should this person know?' If you are 60 and you just don't know, because this is something new, we'll educate. If it's an honest mistake in the language that you've used, we'll educate. If it's blatant, you're gone.*
>
> - shelter staff (management)

Finally, service non-engagement or case plan non-adherence was another cause for service restriction that was discussed by several study participants. This cause was perceived more contentiously by study participants given the view that the severity of the consequence outweighed the infraction. One shelter staff drew a parallel by applying service restrictions for non-engagement to her own life: "If I miss my dentist appointment, am I losing my housing?" However, not all shelter staff disagreed with service non-engagement as a cause for restriction, as shown in the quote at the beginning of the next page.

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> *We had one [service user] that had got to the point where, 'Now, it's almost like you are not working on your health, you're not coming up with a plan, and you are choosing not to take the medication, and we cannot support you anymore. And now, we are restricting you and we are discharging you.' And, I agree with things like that because we are recognizing that this is not something that's happening because you are choosing to do it, but at the same time, if you are not willing to recognize your mental health and what you need for you to be safe, even for yourself, then you do need to leave this program and hopefully somebody in the next program you go to will be able to connect with you, so that you can get the appropriate support.*
>
> - shelter staff (direct service)

Perceptions of Service Restrictions among Shelter Staff

Key Findings Summary

- Most shelter staff were supportive of service restrictions and may perceive these practices as important in violence prevention policies. In contrast, among shelter staff who disagree with their use, service restriction policies and practices are likely a source of job dissatisfaction, as well as potentially a mental health burden.
- There was general consensus among shelter staff and key informants that violence and other forms of victimization would be grounds for service restriction. However, views were more varied on whether or not service restrictions should be used in response to substance use, verbal abuse, and service non-engagement or case plan non-adherence. The importance of considering situational factors on a case-by-case basis during service restriction decision-making was also emphasized.

Issues with Service Restriction Processes

Lack of Consistency in Service Restrictions

The most frequently identified issue with service restriction processes was the lack of consistency. Almost all shelter staff and key informants described inconsistency in service restriction processes and decisions within and across shelter programs. There were many contributing factors to the lack of consistency. First, the perspectives of shelter staff could differ with regard to the need for service restrictions and their duration. Most shelters were described as having an individual-based decision-making process when it came to service restrictions that may or may not involve input from other team members. Decision-making was often the responsibility of the shift supervisor or a manager. As a result, differences in perspective between shift supervisors and managers within a shelter program yielded different decisions. This could even result in differences about whether or not to involve police: "It's very variable and depends who you get. There can be a situation where somebody does something pretty severe, like they hit somebody, and they're restricted for 30 days. Or, it could be dealt with onsite, or the police could be called. It's really variable."

> *It's quite up to the individual [making the decision]. So, I know, personally, of a shift leader that six months was a minimum restriction for anything, which is a little bit crazy. And then we have shift leaders that don't feel that anything over a week is necessary. So, it's all over the place.*
>
> - shelter staff (shift supervisor)

Use of tools to create consistency in service restriction decisions was contentious. Some agencies used tools that paired behavioural infractions with a set duration for service

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restriction (e.g., 60-day restriction for theft, 14-day restriction for threatening language)[44] as a means of reducing biases and yielding consistent decisions: "The supervisors essentially look at what's happened and look at the service restriction list and make a decision based on that. So, we've got the policy in place because people can't arbitrarily pick a number out of a hat and go, 'Well, you're getting 60 days,' or 'You're getting 102 days.' They've got a guideline that they have to follow." The perceived effectiveness of such tools in yielding consistent decisions was unclear. These tools could also yield confusion for shelter staff when multiple infractions had occurred. Other organizations that did not use service restriction tools did so to enable more consideration of contextual factors and facilitate a response that did not "always resort to a service restriction." In the absence of a tool, one shelter staff described developing their own rubric: "So, verbally abusing staff, first time: four days. The second time: a week. Third time: two weeks … I only did that because I want to show that I'm being fair and unbiased." Relatedly, some shelter staff expressed a desire for system-wide standardized protocols, so as to prevent misuse of service restrictions involving excessive durations: "You should really have to justify why you're doing longer than the standard." However, such an approach may present similar issues if there is not sufficient flexibility to consider contextual factors on a case-by-case basis.

Overall, these perspectives are consistent with earlier findings using SMIS data, which showed considerable variation in service restriction durations, as well as significant sectoral differences.

> *"It isn't consistent. On one hand, not every person is the same and not every situation is the same. But then, on the other hand, that creates opportunities for bias. Shortly after I started working here, I did an analysis of service restrictions, both the amount of time and who was the shift leader on. So, the shift leader makes the recommendation and then it gets approved by their supervisor. If it's over a certain amount, then it has to go to head office, like SSHA … [shift leaders were making decisions so] that it wouldn't have to go to head office where it got another set of eyes. And then when I found out about that, I banned that … if it was like anything over 30 days, they were doing 29 days. No more 29-day service restrictions … and I also looked at which shift leader was on for the most service restrictions and the nature of the service restrictions. And, sure enough, one shift leader, the majority of incidents of violence and the longest service restrictions were happening always on his watch. And, I was like, 'Oh, if [fictional name] is on shift, something's going down.' So, you have to start thinking what is happening here?"*
>
> - shelter staff (management)

Limited Shelter Options after Service Restrictions

Per the Toronto Shelter Standards, shelter operators are required to support service users to access another shelter following a service restriction (8.6.2.j.; City of Toronto, 2023). Almost all shelter staff were aware of this policy and described it as part of their shelter's service restriction procedures. However, limited available beds on any given night in the shelter system was identified as a barrier to meeting this standard. The most commonly described response taken by shelter staff when they encountered this barrier was to send service users to the Assessment and Referral Centre. This could potentially lead service users to successfully access a shelter bed; however, this

[44] These examples are fictional and do not reflect a particular organization's service restriction policy.

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was also perceived to potentially increase the risk of further problems (e.g., violence and aggression at that site in response to a recently issued service restriction or the inability to access a shelter bed).

Study participants also feared that service restrictions could lead to cyclical patterns of shelter use where service users went from shelter to shelter due to restrictions. The lack of information sharing between shelters partially contributed to this. However, the more significant issue was that there are no suitable service options for people with extensive service restrictions and histories of violence, such as the high-incident service users and frequently restricted service users described earlier in this report. There was general consensus on this among shelter staff and key informants, with many identifying that this is a key need to reduce the harms associated with service restrictions and prevent recurrences of violence. Those with longer histories of employment in the shelter system recalled specialized, low-barrier programs for service users with numerous service restrictions and complex support needs, which had since closed (e.g., The Lounge at Women's Residence); these were referenced in relation to the current service gap in the shelter system for people with high support needs. Similarly, Bridge Housing in Niagara Region was developed for a similar population (see Promising Practice summary on the next page).

> *You wish there was somewhere – something – that you can refer someone to get support services, to not bounce basically from shelter to shelter to shelter, because of basically the same behaviors everywhere.*
>
> - shelter staff (management)

89-Day Service Restrictions

As per standard 8.6.2.m. of the Toronto Shelter Standards, "service restrictions lasting three (3) months or longer may only be issued with the approval of SSHA" (City of Toronto, 2023). This threshold was frequently discussed by shelter staff and key informants, though often framed in terms of days as opposed to months (i.e., service restrictions of 90 days or longer). Some study participants, primarily in direct service roles, inaccurately noted that service restrictions could not be longer than 89 days in length: "89 days is like the max." However, others who were often in more senior positions correctly noted that this was possible with TSSS approval.

Shelter-based violence against shelter staff was sometimes described as leading to an 89-day restriction: "Violence is usually like the longest you can do, which is 89 days. So, if it's very violent and it was an on purpose violence thing, usually, you're going to see 89 days for that." However, there was a sense that service users could be restricted for 89 days with limited oversight, whereas the additional day yielded an automatic review.

> *We can't do more than three months for the City of Toronto. So, we come in at 89 days where we don't need permission. But it's like, 'No, if you want to come back here, change your behaviours.'*
>
> - shelter staff (management)

> *So, most of our restrictions that are more severe in nature, 89 days [is given], so that it doesn't go to City Hall.*
>
> - shelter staff (direct service)

Given the aforementioned inconsistencies in service restriction decisions, ones that are 89 days in length may be the result of providers

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wanting to circumvent oversight policies for convenience purposes: "I've seen 89 days issued, but nobody's really restricted past three months because it goes up to our general manager and often beyond our general manager. It goes up quite high to be approved by our duty office. Some people won't do it because it's not worth it." Thus, 89-day service restrictions may function as a loophole within the shelter system where agencies can implement any-cause restrictions with limited oversight and accountability.[45]

Findings from analyses of SMIS data presented earlier in this report support this perspective, as there were a higher number of service restrictions lasting 89 days compared to other days in close proximity (excluding the more rounded 60- and 90-day durations). Further, use of 89-day service restrictions increased in 2020 and 2021, suggesting that interviewed shelter staff and key informants were discussing a topical issue.

Promising Practice

Bridge Housing, Niagara Region

Bridge Housing is a 15-unit short-term, low-barrier housing program in Niagara Falls, Ontario, for people experiencing chronic unsheltered homelessness who cannot access traditional shelter settings (either due to barriers, choice, or service restrictions). Bridge Housing provides shelter with 24/7 intensive case management supports for 6-8 months. All residents have their own bachelor unit that includes a kitchenette and washroom. The building also has a teaching kitchen where community dinners are held three times per week. Support is provided to help residents build life skills and access permanent housing. Additional primary care and harm reduction supports are also provided onsite. In the event of a short-term hospitalization, a resident does not lose their unit. Bridge Housing opened in August 2022.

What Led to the Development of Bridge Housing and What Gap Is It Intended to Address?

- Leveraging administrative data from the Homeless Individuals and Families Information System and by-name list, the Niagara Region identified that there is a small group of people experiencing unsheltered homelessness with severe mental health and substance use problems, histories of violence, and extensive service restrictions who were not or could not access shelters, except during extreme temperatures.
- In response to the pandemic, the Niagara Region developed a temporary housing-focused isolation hotel program for people experiencing unsheltered homelessness. During the operation of this shelter hotel program, it became clear that many of the individuals who were accessing it were also the ones not using traditional shelter settings. As the isolation shelter was temporary, Niagara Region staff began to explore how to continue to shelter the individuals who had resided in the isolation shelter. The Bridge Housing program was designed to reduce unsheltered homelessness in the region by more effectively supporting this population.

What Have Been the Perceived Impacts of the Program Thus Far?

- Staff work with other community partners, including the local Housing First team, to facilitate entry into permanent housing.
- There is a sense of community and belonging in the building, with high rates of participation in group activities (e.g., trips to the food bank, attendance at community dinners).
- No residents had been service restricted as of December 2022.

