"It was a perfect storm"

Experiences and perspectives of service providers, advocates and policymakers following the closure of a shelter and consumption and treatment services site in response to a critical incident in a mid-sized city in Ontario, Canada.

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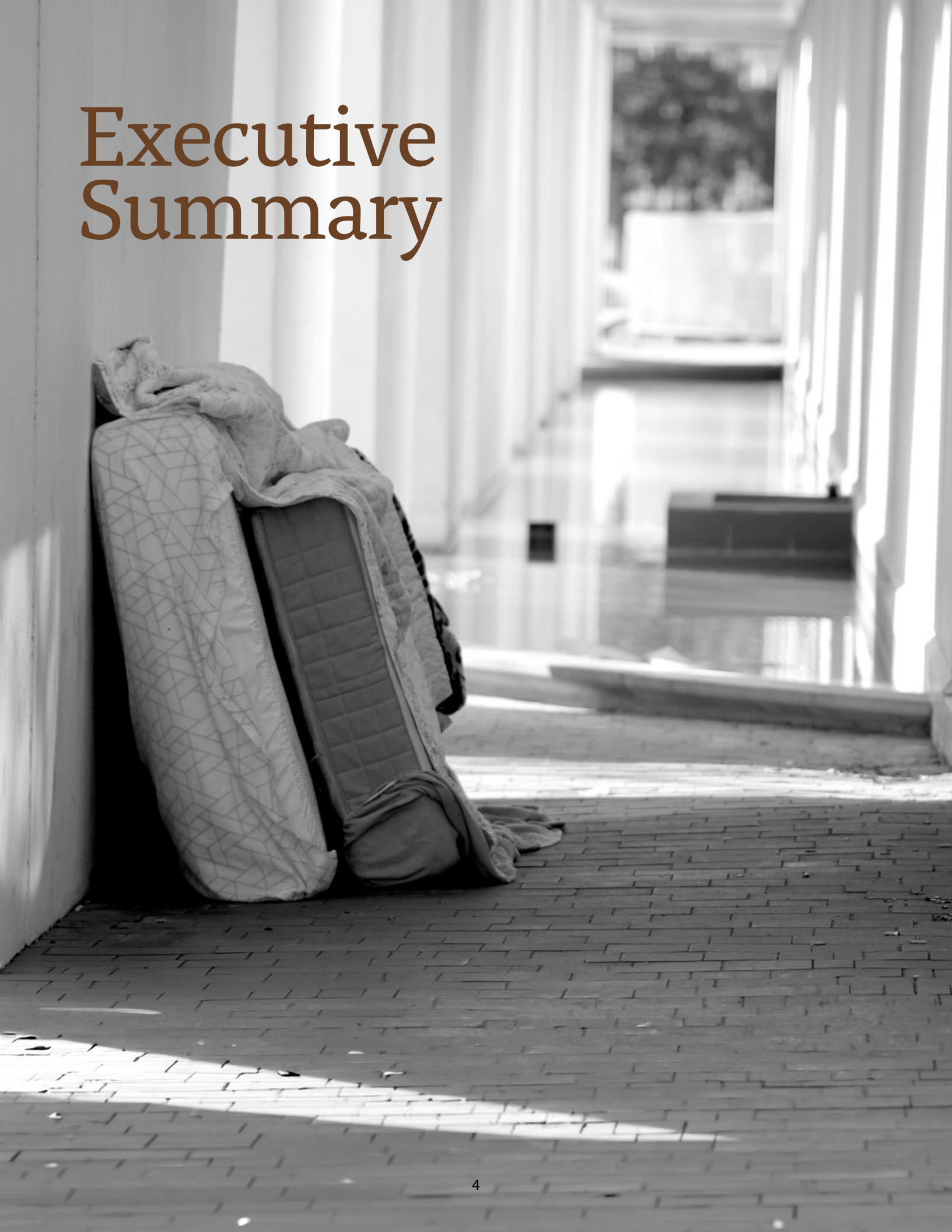
Dedication

This study is dedicated to the three people who were brutally victimized during the events that occurred on September 12, 2024, resulting in the death of two people far too soon. We also dedicate this study to all of the people who witnessed these events who still carry with them the trauma of this day. We acknowledge the alleged perpetrator, who died tragically on May 22, 2025 while in custody. All are victims of this critical incident. We hope that this study provides some opportunity to promote community understanding, and to open a conversation within an increasingly divided society.

Executive Summary



Homelessness is growing in Canadian communities and beyond, with warnings that without significant intervention, the problem in Ontario alone could increase from 84,973 individuals in 2025 to over 294,266 by 2035 [1,2]. The presence of this worsening social situation has exposed deep divisions across our communities. Everyone wants homelessness to go away. For some, this means solving the problem. That is, creating a system where homelessness is no longer a reality due to the presence of sufficient, deeply affordable housing for all citizens in our communities. For others, making homelessness go away means that unhoused individuals are hidden out of view, or disappear altogether, such as through encampment evictions, and the enforcement of laws that prohibit unhoused people to exist in public places, even when shelter beds and housing are largely unavailable.

Homelessness alone is a deeply stigmatized social condition, but when layered over substance use disorder, the impulse to hide or even punish unhoused people becomes especially pronounced. In recent years, homelessness and the substance use of individuals who experience it has become the focus of political campaigns where unhoused individuals are framed as deviant and dangerous, thereby instilling fear in members of the general public towards this population. Increasingly, mental illness itself, including substance use disorder, is characterized as the sole cause of homelessness by policymakers. Consequently, the solutions that such policymakers propose are not to provide housing, but rather to eliminate the symptoms of mental illness and substance use disorder. In line with this thinking, policymakers then fund mental health and substance use treatment programs instead of permanent supportive housing. The flaw in this logic is that it fails to acknowledge that in order to be mentally well, one requires housing, and the safety and security it affords. Mental health and substance use recovery cannot exist in the absence of permanent and deeply affordable housing. Housing is the foundation for recovery to occur.

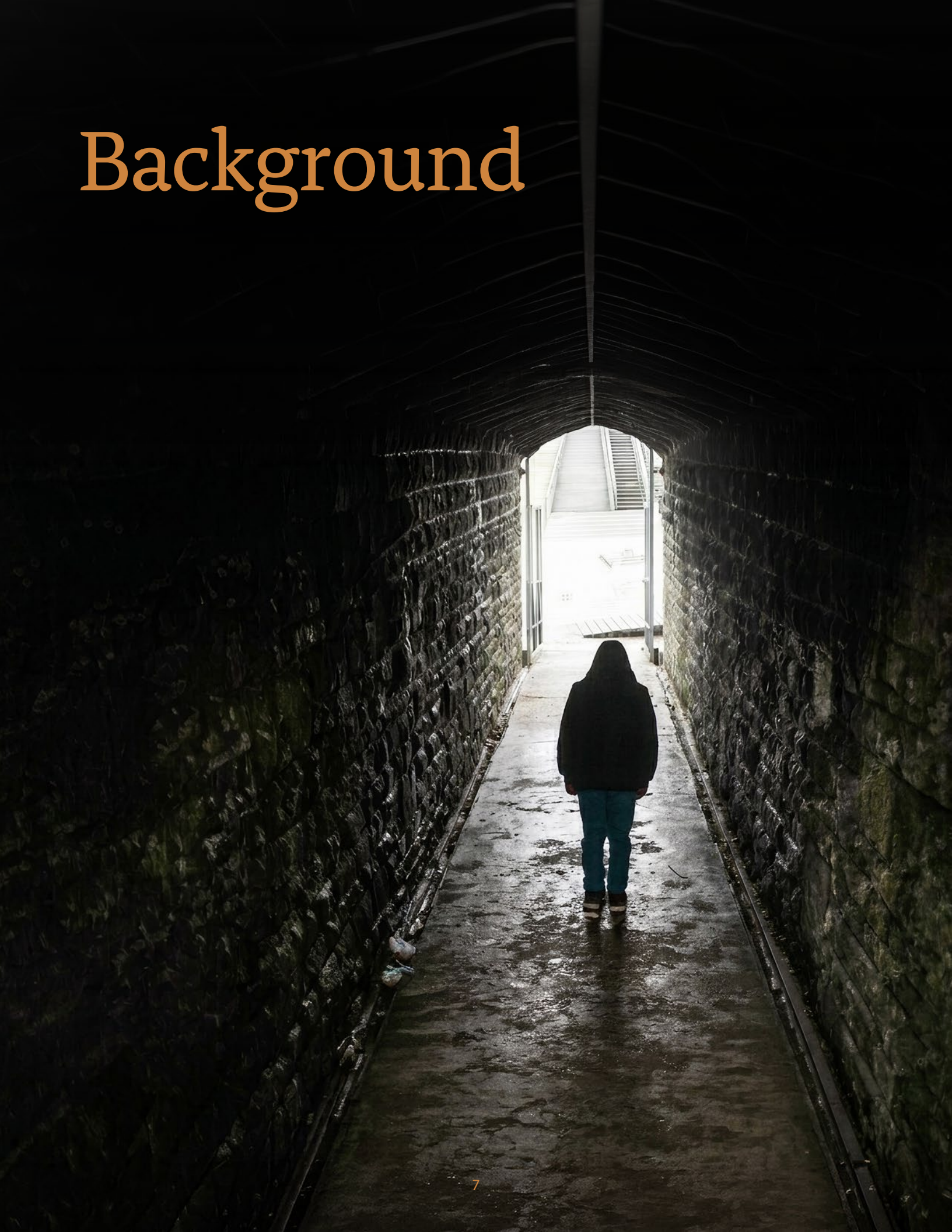
In this report, we present a critical narrative inquiry exploring the perspectives and experiences of 22 service providers, advocates and policymakers following the immediate closure of an emergency shelter and co-located consumption and treatment services site following a violent incident in one community in Ontario, Canada. We identify how this incident affected the community in which it occurred, and how deeply it was felt by all involved. Further, we explore how a range of perspectives on homelessness and substance use disorder among unhoused individuals were revealed and mobilized by policymakers, service providers, and the general public during and following this incident, and came to inform the approaches taken. We argue that the incident described, and how it unfolded in this community reveal the presence of homeism and sanism in policymaking, and a movement toward ideology instead of evidence-informed decision-making.