What Has Made the Program Successful?

- A specific target population was identified for the program.
- All residents have a private self-contained unit (inclusion of cooking appliances is individualized to the capabilities of residents).
- The hiring process involved an information session that allowed the program manager to be transparent about the case manager role, and assess value alignment between prospective employees and the model.
- Early engagement of staff and external consultants in the development of program policies.
- The ratio of residents to staff (7.5:1) gives case managers the time to develop working relationships, support residents to build life skills, and provide housing support.
- Overlap between the case manager work shifts and the program supervisor shifts, with the program manager also being frequently onsite and available to support staff as needed.

[45] Per information provided by TSSS staff directly to the research team, service restrictions under 90 days in shelter settings (i.e., non-respite sites) are not currently reviewed by TSSS' Service Restrictions committee.

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Lack of Information Sharing Following Service Restrictions

As previously noted, following service restrictions, shelters are required to refer service users to another shelter following the Toronto Shelter Standards' procedures for referrals. This process must also adhere to standard 12.6.4., which involves a provision that shelter staff not disclose personal or health information about a service user without their signed consent (City of Toronto, 2023). Because of this, information related to the service restriction cannot be shared during the referral. Shelter staff and key informants noted that these requirements prevented the next shelter operator from having potentially relevant safety and casework information. Some study participants expressed understanding as to why this was, including the prospect of such information being misused (e.g., denying services to an individual due to their history).

> *"Everything from your case plan, your ID, your next of kin – all your personal information – is not available to the next shelter that you go to."*
>
> - key informant (policymaker)

> *"I feel that would be useful information to have, but at the same time, it might colour our treatment of that client. So how do you balance that, you know?"*
>
> - shelter staff (direct service)

One shelter staff discussed serious concerns with regard to the information sharing restrictions following incidents of violence and harassment. This study participant then noted that they will provide information during the referral process related to service restriction incidents that "could put staff [at the next shelter] at risk" in contravention of the Toronto Shelter Standards.

Information Availability, Accessibility, and Oversight on Service Restrictions

Study participants highlighted the importance of available and accessible information on service restrictions for various stakeholder groups. As per standard 8.4.2.g. of the Toronto Shelter Standards, service users who have been restricted from a shelter are to be provided with verbal and written information on: length of restriction, including start and end dates; reason for restriction; and appeal options (City of Toronto, 2023). Shelter staff often discussed service restriction processes as involving the provision of verbal information; however, the provision of written information as part of restriction processes was rarely identified by study participants. Further, verbal information provided to service users could be limited due to ongoing internal review processes (e.g., a service restriction decision being reviewed by management in the subsequent days). This yielded barriers for service users who had to contact the shelter or Central Intake for the final decision and details.[46] One key informant involved in supporting service users following restrictions noted that this information was not consistently provided or made available to restricted individuals, undermining their capacity to appeal the decision.

[46] Per information provided by TSSS staff directly to the research team, Central Intake will typically inform service users if they are restricted from a shelter; however, further details are not provided (e.g., reason for restriction, duration of restriction).

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> *A day, a week, 90 days, it doesn't matter – somebody who is denied a really critical service should be provided a piece of information that states the date, the incident or the allegations for which they're being banned, for how long, and information about how to challenge it. It is a basic. That would, in and of itself, help. There has to be some paper trail.*
>
> - key informant (law)

Interviews with service users who had been restricted in the past year supported the likelihood that insufficient or incomplete information is sometimes communicated to service users during service restriction processes. Of the 29 study participants who had a past-year service restriction, 7 (24.1%) were uncertain of how long their restrictions had been, or reported a length that suggested a misunderstanding or the provision of incorrect information ("I was told I was never getting back in there"). Several study participants also reported that they did not know why they were service restricted or described the reason in a way that indicated a probable misinterpretation of the cause.

A second information availability issue was the limited collection of race data on service users. Throughout data collection, study participants drew on their experiences with regard to individuals and groups at greater risk of being service restricted. It was perceived by a number of study participants that Black, Indigenous, and People of Colour (BIPOC) service users were more likely to be service restricted than non-BIPOC individuals due to systemic racism. However, SMIS has traditionally collected limited data on race (restricted to Indigenous status).[47] The lack of objective data precludes the undertaking of further analyses to determine race-related disparities in service restriction decisions in the shelter system.

Several study participants also expressed that they were unsure about what oversight was in place on service restrictions and how information was being used to reduce any associated harms. These individuals discussed the need to use data to identify where service restrictions were occurring most frequently and how to optimally support the individuals who were most affected by them. As shown earlier in this report, SMIS can be leveraged to identify frequently restricted service users.

> *The overwhelming majority of individuals, from my experience, are Black men and Indigenous men experiencing these types of punitive measures. If that's the case, then something needs to be done about it and that requires a high-level systems overview. Our clients can say that that's their experience, but we need to have an eye on those trends … Who is holding this sector accountable? Who is auditing the number of bans? Who is reviewing that they're appropriate? This is how strong systems are created. We don't ask the most vulnerable and marginalized of our society to bear the weight of ensuring that the system is just and fair. We build mechanisms to ensure that that is happening.*
>
> - key informant (law)

> *We haven't spent a whole lot of time looking at where are [service restrictions] happening? How often? By which agency?*
>
> - key informant (policymaker)

[47] A new SMIS Intake and Triage Form, which collects more comprehensive race data, was piloted from November 2020 to March 2021, and has now been launched at all other shelters. This will enable future examination of the extent to which service restrictions differ by the race of service users.

Service Restrictions

Issues with Service Restriction Processes

Key Findings Summary

- Consistent with findings from the SMIS data, shelter staff and key informants perceived wide variability in service restriction processes and decisions within and across agencies.
- Shelter staff reported difficulties in supporting service users to find a new shelter bed following a service restriction due to the limited availability of beds in the shelter system on any given night. Even fewer suitable options were reported to be available for service users with extensive service restrictions and histories of violence.
- Consistent with findings from the SMIS data, some shelter staff and key informants reported that it is not uncommon for service restrictions of 89 days to be issued. This permitted these restrictions to not be reviewed by TSSS per the Toronto Shelter Standards.
- Concerns were expressed with regard to availability and accessibility of information on service restrictions, both to service users and other agencies supporting them.
- Although shelter staff and key informants perceived that BIPOC service users were at greater risk of service restriction, data on service users' race (with the exception of Indigenous status) were not collected until late 2020, precluding any conclusions at this time.

Consequences of Service Restrictions: Experiences of Service Users

Interviews with 29 people experiencing homelessness who had been restricted from a shelter in the past year were analyzed to understand how their service restrictions unfolded, including the perceived consequences. Three types of consequences were identified: [1] emotional and cognitive reactions, [2] changes in living arrangements, and [3] health and social impacts.

Emotional and Cognitive Reactions

Many study participants described strong feelings of anger in response to their service restrictions. Perceptions that the service restriction was unfairly issued contributed to this anger. Further, study participants felt misunderstood by shelter staff involved in the precipitating incidents or service restriction decision-making.

> *"I'm drunk and I don't know where to go, you know what I mean? So, I was even more livid … I just left, whatever. They didn't have to restrain me, put me outside, even as fucking angry as I was, you know what I mean? I was just having a rough day."*
>
> - adult man experiencing homelessness

Fear and hopelessness were other common emotional reactions reported by study participants following their restrictions. These emotions were linked to difficulties in finding a new shelter bed and concerns about their safety. Uncertainty about where to go post-restriction was also raised by many study participants, with some feeling pessimistic about the future.

Service Restrictions

> *I was scared and I was frightened. I wasn't sure what to do.*
>
> - male youth experiencing homelessness

> *There's no way out. You have to call Central Intake, cross your fingers you're going to see Streets to Homes. Bro, you're more likely to win the lottery.*
>
> - adult man experiencing homelessness

Changes in Living Arrangements

Service restrictions resulted in changes to the living arrangements (i.e., sheltered homelessness, unsheltered homelessness, hidden homelessness, or institutional stays) of most study participants. In particular, unsheltered homelessness was a commonly reported consequence of service restrictions. Of the 29 study participants in Toronto, 13 (44.8%) experienced unsheltered homelessness for one or more nights immediately following their past-year service restriction. However, this number increased to 23 study participants (79.3%) when examining whether unsheltered homelessness was experienced at any point between the service restriction in the past year and the interview date (i.e., their current living arrangement).[48,49] Thus, service restrictions can either initiate or perpetuate a pattern of instability in living arrangements, which frequently involve unsheltered homelessness.

Additional analyses were conducted to examine patterns in post-restriction living arrangements among study participants. The following four patterns were identified:

1. Homeless and health service cycling: This pattern was characterized by residential instability that involved stays at multiple shelters, often with re-occurring service restrictions; hospitals; jails; addiction treatment centres; and other institutions (example shown in quote on next page). A total of 12 (41.4%) study participants had this pattern following their identified past-year service restrictions.
2. Primarily unsheltered homelessness: This pattern involved stays in mostly unsheltered locations, with few to no other types of living arrangements (example shown in quote on next page). Only 3 (10.3%) study participants had this pattern.[50]
3. Unstable re-sheltering: This pattern was characterized by residential instability that involved short periods of unsheltered homelessness, variable stretches of hidden homelessness, and/or multiple short shelter stays without further service restrictions. A total of 11 (37.9%) study participants had this pattern. For women and youth, unstable re-sheltering sometimes involved unsafe experiences of hidden homelessness.
4. Stable re-sheltering: This pattern involved the rapid reacquisition of a shelter bed, with few to no other types of living arrangements and no additional shelter-related problems (i.e., no further service restrictions, critical incidents, or major interpersonal conflicts). Only 2 (6.9%) study participants had this pattern.

[48] This range of time differed between study participants, as some reported restrictions that were approximately one year earlier, whereas others had been restricted as recently as the week prior to the interview. All living arrangements following study participants' service restrictions were discussed in the interview, enabling an assessment of the number of study participants who experienced unsheltered homelessness at any point between their identified service restriction and the date of the interview.

[49] Compared to the 20 study participants recruited in London, Ontario, the rates of unsheltered homelessness immediately following service restriction were similar. However, more study participants in Toronto reported unsheltered homelessness at any point in their post-restriction timelines (i.e., time from identified service restriction to interview date).

[50] Our study may underestimate the number of people who have primarily unsheltered homelessness patterns in their post-restriction living arrangements, as almost all study participants were recruited from the shelter system where they were currently residing. As such, individuals who experienced a service restriction, but were unable to access a shelter bed or chose not to return to the shelter system, would have been excluded from the sample. Such a group may include some people experiencing chronic, unsheltered homelessness.