We conclude by reflecting on the aftermath of this incident in the context of broader, recent policy changes across Canada. In so doing, we contend that policymakers have shifted away from a "war on drugs" mentality to a "war on harm reduction." This shift is evident in how homelessness and substance use have become conflated in public debate and policy discussions about how to address the crisis of homelessness in Canada, and a lack of interest in re-investing in a deeply affordable social housing system.

We are in the midst of one of the most serious human right crises of our time. We can respond thoughtfully by addressing the causes of homelessness – a lack of deeply affordable housing and rising rates of poverty; or we can react to the outcome of poor policy decisions by punishing unhoused people and making them disappear. We offer this report with an objective of educating policymakers, service providers, and the general public and encouraging increased compassion in policy and everyday discussions about the needs of unhoused people in our communities. Most importantly, we offer this report with the hope of helping a community to heal and make meaning of an incident that affected the lives of so many from the time that it occurred to the present day. We offer these perspectives to inform sounder and more compassionate decisions that affect the lives of individuals who have been denied the right to housing in our communities in the future.

Table of Contents

Background



As homelessness continues to grow across Canada and the rest of the globe, attitudes towards unhoused individuals appear to be shifting from compassion and understanding to disdain and derision [3].

The stigma of homelessness is easy to observe in our everyday conversations, in mainstream media, and in the rhetoric of political actors within and beyond our communities. Not only are we readily exposed to the stigma of homelessness in movies, online videos and commentary posted on social media, but this stigma is increasingly and openly expressed by elected officials, thereby validating these beliefs and providing average citizens with the license to freely express discriminatory attitudes towards one of the most oppressed groups in our society. In 2024, for example, Doug Ford, the Premier of the Province of Ontario made public remarks where he provided unhoused people with the advice to "get off your ass and start working like everyone else" [4]. In 2025, Wally Daudrich, a Manitoba Conservative Party leadership candidate, "joked" publicly about releasing polar bears in downtown Winnipeg to address the problem of homelessness in that city [5]. The freedom with which public officials share these comments is illustrative of growing political polarization and the broadly held stigmatized beliefs of many in society. Rather than viewing unhoused persons as collateral damage in an age of growing income inequality in Canada and beyond, many are choosing to see people who lose their housing not as one of 'us,' but members of an 'other group' who have failed to live up to our expectations as citizens in our communities.