Service Restrictions

Example of a homeless and health service cycling path:

> *I went to a family friend's house. I stayed there for like two days, then I went to a shelter in [different Ontario city] … I was service restricted from there … Then I returned back to Toronto. I wasn't able to get into any shelter. I called, I tried. No shelter. So, I kept getting high on the street, which was terrible … I ended up in jail … I got released and then I couldn't get into any shelter. I didn't even too much make an effort. Just kind of gave up … I went to a warming centre. I went there, I stayed there for like three days and they asked me to leave, but they found me this place.*
>
> - adult man experiencing homelessness

Example of a primarily unsheltered homelessness path:

> *It ended up to me being outside for like six months … then I moved in with a buddy of mine for a few months … he ended up losing his place … I was in tent again for another month or two and then I got back into this place.*
>
> - adult man experiencing homelessness

The four patterns reveal that most people experiencing homelessness have a period of instability in their living arrangements in the weeks and months following their service restrictions.[51] It is important to recognize that a causal inference can only be made for the first post-service restriction living arrangement (i.e., service restrictions involve the termination of one shelter stay, which directly leads study participants to have another living arrangement of some kind whether that be elsewhere in the shelter system or outside of it). Although a service restriction may not be the direct cause of subsequent living arrangements after the first one, it is evident that service restrictions impact shelter trajectories of during homelessness.

Health and Social Impacts

The most commonly reported health consequence of service restrictions was increased substance use, including relapses. This occurred immediately following restrictions for some study participants and could lead to hospitalization. Others described this in relation to being outdoors during cold weather, with substance use being intended for warmth. Relatedly, cold-related injuries, such as frostbite, were also reported by some study participants who had experienced unsheltered homelessness. Several study participants also experienced feelings of worthlessness and suicidal ideation.[52]

> *I finished packing, went across the street, got liquor … I just sat on the bench and I drank for a little bit.*
>
> - adult woman experiencing homelessness

> *I spent a full 30 days sleeping outside, I got frostbite and ended up in the emergency at [hospital name].*
>
> - nonbinary adult experiencing homelessness

Study participants also discussed how service restrictions impeded or terminated contact with their support networks. This included reduced access to caseworkers and friends who were at

[51] Compared to study participants recruited in London, Ontario, more study participants in Toronto had unstable re-sheltering paths and fewer had stable re-sheltering paths. The proportions of study participants who had the other two paths were similar between the two cities.
[52] Food insecurity was a post-service restriction health consequence reported by study participants in London, Ontario. In contrast, Toronto study participants did not identify this as a major concern.

Service Restrictions

the shelters from which they were restricted. Further, for some study participants, there was a greater sense of mistrust with staff when they re-entered the shelter system, even if it was not the same shelter from which they had been restricted. Some service users reported that they attempted to keep to themselves upon returning to the shelter system because of this mistrust.

> *On the third day, after sleeping outside … I'm without my medication. All my medication's inside.*
>
> - adult man experiencing homelessness

> *I was left with nobody, no support, nobody helping me.*
>
> - adult woman experiencing homelessness

Consequences of Service Restrictions: Experiences of Service Users

Key Findings Summary

- 44.8% of the 29 study participants in Toronto experienced unsheltered homelessness immediately following their past-year service restriction, with an additional 34.5% experiencing unsheltered homelessness at some point in the weeks and months that followed.
- Increased substance use was commonly reported following service restrictions.
- Service restrictions could impede access to support networks and yield a sense of mistrust for some study participants upon re-entering the shelter system.
- Anger and fear were very common emotional reactions to being service restricted.

Consequences of Service Restrictions: Perspectives of Shelter Staff

Immediate "Pressure Relief Valve" that Yields Relief and Tension for Shelter Staff

Service restrictions were described as functioning as an immediate "pressure relief valve" for volatile situations that yielded relief, as well as potentially tension for shelter staff and teams. The relief was generally the result of a perceived reduction in risk following the implementation of a service restriction. However, the perceived effects of service restrictions on safety were bound to the immediate situation in the shelter where the restriction was implemented. Service restrictions were not seen to prevent further violence in the shelter system after a service user leaves the premises (described in more detail below).

> *A sense of relief … but, you know, I just feel like, 'Is this person going to come get me in a parking lot? Will this person retaliate some other way? … if I didn't park in the parking lot here, I don't know, I would be more anxious.*
>
> - shelter staff (direct service)

Shelter staff described service restrictions as a highly challenging aspect of working in the shelter system and a potential source of tension. It was evident that service restrictions weighed on some shelter staff, as they grappled with the moral implications of such decisions. The tension was related to concerns about how the service restriction would impact the service user, as well as how to balance competing rights and needs (i.e., safety of staff and service users versus the right to shelter). Other study participants reconciled their mixed emotions about service restrictions by prioritizing the need for safety in the shelter and their workplace.

Service Restrictions

> *So, I find it's probably one of the most challenging pieces of our work, because we are an emergency shelter, people have a right to shelter. But, people also have a right to safety.*
>
> - shelter staff (management)

> *No, I don't like saying goodbye to kids. However, safety is safety. Whether that's someone's emotional safety, physical safety, psychological safety – whatever it is – you have to look at the bigger picture.*
>
> - shelter staff (shift supervisor)

The tension that shelter staff experienced with regard to service restrictions was greater for issues that did not include physical or sexual violence, such as substance use and verbal abuse. Moral distress among shelter staff appeared most prominent when service restrictions were perceived to lead to consequences, such as unsheltered homelessness, health harms, and violence risks. Another contributing factor to the tension experienced by shelter staff was whether or not service restrictions were being used as a "last resort." These study participants noted concerns with service restrictions being administered too hastily or easily at times. Another important but less discussed consequence of service restrictions among shelter staff was tension within teams due to disagreements in how issues were handled.

> *In terms of verbal abuse, for example, it's a cause for you to lose shelter. So, if you're asking me how fair I think it is, I don't think it is fair at all.*
>
> - key informant (shelter operator)

> *We, as a team, discourage those shorter ones because sometimes they're less beneficial. It's like the shelter system is so full that they might take a day or two to find someone another space … restrictions are supposed to be the last resort and so, if we're at that last resort phase, it's usually not just for a couple of days.*
>
> - shelter staff (management)

> *I'm frustrated by [service restrictions] because we're moving people out of the emergency shelter system into other more dangerous spaces for them. Or, spaces where they're more at-risk of hurting other people, too.*
>
> - key informant (shelter operator)

> *I think restrictions are necessary, in some cases, especially with violence. With other things, as a shift leader, I can restrict my clients. I try not to do that at all. It's an interruption in the service, it's an interruption of relationship.*
>
> - shelter staff (shift supervisor)

> *[Service restrictions cause] conflicts within staff. Some believe it's right, some believe that this is not how we're supposed to work. I think looking at the vision and mission of [name of organization], this is not supposed to be the way. But there's clashes between what's right, what's wrong, what's moral, what's immoral.*
>
> - shelter staff (shift supervisor)

Service Restrictions

Limited Behavioural Changes, but Perpetuation of Further Violence Risk

Service restrictions were generally perceived by shelter staff and key informants to not yield behavioural changes related to risk among service users. That is, service restrictions were not seen to reduce the types of behaviours that caused them. This was due to several factors. First, information sharing restrictions between shelters prevented information related to a service restriction to be used for support planning by another shelter operator. Thus, similar patterns of behaviour and interactions may occur when service users access another shelter following a restriction, leading to replicated outcomes. Second, study participants recognized the emotionality of service restrictions and the possibility that service users feel angry, tired, and victimized following restriction decisions. However, no supports to cope with these emotions are made available to service users following service restrictions, which perpetuates risk of violence elsewhere in the shelter system and city. The Assessment and Referral Centre was identified as one site where there was heightened risk of this occurring due to people experiencing homelessness more often being sent to this site following service restrictions. Third, there was no mechanism in place or limited capacity in many shelters for staff to engage service users following the completion of a service restriction in a discussion about what had happened and develop a plan to prevent this from reoccurring. Even in shelters that had a formal policy related to this, this could be missed in practice due to the busyness of shelter staff, shiftwork challenges, and general lack of knowledge about relevant policies.

> *What I see not working well with service restrictions is it's not correcting the behaviours necessarily. It's not a deterrent.*
>
> - shelter staff (management)

> *You can't call the other agency and say, 'This person just assaulted our staff. You should know.' There's no alerts on SMIS in relation to that. So we're all a little bit in the blind. Occasionally, we breach that.*
>
> - shelter staff (management)

> *What is happening in that 30 days [of a service restriction that's good? That you know will make a difference … what are you hoping to happen within that 30 days? It never made sense to me.*
>
> - key informant (shelter operator)

Of note, there were some partially divergent views on the impacts of service restrictions on behaviour change among study participants. These perspectives were principally held by shelter staff whose job responsibilities involved service restriction decision-making and appeals. In contrast to the larger study sample, these study participants identified opportunities to engage service users in conversations about what can be done differently following service restrictions.

Risk of Unsheltered Homelessness

The shelter system was described as frequently being at capacity on a nightly basis, making it challenging for shelter staff to find service users a new bed following restrictions. As a result and consistent with the findings from people experiencing homelessness described earlier, shelter staff and key informants recognized that service restrictions could result in unsheltered homelessness where people were at greater risk of victimization and health harms.

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> *The reality is that if they're getting kicked out of here, there is probably no other shelter bed. There's probably somebody getting kicked out of another shelter and they're going to get this bed and it's just kind of like, as soon as a bed is open, it's already gone, so it can be really hard.*
>
> - shelter staff (management)

Although most study participants focused on shelter system capacity issues leading to unsheltered homelessness following service restrictions, two other paths to this occurring were when service users were restricted from all other shelters with available beds or they left a shelter immediately following a restriction. As a result of the latter, shelter staff do not explore and facilitate a referral to another shelter, as the service user has already left the premises.

Lost Healthcare and Housing Casework Connections

Service restrictions could undermine continuity of shelter-based healthcare and housing supports. This occurred because service users were no longer able to access the supports (i.e., these are available only in the shelter from which they are restricted) or service providers experienced challenges in connecting with service users following restrictions. Confidentiality and privacy policies were an identified barrier to information sharing following service restrictions, preventing shelter staff from transferring casework to other providers. Community-based healthcare providers informally leveraged their contacts within the shelter system to identify where service users were following restrictions, though this could be a laborious process. Although most study participants who discussed this consequence focused on current and ongoing casework, one key informant highlighted how service restrictions also have the potential to harm future working relationships between service users and shelter staff: "By shutting the door, you're losing the opportunity to work with that person."

> *[Reconnecting with service users following restrictions] is a huge, huge, huge problem. Oftentimes, we are scouring the city for our clients. And it's really, really hard to find people … because once somebody is restricted, there is often no communication with that person. You find out like five days later, 'Oh, no, that person was discharged, service restricted five days ago.*
>
> - key informant (healthcare provider)

> *In terms of service restrictions, it does become quite challenging because we're onsite, we get a referral for a client, and then all of a sudden, they're service restricted and it's spending time to figure out where the person has gone to because the whole point of our program is to work with people no matter where they go. So, yes, we have dedicated case managers at these spaces, but if the case manager gets a referral for a client in the hotel and the client gets discharged, our job is to find them in the community, see if they want to continue to receive support, and work with them wherever they are.*
>
> - key informant (healthcare provider)

Study participants identified the need for shelters to more effectively coordinate and collaborate following service restrictions to prevent the harms associated with loss of healthcare and housing supports, recognizing that there would need to be policy-related changes with respect to confidentiality and privacy to permit this.

Service Restrictions

> *There's a big issue of confidentiality and a client's right to not have their information shared across systems, but it also perpetuates the person staying in the system. Like, so much longer. So, I think there needs to be a decision about weighing what is the best way to move a person from continuing to stay in a shelter system and moving forward on a really solid case plan.*
>
> - shelter staff (management)

> *I understand privacy and confidentiality are important. I think that that will sometimes very directly be in opposition to people's health needs. And, I've had so many situations with a patient and they really need their meds, we need to get them to them. Or, we've had a housing opportunity that came up, we need to talk to them about that … and the shelter's like, 'We can't confirm or deny anything' and it's so frustrating … I feel like from a health perspective, this causes really significant challenges.*
>
> - key informant (healthcare provider)

Consequences of Service Restrictions: Perspectives of Shelter Staff

Key Findings Summary

- Consistent with the experiences of service users, shelter staff and key informants perceived that service restrictions could yield a risk of unsheltered homelessness and impede access to supports (e.g., healthcare, housing casework).
- Service restrictions contribute to a sense of relief for shelter staff following volatile situations, but could also be a source of tension due to the moral implications of such decisions and disagreements within teams on how issues should be handled.
- Service restrictions were generally not perceived to reduce risk of violence or precipitate change in the behaviours that cause service restriction.

Conclusion

Shelters are a core component of homeless service systems. It is imperative that these services be safe and accessible for people experiencing homelessness, as well as the staff who work there. Shelter-based violence can undermine safety for service users and staff, creating the potential for these settings to be perceived and experienced as dangerous, unhealthy, and unsupportive. This first-of-its-kind study was undertaken to examine the factors that contribute to safety in shelters for service users and staff, as well as the causes and consequences of violence and service restrictions in Toronto's shelter system.

This study demonstrated that critical incidents, including various forms of violence, have significantly increased in Toronto's shelter system from 2011-2021. The COVID-19 pandemic exacerbated the rate of critical incidents in the shelter system. A range of other factors in shelter-based violence risk were also identified including: shelter crowdedness; service users' lack of privacy and control, hopelessness and frustration related to exiting homelessness, and diverse unmet needs; the winter season; and ineffective staff interventions. Several types of individuals and groups were perceived to be at heightened risk of shelter-based violence (e.g., people with mental illness and cognitive impairment; people who use substances; transgender and non-binary individuals; Black, Indigenous, and People of Colour; and women), though objective, confirmatory data are limited. In addition to physical and psychological injuries, avoidance was another consequence of shelter-based violence for both service users (e.g., avoiding specific shelters or the shelter system altogether) and staff (e.g., leaves of absence, employee turnover).

Service restrictions occur when a service user is denied access to shelter services and supports for a limited duration of time for a specified reason. Service restrictions were identified as a frequent outcome of shelter-based violence. Like shelter-based violence, service restrictions for reasons involving violence and potential victimization have significantly increased from 2014-2021, but preliminary data indicates that restrictions decreased in 2022-2023 (see Appendix A). Service restrictions for non-violent causes have decreased over time. Although service restrictions are intended to be a "last resort" intervention, a number of issues were identified with their use. This included inconsistencies in implementation, few shelter referral options for service users post-restriction, and information availability and oversight barriers. Among people experiencing homelessness who had been service restricted from a shelter in the past year, unsheltered homelessness was a common outcome, as were health consequences.

Overall, the findings underscore that violence and service restrictions are serious issues in Toronto's shelter system on which more action is needed. These problems also do not exist in a vacuum, as they interact with other critical social issues, including the rise in unsheltered homelessness, the affordable housing crisis, a worsening toxic drug supply, and an insufficient supply of mental health services and housing-based supports. Further, given the complexity of shelter-based violence, which results from an interaction between structural, systemic, environmental, programmatic, interpersonal, and individual factors, its solutions cannot be the sole responsibility of any single system or government. Cross-sectoral and -governmental collaboration and investment is essential.

Improving safety in the shelter system will be a challenging task that requires nuanced and balanced approaches. Yet, there are clear opportunities to effect change by addressing key needs in the shelter system related to violence and service restrictions. A set of 22 recommendations are proposed to advance safety in the shelter system for people experiencing homelessness and staff.

Study Recommendations

The study findings reveal a number of key needs in the shelter system related to violence, safety, and service restrictions that contributed to the formation of the 22 recommendations below.

A fundamental assumption that underlies each of these recommendations is that reducing shelter-based violence and the harms associated with service restrictions is a complex task and one that needs to be considered in relation to other priorities (e.g., right and access to shelter). Accordingly, these recommendations are made as 'next step' strategies for reducing shelter-based violence and should not be interpreted as a panacea.

A number of the recommendations identified here use secondary and tertiary prevention lenses. Secondary prevention refers to interventions and approaches intended to reduce the impacts of issues, such as shelter-based violence and service restrictions, that have already occurred. Tertiary prevention refers to interventions and approaches intended to reduce the impacts of ongoing issues that are anticipated to have lasting effects. Given this focus, it is important to note that these approaches must complement primary prevention interventions and approaches on homelessness (i.e., upstream-based efforts to prevent homelessness from occurring or reoccurring). Effective primary prevention would have positive implications for reducing overcrowding in the shelter system and the hopelessness associated with homelessness – two factors identified in this study as contributors to shelter-based violence.

Further, given that this was a multi-year study, with data collection having commenced approximately two years ago, the City of Toronto may have already undertaken actions to implement some of the identified recommendations in some form. Similarly, some of the recommendations made below also strongly align with priorities identified in the *Homelessness Solutions Service Plan* (City of Toronto, 2021), *Harm Reduction Framework* (City of Toronto, 2017), *SafeTO* community safety and well-being plan (City of Toronto, 2021), *Toronto Action Plan to Confront Anti-Black Racism* (City of Toronto, 2017), and the more recent *Our Health, Our City* strategic plan on mental health and substance use (City of Toronto, 2023), which may present streamlining opportunities that could be considered.

Finally, the 22 recommendations include the development of new support services for people experiencing homelessness, in addition to other changes to shelter built environments and space; resources, policies, and procedures; staff training and education; and research, evaluation and data use. As some recommendations extend beyond the funding purview of the municipal government, it is critical that that the provincial and federal governments work collaboratively with the City of Toronto to identify opportunities and funding for advancing the implementation of the recommendations below. This cross-governmental collaboration is essential for ensuring that Canada's largest shelter system is safe and accessible to all those who need it and the people who work there.

1. Engage community partners providing mental health services in the shelter system to explore opportunities for enhancing crisis intervention and postvention

There are a number of community partners that deliver mental health services in the shelter system. The extent to which these services support and are engaged in crisis intervention is unknown. There may be opportunities for mental health practitioners to work more closely with shelter staff to support team capacity related to shelter-based violence prevention and postvention (i.e., interventions that occur after violence has occurred to support affected individuals and prevent further harm). For example, shift leaders and managers at shelters

could regularly liaise with visiting mental health practitioners to discuss key risk issues and how to optimally support involved service users.

2. Implement more intensive, team-based mental health supports in the shelter system

Many service providers and key informants described challenges in connecting service users to mental health services in the community. Obtaining mental health supports for service users in crisis was particularly challenging, as it was often perceived that these individuals would not be admitted to hospital if they presented to the emergency department. There was also a support gap described for individuals who had been involved in violent incidents in the shelter system. The lack of support for this group was perceived to increase the risk of recurrent shelter-based violence. Thus, there is a need for more intensive, team-based mental health supports in the shelter system, including following violent incidents, that would complement the existing services provided by the Multi-Disciplinary Outreach Team and other agencies.

One possible model for a shelter-focused, intensive mental health support team would be to work from a secondary prevention lens with people following violent incidents to establish individualized safety and support plans, and liaise with shelter staff about how to optimally support these service users. Team members could provide a mix of intensive case management, crisis and risk management, and behavioural support with the aim of preventing recurrent shelter-based violence. This team could also work with service users and shelter staff to implement restorative justice interventions. The incident report module in SMIS could be leveraged to generate real-time referrals to this team following violent incidents. The goal of this team should be to reduce the rate of repeat violent incidents in the shelter system. Team composition considerations would include access to Applied Behaviour Analysis, peer support, and Psychiatry.

It is important to also note that further development of mental health services beyond the shelter system for the purpose of improving access to assessment and treatment, including community-based supports and inpatient options, is expected to alleviate burden on the shelter system and facilitate pathways into care for people experiencing homelessness in Toronto who have undiagnosed or unsupported mental health needs.

3. Develop accessible, around-the-clock supports for people experiencing homelessness who use substances

The relationship between substance use and safety in the shelter system is complex. The presence of visible substance use and intoxication can be a safety concern for some service users. Further, substance intoxication, including alcohol and stimulants, is associated with increased violence risk (Duke et al., 2018; Farrell et al., 2019). Yet, people who use substances are also at heightened risk of victimization in the shelter system, and comprehensive harm reduction policies and services are critical for reducing overdose risk. The issue is further complicated by a changing toxic drug supply, few supervised consumption sites that allow drug inhalation, and limited access to community services for immediate stabilization and treatment. This service and policy context made it more challenging for shelter staff to support people who were using substances in the shelter system, especially in relation to crisis intervention.

There is a need to strengthen the availability of accessible, around-the-clock substance use

Study Recommendations

support services for people experiencing homelessness in Toronto, which would alleviate burden on shelter staff and the system, and concurrently improve access to care among those in need. Key supports that are expected to be beneficial include access to: 24-hour crisis beds for people using substances; 24-hour on-call support with substance use specialists that is available to shelter staff; and a walk-in service for people using stimulants that provides immediate access to assessment, treatment, and community referrals. These supports could be developed at a central service hub or individually throughout the community. Service hubs for people experiencing homelessness have been developed in other cities, such as London, Ontario (City of London, 2023) and Seattle, Washington (DESC, 2020). New substance use support services should complement and be clearly delineated from other emergency, crisis, and substance use support services in the city, underscoring the need for collaboration in their development with operators of existing programs.