Homeism and Sanism as Barriers to Effectively Addressing Homelessness

"Stigma" is a term that originated in ancient Greece to refer to the symbols that were cut or burned on a person's skin to mark them as an outsider due to their status as a slave, or to communicate to others some deviant act they had committed [6]. It was a mark on the body indicating that the person who bore it should be avoided by mainstream society. Erving Goffman popularized this term to refer to a person who possessed qualities seen as deviant from the perceived "norm." He identified that stigma transforms a person in such a way that they are "reduced in our minds from a whole and usual person to a tainted, discounted one " [6].

Stigma is a mark of difference, yet discrimination and oppression represent the impacts of harm perpetuated by the dominant society in the lives of people who are seen as different or deviant. "Homeism" is a term introduced by researchers studying the stigma of homelessness in healthcare settings [7]. It is a specific type of discrimination that is directed towards individuals based on their status as an unhoused person. In this paper, we argue that social actors including service providers, policymakers, researchers and even persons with lived experience themselves engage in behaviours that are illustrative of homeism, and that this is built upon, and includes, discrimination stemming from the stigma of mental illness, including substance use disorder.

"Sanism," is a form of discrimination that is associated with mental illness rather than housing status [8]. In contrast to homeism, sanism represents discrimination that is specifically linked with the presence of mental illness, or the perception by others that a person is experiencing poor mental health [9]. It is widely acknowledged that homelessness and mental illness are deeply intertwined, and for good reason. It is difficult to imagine living in states of indignity and deep poverty without a consequent impact on mental health. While this is the case, public perceptions represented in media and advocacy efforts suggest that rates of mental illness, and substance use disorder in particular, are far more prevalent than they actually are, and that these health conditions cause and perpetuate homelessness. In January, 2023, the mayor and city council of the City of Kingston, for example, declared a "mental health and addiction crisis" in relation to homelessness, positioning mental illness as the cause of homelessness in their city [10]. In December, 2025, mayors of the 29 largest cities in Ontario, Canada, declared a state of emergency for what they called a "homelessness, mental illness and addiction crisis" [11]. In this declaration, these mayors seemed to suggest that if sufficient funding and resources were provided to address persistent mental illness and addiction among unhoused individuals, that the problem of homelessness would be solved. Not only can this be perceived as a distraction from the fact that policymakers have consistently failed to implement sound housing policies that meet the needs of people living in the deepest degrees of poverty in our society, but a focus on mental illness, and substance use disorders in particular as a cause of homelessness, places the onus solely on the mental health system, and unhoused people rather than the policymakers themselves.

It is true that mental illness and substance use disorders are more prevalent among persons who experience homelessness. A recent systematic review and meta-analysis of 85 unique studies identified the current prevalence of mental illness among persons experiencing

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homelessness to be 67% with a lifetime prevalence of 77% [12]. Substance use disorder, a form of mental illness that is rarely acknowledged as such outside of academic and healthcare contexts, has long been associated with homelessness, and has been estimated to affect 21.7-44% of this population [12,13]. Mental illness sometimes precedes homelessness, yet it may also develop as a response to living in inadequate and challenging conditions while a person is unhoused. Living within shelter environments, facing violence and victimization, and living in undignified conditions for sometimes years at a time is likely to influence a person's mental health in negative ways [14,15]. This means that individuals who are unhoused are much more likely to experience mental health difficulties simply because they are trying to manage their daily lives while living in extreme poverty with unmet needs for shelter, food, and safety [16]. Unhoused individuals may even use substances to cope with the difficult lives that have been created for them [17-19].

Homelessness is not caused by the presence of mental illness. Rather, it is the end result of poor policies that force individuals, particularly people living with mental illness, to live on impossibly low incomes that disable them from competing in a market housing system. These low incomes, combined with a dire lack of deeply affordable and permanent supportive housing, place people in positions where they are living in a perpetual state of survival. Forcing people into lives of constant precarity is associated with a reduced lifespan where individuals living with mental illness are estimated to die nearly 15 years earlier than others in the general population on average [20]. This can be seen as a form of structural genocide where people living with mental illness are relegated to a life where they cannot meet their basic needs on a chronic basis, thereby resulting in premature death.

Individuals who experience homelessness and live with substance use disorder face a particular kind of vitriol reserved only for people who have committed serious crimes. The discrimination and oppression arising from homeist and sanist beliefs is expressed in policies created to control and 'correct' the deviant behaviour of people who use substances and experience homelessness. Across Canada, there is a growing effort on the part of policymakers to advance policy aimed at addressing what they see as the causes of homelessness – mental illness and substance use disorders. Advocacy for forced treatment of substance use disorder is no longer a fringe, and fleeting suggestion. In 2025, the Province of Alberta, Canada passed the "Compassionate Intervention Act," which provides family members, guardians, service providers, or justice officials with the legal right to impose a substance use treatment order for individuals who are seen to be a risk to themselves or others in relation to their substance use [21]. Other provinces across Canada are engaged in public debate about enacting similar legislation. This focus on the treatment of mental illness as a strategy to "solve homelessness" while simultaneously withholding the availability of permanent and deeply affordable housing and a livable income is a manifestation of sanism because it frames homelessness as a problem of mental health, and fails to acknowledge the profound impact of being unhoused on mental well-being. This approach also reflects

homeism because it holds people who are unhoused accountable for the circumstances in which they live, and disacknowledges the role of structural factors in their inability to sustain a tenancy.

From the "War on Drugs" to the "War on Harm Reduction"

Canada is in the midst of a drug poisoning crisis, resulting in a total reported 55,032 opioid and stimulant toxicity deaths between 2016-2025 [22]. Between 2024-2025, 16 people died of opioid poisoning per day in Canada, and 98 emergency medical services (EMS) calls were responded to daily for an opioid poisoning event [22]. These numbers equate to 5,840 deaths and 35,770 EMS responses in a single year, representing a serious health care problem, and a leading cause of death in Canada [23]. Harm reduction is an approach to practice and policy which emphasizes the reduction of harms associated with behaviours which may pose a risk to health including substance use, sex work, disordered eating, and non-suicidal self-injury [24]. This approach, which has been used for over 100 years, took hold in the 1970s and 1980s in response to an observed increase in the prevalence of infectious diseases such as hepatitis and HIV during that time [25]. Harm reduction emphasizes the autonomy of all people to engage in behaviours in which they need or wish to engage, including substance use [26]. For people who use substances, harm reduction promotes the use of strategies to reduce harm, and may include drug testing, needle exchange programs, widespread training in naloxone administration, and the use of overdose prevention sites [26].

In contrast to harm reduction, moralistic approaches to substance use frequently regard the use of substances as immoral, and emphasize the use of laws to punish individuals who engage in the use of illicit substances [27]. Such approaches lack empirical evidence for supporting their use, and were the impetus for the infamous "War on Drugs" initiated by the Nixon administration in the United States in the 1970s [28]. Moralistic approaches to addressing illicit substance use have resulted in considerable harms including the criminalization of people who use substances [29]. For individuals who experience homelessness, criminalization only makes it more challenging to leave homelessness and improve one's social and material circumstances that are necessary for sustaining and thriving in permanent housing [30].

Harm reduction has been controversial since its inception. Opponents of this approach often express concerns that such services 'enable' substance use behaviour [24]. Overdose prevention sites, where a person can use substances in the presence of health and social care providers who are trained to intervene in the event of an overdose, where harm reduction supplies can be provided free of charge, and where individuals can access support for managing or reducing substance use, were opposed by policymakers for the years leading up to their widespread implementation across Canada [31]. The first sanctioned overdose prevention site in Canada opened in 2003 in Vancouver [31]. Since then, harm reduction advocates have tirelessly educated the public and policymakers about the contribution that harm reduction services make in the midst of tension between ongoing opposition, and strong empirical evidence that these services are an essential and effective lifesaving intervention [32]. In March, 2026, for instance, the Province of Ontario announced that they will end funding for seven overdose prevention sites by June 13, 2026 [33]. Within weeks, both Alberta and Saskatchewan followed by announcing the closure of overdose prevention sites across these two provinces [34,35]. In Ontario, the de-funding of overdose prevention sites has occurred in concert with the Province of Ontario providing funding for Homelessness and Addiction Recovery Treatment (HART) hubs, which take an abstinence and withdrawal management approach to supporting people who use substances and experience homelessness [36]. The choice to withdraw funding for overdose prevention sites while also increasing funding for abstinence-based models of service is indicative of the backlash of policymakers on harm reduction approaches in the face of limited evidence to support this approach.