TSSS can take further action to strengthen the availability of substance use support services in the shelter system through the continued development of overdose prevention sites in shelters, including the development of more spaces for safe inhalation, that can discretely accessed and are available to service users around-the-clock. These private spaces are key to achieving a balance between reducing overdose risk and limiting exposure to visible intoxication in shelters, which can make some service users feel unsafe. Relatedly, shelter-based managed alcohol programs are associated with fewer alcohol-related harms, hospital admissions, and time in custody (Vallance et al., 2016). Increasing access to managed alcohol programs for service users with severe alcohol use disorders is recommended. Lastly, strengthening access to peer and mutual support, which is viewed positively by people experiencing homelessness (Carver et al., 2020), within the shelter system can be another important source of support for service users who use substances.

4. Identify service users with the highest rates of critical incidents and service restrictions, and prioritize them for supportive housing and other health service linkages

In 2021, less than 25 service users accounted for approximately 6.5% of all critical incidents and service restrictions in the shelter system that year. The number of incidents with which these service users were involved, as well as the varied nature of those incidents, is suggestive of a group who experiences frequent difficulties in traditional shelters and has multiple unmet support needs. SMIS can be used to identify this group, as was done in this study. Doing so would enable opportunities to intervene with this group for the purpose of preventing further incidents and restrictions. Prioritizing these service users for supportive housing would also alleviate burden in the shelter system. Further, regularly discussing these service users at existing support collaboration tables or convening a dedicated table, like the one developed in New York City for the same group (promising practice described on page 45), is also recommended for exploring health and social service linkages for these service users.

5. Develop a specialized program to support people with extensive histories of violence and service restrictions

SMIS data showed that a small number of service users had at least 20 critical incidents or

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service restrictions in 2021. Further, there was a high degree of overlap between these two groups (i.e., service users who had a high number of critical incidents were also frequently service restricted). Shelter staff and key informants perceived few support options for service users with extensive histories of violence and service restrictions, leading to cyclical patterns of shelter use with perpetual risk of violence and service restrictions. Further, some study participants felt that existing shelter programs did not have the capacity to provide needed supports to these individuals. Thus, there is an identified need for a specialized program to support people with extensive histories of violence and service restrictions. Targeting the small number of service users with the highest rate of critical incidents and service restrictions in the shelter system would be a form of tertiary prevention.

Key considerations for such a program would include:

- Small building in an accessible location
- Availability of private living spaces
- Well-trained staff with a high ratio of service providers to service users
- Use of a person-centred, harm reduction approach
- Integration of mental health and medical supports
- Involvement of peers and people with lived experience
- A very high threshold for use of service restrictions, and employment of staff who are generally less supportive of the use of service restrictions

Additional program design considerations could be informed by Niagara Region's Bridge Housing program (promising practice described on page 82) and Safe Haven shelters (promising practice described on page 29), as these programs serve individuals with similar types of support needs. An additional consideration would be to prioritize service users of this program for housing. This would facilitate systems flow out of the specialized program, while concurrently reducing homelessness for individuals with some of the highest support needs in the shelter system.

6. Establish more supports for shelter staff following critical incidents and workplace violence

Service provision in the shelter system was widely recognized as challenging work. On the survey of shelter staff, 36.2% reported feeling somewhat or very unsafe in the workplace and 34.0% described their mental health as poor or fair. Direct exposure to critical incidents and stressors in the workplace was also common. The findings suggest the need for more mental health supports for shelter staff.

Recommendations made by study participants primarily centred on the provision of additional supports following critical incidents. These included more standardized use of one-to-one debriefing and follow-up interventions with shelter staff, more paid days off for reasons related to workplace violence exposure, and more available supports when returning to work after critical incidents (the types of needed supports were not specified). Increasing the availability and use of supports following critical incidents and workplace violence was also discussed by some study participants as being potentially beneficial for creating safer workplaces for shelter staff and preventing employee turnover.

The Mental Health Support for Health Care Workers, a support initiative launched during the pandemic, offers timely access to brief, virtual psychotherapy and is effective in reducing mental health symptoms and work impairment among recipients (Laposa et al., 2024). In Toronto, this service is available to and accessed by shelter staff, and could be explored as an immediate to short-term option for further meeting the support needs of this workforce

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moving forward. Engaging community partners to discuss how to optimally connect shelter staff to this or related services is recommended.

7. Develop and pilot a flexible, minimally demanding restorative justice intervention model framework for implementation in response to interpersonal conflict and shelter-based violence

Restorative justice refers to various practices, including apologies, restitution, and acknowledgments of harm and injury, that are intended to facilitate healing and reintegration among affected individuals and groups (Menkel-Meadow, 2007). Restorative justice interventions typically involve direct communication between perpetrators and victims that is guided by a facilitator to achieve mutual understandings, forgiveness, and agreed upon undertakings to prevent further harmful behaviours (Menkel-Meadow, 2007). There was interest among some shelter staff and key informants to use a restorative justice approach with service users following incidents of interpersonal conflict and shelter-based violence. However, at the time of data collection, use of restorative justice interventions was aspirational and had not yet been routinely implemented in study participants' shelters. Further, the literature review and promising practice scan revealed few examples of established restorative justice practices in shelter settings. One exception to this was a restorative justice intervention called *Circles*, which has been described in the literature (Sletten, 2022), but this research was not peer-reviewed and drawing any conclusions about feasibility and effectiveness would be premature. As the workloads of shelter staff were identified as a barrier to the potential implementation of restorative justice practices, it is important that intervention models be flexible and minimally demanding for shelter programs and staff. Accordingly, it is recommended that TSSS, along with community partners, collaborate to develop a flexible, minimally demanding restorative justice intervention model framework that could then be piloted by different shelter programs interested in pursuing greater use of restorative justice approaches.

8. Increase access to recreational, social, and physical activities for service users in the shelter system

Engagement in recreational and social activities was discussed as an important component in shelter-based violence prevention, especially among youth, as boredom and inactivity were perceived to increase risk of interpersonal conflict – a finding that is consistent with guidance on violence prevention in mental health hospital settings (NICE, 2005). Further, physical activity, including sport, are experienced positively by people experiencing homelessness, with self-reported mental health benefits (Dawes et al., 2024). Accordingly, it is recommended that TSSS works with its community partner agencies, including drop-in programs, community recreation centres, and libraries, to explore opportunities for expanding access to recreational, social, and physical activities for service users in the shelter system. Companion animals are another potential source of recreation and physical activity for pet owners experiencing homelessness, making it important that the shelter system continues to develop the infrastructure necessary for people and their pets to safely stay together.

9. Prioritize the reduction of crowdedness in shelters

Overcrowding was identified by shelter staff and key informants as a key factor in shelter-based violence – an assertion that was also supported by SMIS data. Thus, reducing crowdedness in shelters is essential for reducing shelter-based

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violence. It is important to recognize that such a goal may conflict with other system-level priorities, such as increasing access to shelter beds, given the level of need in the city. Because of this, it is important to consider strategies for concurrently balancing these objectives. Identifying opportunities to expand access to shelter beds through the use of smaller programs with private and semi-private rooms may be particularly beneficial. Further, developing private spaces in shelters where service users can be alone when needed could offer reprieve from any commotion elsewhere in the shelter.

10. Foster more collaboration and information sharing between shelters and with healthcare professionals who support service users

Information sharing was discussed in relation to both shelter-based violence and service restrictions. On the former, some shelter staff and key informants expressed safety concerns with the limited information on service users' past incidents of violence in the shelter system that is available at program entry. These study participants generally felt that this lack of information put shelter staff and other service users at-risk of violence. Further, service restrictions were discussed as having the potential to terminate casework related to housing and jeopardize continuity of care with health services. This may increase the risk of prolonged episodes of homelessness and poorer health outcomes. Barriers to information sharing in the shelter system, including within SMIS, contribute to the risk of discontinuation of housing casework and health service delivery. Thus, there is a need for more collaboration and information sharing across the shelter system, as well as between shelter and healthcare providers to enhance safety and mitigate the harms associated with service restrictions. Engaging information technology and privacy officers to explore opportunities for facilitating information sharing within the shelter system is recommended. Increased information sharing is not without its risks and these need to be carefully considered in any work related to this.

11. Establish more consistent service restriction processes and decisions within and between shelter organizations

Almost all shelter staff and key informants described service restriction processes and decisions as being inconsistent within and between shelter organizations. SMIS data also strongly supported this, as there was considerable variation in service restriction durations, including between the shelter system sectors.

There was no consensus among study participants on how to improve the consistency of service restriction processes and decisions. This was due to the complexity of some incidents where a service restriction is being considered or implemented, differences in philosophy and approach between shelters, differences in perspective between shelter staff on service restrictions and about how to respond to verbal abuse, and limited capacity to implement other interventions prior to service restriction. Given the diversity in perspectives and approaches, some preliminary considerations for increasing consistency in service restriction processes and decisions are to:

- Establish transparent and accessible appeal processes within shelter programs that are overseen by neutral parties
- Assess whether there is a need for TSSS to review service restrictions under 90 days, which may not be an approval-type review, such is the case with ≥90-day restrictions, but rather for the purpose of enhanced oversight

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- Re-evaluate the appropriateness of service restrictions for service non-engagement, which would currently be a permissible cause for restriction in the Toronto Shelter Standards under standard 8.6.2.d.iv.
- Ensure that TSSS has a copy of each shelter operator's current service restriction policy, as stipulated in the Toronto Shelter Standards (standard 8.6.2.a.ii.), and conduct a comparison of these policies to determine opportunities to further standardize service restriction processes

12. Prioritize use of multi-hour, non-bed loss service restrictions for escalating interpersonal conflict and verbal abuse

Use of service restrictions that were less than 24 hours in length and did not result in service users losing access to a shelter bed (sometimes described informally as "take a walk" interventions) were perceived more positively and may have fewer associated harms than service restrictions involving bed loss. These shorter restrictions could be used more frequently as a de-escalation intervention in response to escalating interpersonal conflict and verbal abuse prior to bed-loss service restrictions being considered.

Multi-hour, non-bed loss restrictions could be used recurrently, if necessary (e.g., a second service restriction of one hour is issued when a service user returns to a shelter upon completion of the first one, but remains visibly escalated). Their use should clearly communicate to service users that they have not lost their beds, will be able to return to the shelter when their emotions are more regulated, and can ask staff questions about the restriction at any time. Further, service users should not be denied access to meals, healthcare, or case management during these restrictions, though the provision of the services may need to be adapted given the restriction (e.g., providing a takeaway meal as opposed to access to a dining room).