Just prior to these developments, the Province of Ontario enacted two types of legislation that appear to be aimed at controlling the behaviours of individuals who use substances and experience homelessness under the guise of community safety. In 2024, the Province of Ontario enacted the "Community Care and Recovery Act" which prohibited the operation of an overdose prevention site within 200 metres of a child care

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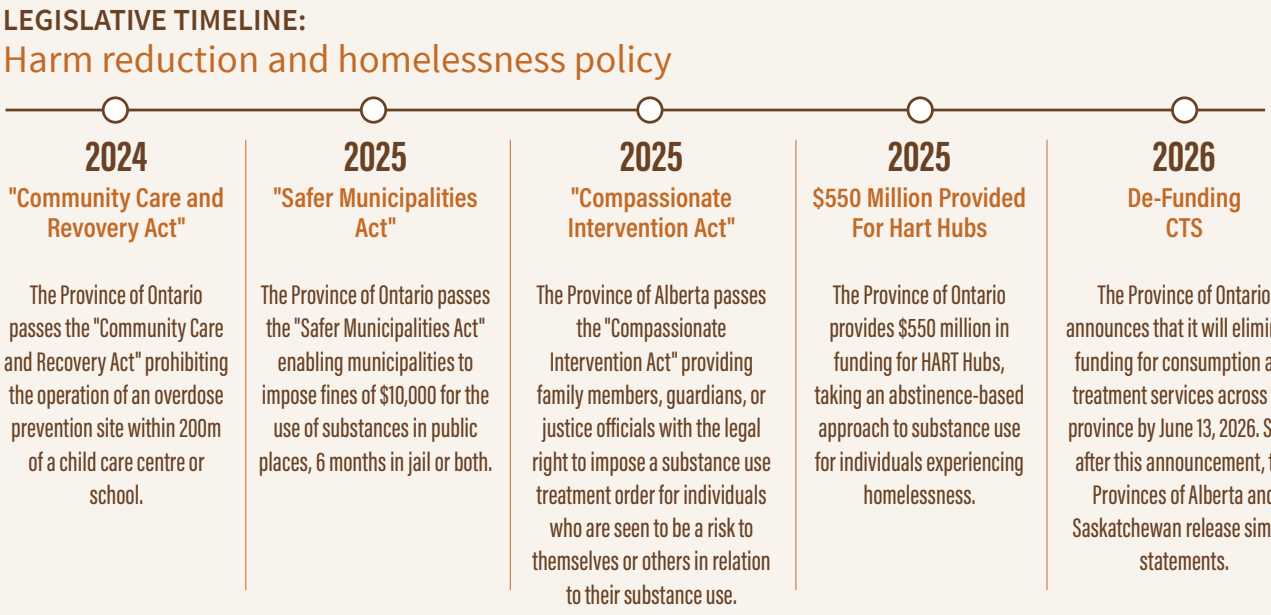
centre or school [37], causing the closure of 10 overdose prevention sites across the province resulting in a Charter Challenge [38]. Following this, the same province passed legislation called the "Safer Municipalities Act" in 2025, which enables municipalities to impose fines of up to $10,000 for the use of substances in public places, six months in jail, or both [39]. Use of substances in overdose prevention sites is one exception in this legislation [39]. With the announced de-funding of overdose prevention sites, however, people who use substances and experience homelessness will be placed in an even more precarious situation than they already are. Not only will they have fewer options for using safely with support, but they will also be placed at heightened risk of criminalization. This situation is not only illustrative of a "war on harm reduction," but also demonstrates examples of both homeism and sanism deeply embedded within the legislative process. See Figure 1 for a summary of the legislative timeline summarizing policy developments.

Figure 1



Research Focus:
Service Closure During a Community Crisis

In this study, we explore the experiences of service providers, advocates and policymakers before, during, and after the closure of critical services following a crisis that occurred in Kingston, Ontario Canada in 2024-2025. On September 12, 2024, a housed individual allegedly entered an encampment for unhoused individuals, and caused two fatalities after seriously assaulting a woman on the way to the encampment [40]. This encampment was situated behind one of the city's largest, and low-barrier, shelters in the city within an Integrated Care Hub (ICH), which also hosted a co-located overdose prevention or consumption and treatment services (CTS) site. The ICH was informed by a harm reduction approach. In the months and years leading up to this incident, there were a range of concerns raised about these services and the people who used them by neighbours and policymakers. These concerns centred around safety surrounding the encampment and ICH and enjoyment of the neighbourhood that surrounded them [41,42]. At various times, demands by the municipality were imposed for changes in how these services were operated. This in turn raised concerns by service providers, who largely viewed these demands as stemming from inaccurate information presented by community members and the stigma related to substance use in their community [43].