As issuing service restrictions, even without bed loss, constitutes a service denial that needs to be documented, changes to SMIS may be needed to facilitate use of this practice.

13. Expand the meaningful inclusion of people with lived experience of homelessness in TSSS' committees and decision-making processes related to service delivery

Service users and staff across the shelter system have diverse needs, including in relation to safety, that must be carefully considered together so as to ensure that policy changes are optimally meeting the needs of these groups. TSSS has a history of engaging people with lived experience of homelessness in various ways, including through consultations on specific issues, annual and biennial surveys, participation in working groups, and in partnership with community agencies. It is essential that people with lived experience continue to be meaningfully engaged and involved in decision-making processes related to service delivery in the shelter system, including in support of future policy actions taken to reduce shelter-based violence. Diversifying TSSS' Service Restriction committee to include the perspectives of people with lived experience is also recommended.

14. Establish an accessible source (e.g., Central Intake) where service users can obtain information on any active service restrictions, including their lengths and appeal rights

It was not uncommon for service users who had been service restricted in the past year to be

unable to recall the length of their restrictions, with some also noting that this was not communicated to them. These service users would have had to telephone or return to the shelter from which they were restricted to receive more information about their restrictions. However, this can be a barrier for people experiencing homelessness, especially among those who perceived their restrictions as unfair and no longer wanted to engage with that service. Yet, it is important that service users have this information for making informed decisions about the services they are able to access now and in the future.

Establishing an accessible source, such as Central Intake, where people experiencing homelessness can obtain information about active service restrictions is needed. Currently, Central Intake provides information upon request about whether or not a service user has an active service restriction, but does not provide information on its length or the service user's appeal rights. As information on service restriction duration is available via SMIS, it is recommended that this information be provided to callers who want to learn more about their service restrictions. Iterating information about service restriction appeal rights and processes during these calls is also needed.

Shelter policies on service restrictions should also be updated once an accessible source, such as Central Intake, is established to provide service restriction information to callers, so that service users are informed that they can contact the central source, in addition to a manager at the shelter from which they are restricted, to learn more about a service restriction.

15. Build capacity within TSSS to provide greater oversight and respond to issues pertaining to shelter-based violence and service restrictions

Shelter-based violence and service restrictions are complex, multifaceted issues that are likely to change in response to other developments within and beyond the shelter system (e.g., the scope of homelessness in the city). Given the seriousness of these dynamic issues, it is important that there be dedicated resources within TSSS to monitor and respond to these progressions in a timely manner that is leveraged at the systems level. These personnel resources could also be leveraged to implement the other recommendations in this report and support their sustainment over time.

16. Strengthen training for shelter staff on practices for supporting service users who use methamphetamine

Some shelter staff and key informants associated methamphetamine use with greater likelihood of violence. This perspective is supported by existing evidence non-specific to homelessness (Farrell et al., 2019); however, research has also demonstrated a relationship between methamphetamine use, violent victimization, and trauma vulnerability among people experiencing homelessness (Carrillo Beck et al., 2022). Accordingly, there may be opportunities to strengthen staff knowledge related to more effectively supporting people who use methamphetamine in the shelter system. Collaborating with harm reduction community partners to develop educational resources for shelter staff on methamphetamine use is recommended.

Content considerations for educational resources include: do's and don'ts when working with

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service users who use methamphetamine, including how to respond to agitation; reasons for methamphetamine use among service users; intoxication effects of methamphetamine and how these differ from other substances (e.g., differences between alcohol and methamphetamine intoxication, and their support implications); and available community resources for people who use drugs.

17. Evaluate the extent to which the training competencies matrix, including the individual trainings, are meeting the needs of shelter staff

Staff training was identified as a key component in violence prevention. Yet, many shelter staff and key informants expressed a need for more training or a reprioritization toward in-person training courses focused on compassionate service delivery and crisis intervention. Staff in managerial roles and key informants who operated shelters also identified barriers to ensuring staff were adequately trained. As Toronto Shelter Standards' training competencies matrix now includes 38-46 mandatory or recommended trainings for client support (direct service) staff, depending on their sector, a comprehensive evaluation of the training competencies matrix is warranted. It would be important for any evaluation to focus on assessing the usefulness of the individual trainings; identifying any training gaps, including in relation to safety and violence prevention; and developing strategies for addressing training inequities between programs throughout the shelter system.

18. Develop a staff training program and educational resources focused on person-centred safety interventions adapted from the *Safewards* model

No evidence-based interventions are known to exist for enhancing safety in shelters. Because of this, it is necessary to consider interventions that have been applied in related contexts outside of the homeless service system. *Safewards* is a set of ten interpersonal interventions used by clinical staff on inpatient psychiatric units to reduce conflict (i.e., behaviours that can result in harm) and containment (i.e., methods used by staff to control difficulties on a unit, often through restrictive or coercive means). The *Safewards* model and interventions are described in more detail in Appendix C. Research suggests that the intervention is effective in reducing conflict and containment in general mental health settings, with some evidence of improved sense of safety among clinical staff as well (Finch et al., 2022).

The *Safewards* model and its interventions are congruent with some of the key contributing factors to shelter-based violence and prevention approaches identified in this research. Accordingly, the *Safewards* model could be adapted and piloted in shelters as an intervention approach for reducing shelter-based violence and the need for service restrictions.

19. Develop performance indicators on shelter safety

The number of critical incidents in the shelter system has significantly increased over time, with all sectors (Adult Men, Adult Women, Mixed Adult/All Gender, and Youth) experiencing more incidents.[53] Given this, there would be value in developing performance indicators on shelter

[53] This research did not examine critical incidents and service restrictions in the Families sector.

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safety to further monitor trends and intervene accordingly.

This could involve determining the mean number of quarterly incidents per 1,000 shelter users to establish a systemwide benchmark, though sector-specific benchmarks may be more appropriate. As an example, across the shelter system in 2021, there were 9,982 critical incidents and 2,329,525 non-unique individuals who stayed in the shelter system. This amounts to a daily mean of 4.28 incidents per 1,000 service users. Over one-quarter of the year (91.25 days), this would equal 391.00 incidents per 1,000 service users. A decrease from 391 incidents per 1,000 service users per quarter would suggest a potentially positive trend in safety across the shelter system, whereas the opposite would signal the possible need for further intervention.

The benchmark could also be used to identify shelters with incident rates that greatly exceed and fall short of this threshold to better understand the factors that contribute to critical incident rates. Programs with lower critical incident rates may have potential promising practices for shelter-based violence prevention that could be beneficial in other programs as well. Developing similar, additional benchmarks for key critical incidents, such as physical and interpersonal violence, suspected overdose, self-harm, and property damage – all of which have been trending upward in recent years – is also recommended.

20. Collect and analyze data on the role of race and ethnicity in service restrictions

Some shelter staff and key informants perceived that BIPOC service users, particularly Black and Indigenous men, may be at greater risk of being service restricted. However, objective data to support this view are unavailable. Prior to Fall 2020, SMIS collected limited data on race and ethnicity (restricted to Indigenous status). Implementation of the new SMIS Intake and Triage Form now collects more comprehensive race data, which should be used in future analyses to determine how service users' racial and ethnic identity affects service restriction risk and any procedural justice inequities.[54]

21. Reduce the use of the "other" service restriction category in SMIS reports

Nearly one-quarter of all service restrictions were categorized as "other" in SMIS' service restriction reason field. Although this category should only be used when the service restriction reason is not captured by other options, an analysis of 100 random "other" descriptions revealed that this was not the case. Frequent use of the "other" category produces data that would be onerous to analyze, rendering them largely meaningless. Further, service restrictions coded as "other" limit confidence in observed changes, especially reductions, in service restriction rates found for other reason categories. As such, to strengthen accurate detection of service restriction trends, it is critical that the use of the "other" category be reduced.

TSSS can take steps to achieve this objective by issuing a system-wide memo regarding this and making available additional support and training to shelter staff on the SMIS service restriction categories. Temporarily tasking TSSS' Service Restriction Committee with reviewing service restrictions categorized as "other" and following-up with programs when this category is being repeatedly misused may also be beneficial for reducing use of the "other" category. Lastly, the development of operational definitions for each

[54] Of note, there likely would be methodological limitations to these planned analyses, as relevant data related to service restriction rates (e.g., mental health diagnoses, substance use, prior history of violence) on individual service users may be unavailable or unreliable, preventing the capacity to control for these other variables (i.e., to truly isolate the role of racial and ethnic identity in service restriction risk).

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type of service restriction reason, with examples, is also recommended.[55]

22. Consider further study of shelter-based violence, service restrictions, and safety needs among families in the shelter system

This study focused on individuals experiencing homelessness in Toronto. An examination of violence, safety, and service restrictions in the Families sector was beyond the scope of this research. Although this sector has lower rates of critical incidents and service restrictions compared to the other shelter sectors, there are also unique challenges and safety considerations for families experiencing homelessness. As such, it is recommended that a smaller, follow-up study be considered to examine the key components of safety in family shelters and stakeholder recommendations for creating safer shelter settings for families experiencing homelessness.

[55] The development of operational definitions for the 22 critical incidents identified in SMIS, especially the more ambiguous types (e.g., mischief, criminal acts, disruptive behaviour, medical occurrence), would also be beneficial.

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Recommendation	Domain				
	Support Services	Built Environment and Space	Resources, Policies, and Procedures	Staff Training and Education	Research, Evaluation, and Data Use
2. Implement more intensive, team-based mental health supports in the shelter system	X				
3. Develop accessible, around-the-clock supports for people experiencing homelessness who use substances	X				
4. Identify service users with the highest rates of critical incidents and service restrictions, and prioritize them for supportive housing and other health service linkages	X				
5. Develop a specialized program to support people with extensive histories of violence and service restrictions					
6. Establish more supports for shelter staff following critical incidents and workplace violence	X				
7. Develop and pilot a flexible, minimally demanding restorative justice intervention model framework for implementation in response to interpersonal conflict and shelter-based violence	X		X		
8. Increase access to recreational, social, and physical activities for service users in the shelter system	X				
9. Prioritize the reduction of crowdedness in shelters		X			
10. Foster more collaboration and information sharing between shelters and with healthcare professionals who support service users			X		
11. Establish more consistent service restriction processes and decisions within and between shelter organizations			X		
			X		
13. Expand the meaningful inclusion of people with lived experience of homelessness in TSSS' committees and decision-making processes related to service			X		
14. Establish an accessible source (e.g., Central Intake) where service users can obtain information on any active service restrictions, including their lengths and appeal rights					
15. Build capacity within TSSS to provide greater oversight and respond to issues pertaining to shelter-based violence and service restrictions					
17. Evaluate the extent to which the training competencies matrix, including the individual trainings, are meeting the needs of shelter staff					
18. Develop a staff training program and educational resources focused on person-centred safety interventions adapted from the *Safewards* model					
19. Develop performance indicators on shelter safety					X
20. Collect and analyze data on the role of race and ethnicity in service restrictions					X
21. Reduce the use of the "other" service restriction category in SMIS reports					X
22. Consider further study of shelter-based violence, service restrictions, and safety needs among families in the shelter system					

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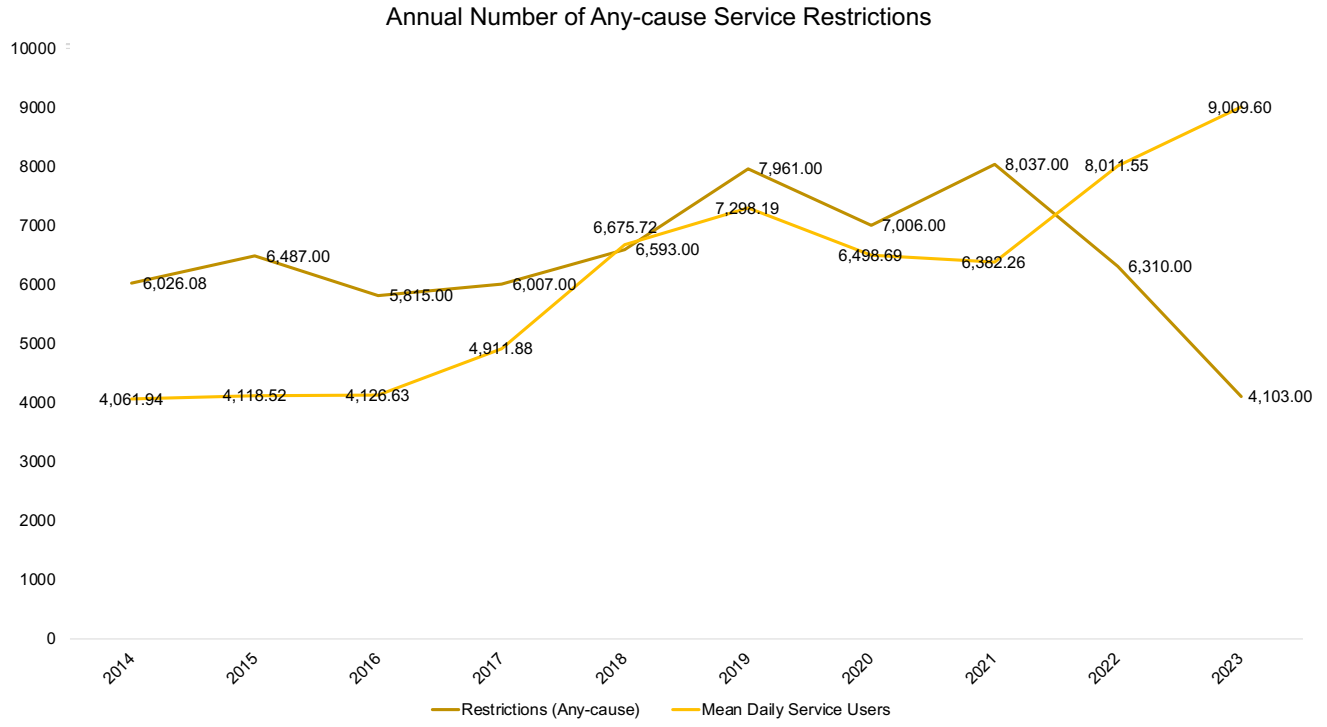
Appendix A: Preliminary Findings of Service Restrictions in 2022-2023

In mid-January 2024, TSSS analyzed SMIS data on service restrictions from 2022-2023. These data offer a preliminary assessment of recent service restriction trends across the shelter system. On request, TSSS provided the research team with aggregated data on key service restriction indicators for 2022-2023 that corresponded with the analytic methods used in this study (i.e., these data are directly comparable to previous years). Four figures that were presented earlier in the report have been updated with data for 2022-2023. The trends are described below, but not interpreted in great detail.

As shown in the figure below, the mean number of daily service users in the shelter system showed a sharp 25.5% increase in 2022 from the previous year, followed by another 12.5% increase in 2023 from the previous year. In contrast, the number of any-cause service restrictions declined sizably in 2022 (21.5% decrease from previous year) and 2023 (35.0% decrease from previous year). From 2021-2023, the annual number of any-cause service restrictions decreased by 48.9%.

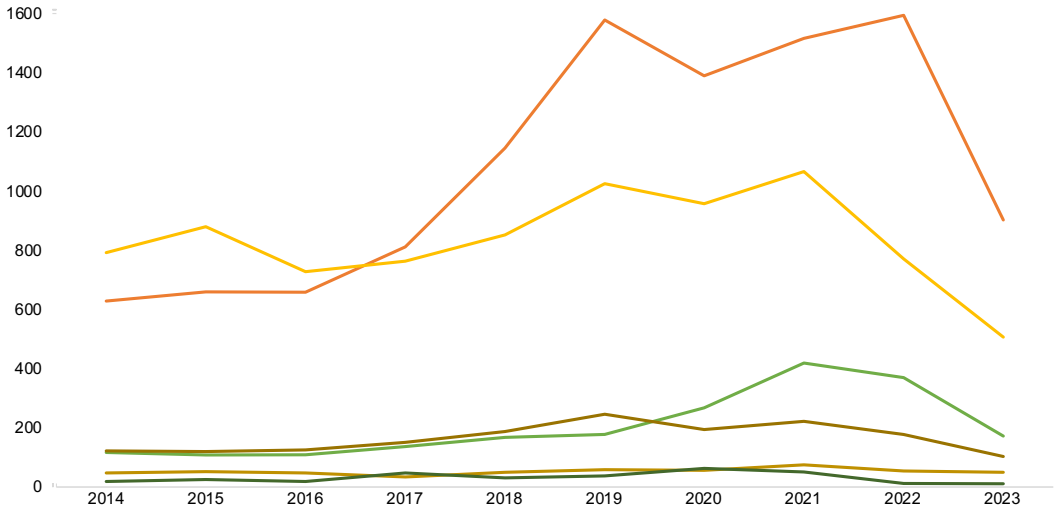
Examining service restrictions by cause, the number of restrictions for violence and potential victimization showed similar decreases. In 2022, decreases from the previous year were observed for violent/threatening behaviour (27.7%), property damage (11.7%), weapon use/firearm possession (28.0%), theft (19.8%), and drug trafficking (76.5%). Each of these continued to decrease further or stabilized in 2023.

Restrictions for assault showed a differing pattern, with a continued increase of 5.1% in 2022 from the previous year, followed by a sharp decrease of 43.4% in 2023.



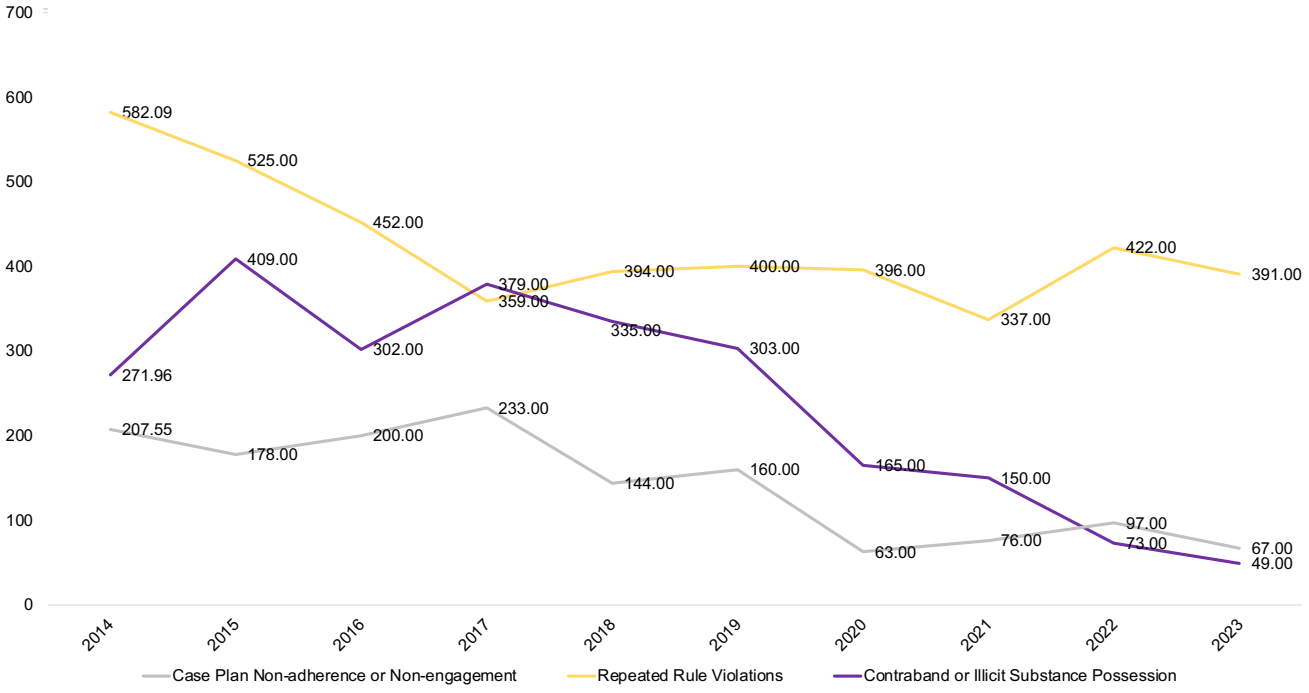
Appendix A: Preliminary Findings of Service Restrictions in 2022-2023

Annual Number of Service Restrictions for Violence and Potential Victimization Reasons

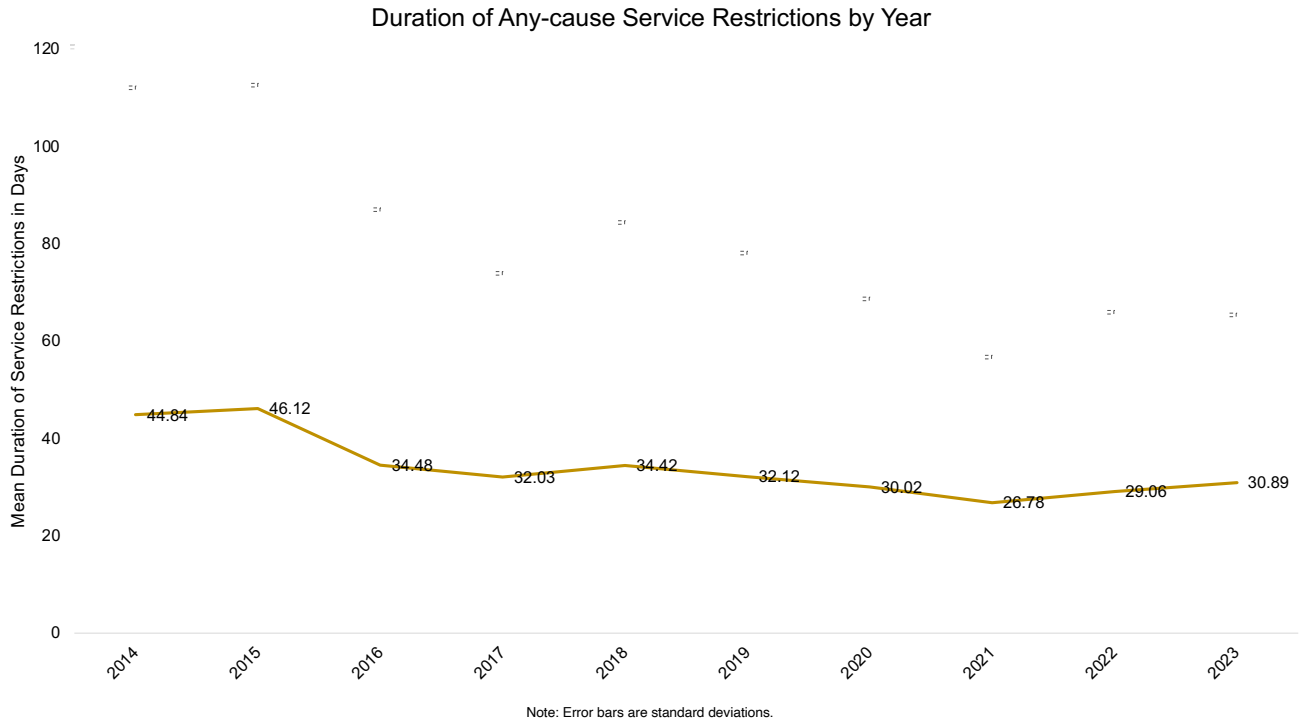


	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Assault	627.42	658	657	811	1145	1578	1389	1516	1594	902
Violent or Threatening Behaviour	792.03	880	727	763	852	1025	957	1066	771	506
Property Damage	116.89	108	109	136	167	178	267	419	370	172
Weapon Use/Firearm Possession	47.71	52	48	34	50	59	56	75	54	50
Theft	121.67	120	125	151	187	246	194	222	178	103
Drug Trafficking	19.08	25	19	48	31	38	63	51	12	11

Annual Number of Service Restrictions for Non-Violent Causes



Appendix A: Preliminary Findings of Service Restrictions in 2022-2023



As for service restrictions for non-violent causes, a more stable pattern was observed in 2022 and 2023. Repeated rule violations increased slightly in 2022 and then declined slightly in 2023. A similar pattern was observed for case plan non-adherence or non-engagement. In contrast, restrictions for contraband or illicit substance possession showed a sizeable decrease of 51.3% in 2022 from the previous year and then declined further in 2023 (32.9% decrease).

The mean duration of any-cause service restrictions increased slightly in 2022 and 2023, with continued variability as demonstrated by high standard deviations.

Overall, data from 2022 and 2023 suggest changing trends in service restrictions from previous years. Given the relationship between critical incidents and service restrictions, especially for violence, the findings may suggest declining critical incident rates in the shelter system or greater use of alternative practices to such incidents that do not involve service restriction. This warrants further examination.

Appendix B: Study Limitations

This study had a number of limitations that are important to acknowledge. First, some planned analyses were not feasible during the study, which prevents a more comprehensive understanding of the contributing factors to critical incidents and service restrictions. These are as follows:

1. Critical incident rates by type of shelter model (i.e., shelter hotel vs. traditional congregate shelter model): This was due to the structure of the datasets, which would have required considerably more time to reorganize the data to perform such comparisons.
2. Role of income support payment schedule (i.e., Ontario Disability Support Program and Ontario Works payment dates) on critical incident rates: This was due to these data not being acquirable by the end of the study.
3. Role of service user race and ethnicity in critical incident and service restriction rates: Race data were not collected in SMIS, with the exception of Indigenous status, prior to November 2020. Race data are now collected on SMIS Intake and Triage forms, which could permit such analyses in the future. However, there would be methodological limitations to those analyses if other potentially relevant data related to service restriction rates (e.g., mental health diagnoses, substance use, prior history of violence) on individual service users are unavailable or unreliable.
4. Role of mental illness and other health conditions on critical incident and service restriction rates: Self-report and staff-observational assessment data on mental illness and substance use are collected on the SMIS intake form; however, available data were assessed as being too unreliable, hence not analyzed in this study.
5. Inferential tests to determine statistically significant differences between sectors or by shelter size in critical incident and service restriction rates per 1,000 service users: Data needed to compute these estimates were drawn from separate datasets and considerably more time would have been required to reorganize the data to perform such comparisons.

Second, SMIS data were used to examine critical incident rates and changes over time. Some types of critical incidents may be underrepresented in SMIS reports when undetected by or unreported to shelter staff. For example, it is likely that SMIS data underestimate the number of incidents involving verbal violence between service users, theft, and self-harm. This limitation is less likely to affect the service restriction analyses that used SMIS data, as shelter staff are required to document restrictions in SMIS as part of their implementation. Third, this study did not examine shelter-based violence, service restrictions, and safety in the Families sector. Although this sector was included in some system-wide analyses of SMIS data, the findings may be less applicable to family shelters. Moreover, as child abuse or neglect was more common in the Families sector (76 of the 85 documented incidents in SMIS between 2011-2021 occurred in the Families sector), there are likely key safety and risk considerations for family shelters that are not identified in this research. Fourth, people experiencing homelessness were primarily recruited for study interviews via shelters where they were currently staying. Because of this, the findings may underestimate shelter system avoidance or inaccessibility following violent incidents and service restrictions. Fifth, the online survey asked shelter staff about their perceptions of service restrictions broadly (i.e., not in relation to specific types of incidents). This may have affected the findings, as it is likely that shelter staff are more supportive of service restrictions for violent incidents than non-violent ones.

Appendix C: *Safewards* Model

Safewards is a set of ten interpersonal interventions used by clinical staff on inpatient psychiatric units to reduce conflict (i.e., behaviours that can result in harm) and containment (i.e., methods used by staff to control difficulties on a unit, often through restrictive or coercive means). *Safewards* is primarily focused on the role and actions of staff in preventing situations that can lead to conflict (called "flashpoints" in the model), as well as how staff respond to conflict, so as to contain the situation from becoming worse.

Research suggests that *Safewards* is effective in reducing conflict and containment in general mental health settings, with some evidence of improved sense of safety among clinical staff as well (Finch et al., 2022). Although *Safewards* has not been tested in shelter settings, there is overlap in the types of conflictual situations that the interventions are intending to prevent. Further, there is congruence between some of the *Safewards* interventions and the fundamental approaches to preventing shelter-based violence that were identified in this study. Thus, *Safewards* could be adapted and tested in shelter settings to improve the prevention and management of violence.

The ten *Safewards* interventions are as follows (some language has been adjusted for greater applicability and relevance to shelter settings):

1. **Clear mutual expectations**: Conflict can arise in response to a lack of clarity and consistency in the expectations that staff have for service users and vice versa. Clarifying these working relationships by co-developing mutual expectations can enable staff to be more consistent in their interactions with service users, and help service users to understand their responsibilities and those of staff.
2. **Soft words**: Agitation and distress are common experiences among service users, and conflict can arise when staff need to enforce rules or set boundaries. Soft words involves a focus on polite and respectful forms of communication during potentially difficult interpersonal interactions.
3. **Talk down**: When service users are agitated, angry, or in crisis, it is still possible to help them calm down by talking to them. Talk down involves the use of advanced de-escalation techniques and the identification of an intervention champion to support staff with implementation of these skills.
4. **Positive words**: Shift changes may involve staff discussing current or recent risk issues among service users. As these conversations are more likely to focus on exceptional behaviour, service user strengths may be overlooked. Positive words involves the identification and discussion of at least one positive comment or strength for each service user discussed during shift changes.
5. **Bad news mitigation**: Unwelcome events can precipitate expressions of anger. Bad news mitigation involves staff being aware of potential upcoming events that may cause service users to become upset and connecting with them to convey sympathy or process such events when these occur.
6. **Know each other**: There are many barriers to staff and service users getting to know each other (e.g., shiftwork, workload, discharges). Yet, mutual knowledge, familiarity, and interests can be an asset to the working relationships between staff and service users. Know each other involves staff making known safe, non-controversial information to service users (e.g., years in sector; favourite TV shows, movies, books, music genres, sports team, et cetera; best life advice received) and giving service users the option to provide similar information

Appendix C: *Safewards* Model

about themselves when entering the shelter. This mutual knowledge can enable rapport building conversations, as well as the identification of important coping skills for distress.

7. **Mutual help meeting**: Like inpatient units, shelters are a social community that can shape behaviour among service users. Helping others allows people to take on a socially valued role and make meaningful connections with other people. Mutual help meeting involves service users and staff attending voluntary, structured meetings that are held regularly by programs. These meetings are opportunities to give thanks, provide relevant program news and updates, offer suggestions, and make requests and offers to others.
8. **Calm down methods**: A range of behaviours may signal emergent distress (e.g., facial expressions, tone of voice, irritable and curt responses to reminders and minor requests, restlessness, changes in eye contact). Calm down methods involves the assemblage of distress tolerance items that can be offered to service users in response to emergent signs of distress or upon request. Example items may include message balls, fidget toys, personal fans, chewing gum, blankets of differing thickness and textures, distraction activities (deck of cards, puzzles, I Spy and joke books, adult colouring books, comedy DVDs, access to TV room or a computer), and ear plugs. Concurrently attending to service users' food and drink needs is another calm down method.
9. **Reassurance**: Incidents in communal spaces can affect everyone who is present and increase the risk of secondary incidents from the resultant stress and anxiety. Reassurance involves staff checking-in with service users who experienced, witnessed, or heard about incidents in the program to hear their perspectives on what has occurred, its impacts on them, and provide any necessary information without violating the confidentiality of the involved parties. Increased staff presence following incidents also helps service users to feel safe and secure in the program.
10. **Discharge messages**: When service users leave programs (in shelters, this would occur when service users obtain housing), they can be asked to leave their most positive or helpful piece of advice for new service users, which can be posted on a public notice board in the program. These messages can provide reassurance and foster hopefulness.

The above information was drawn the *Safewards* website (https://www.safewards.net). More information on the model, descriptions of each intervention, and implementation resources are available on the website.