Following the violent incident, the ICH, including the shelter and CTS was immediately closed for a one-month period from September 12 - October 17, 2024. The surrounding encampment was evacuated. A steel fence was erected in a large area extending beyond the ICH and encampment where it was situated on municipal property. Shelter beds were made available in other shelters in the community to accommodate people who had been displaced. Security officers were hired to enforce control and maintain safety in the building and perimeter around the property. Any vehicles entering the premises needed to be admitted by security personnel at a monitored gate. The shelter was closed for four months from September 12, 2024 - January 6, 2025. When the shelter was re-opened, new restrictions including heightened security, and the maintenance of the steel perimeter fence remained 44. This staged re-opening is depicted in Figure 2 and the geographic location of the shelter services, overdose prevention site and encampment are depicted in Figure 3.

In this research, we sought to understand the perspectives and experiences of service providers, advocates and policymakers as they experienced this incident and the municipal response. In particular, we explored how this event exposed divisions in the community in which it occurred, and how the concepts of stigma, sanism, and homeism are illustrated in the municipal and community response to this incident. By understanding these experiences and perspectives, we intend to inform future approaches for managing such crises in other communities, the ways in which a community can be affected by the sudden closure of critical services, and the meaning of services for policymakers and the people who work in them. This study was guided by the research question: What are the perspectives and experiences of service providers, organizational leaders, policymakers, and advocates during the temporary closure of a co-located low-barrier shelter and overdose prevention site following a community crisis?

Figure 2

Staged re-opening of the ICH and CTS

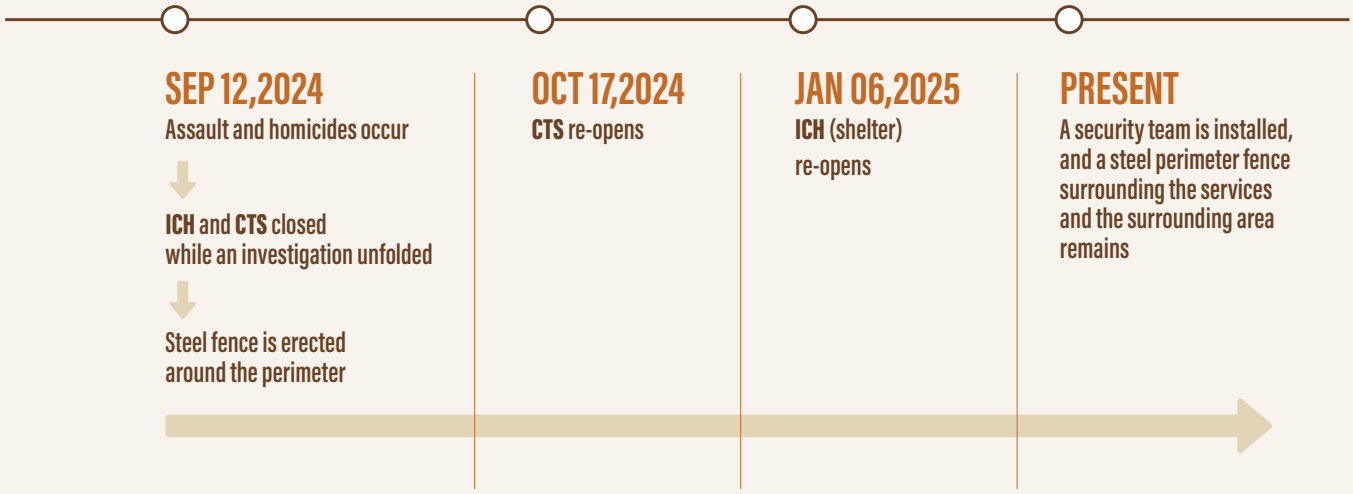


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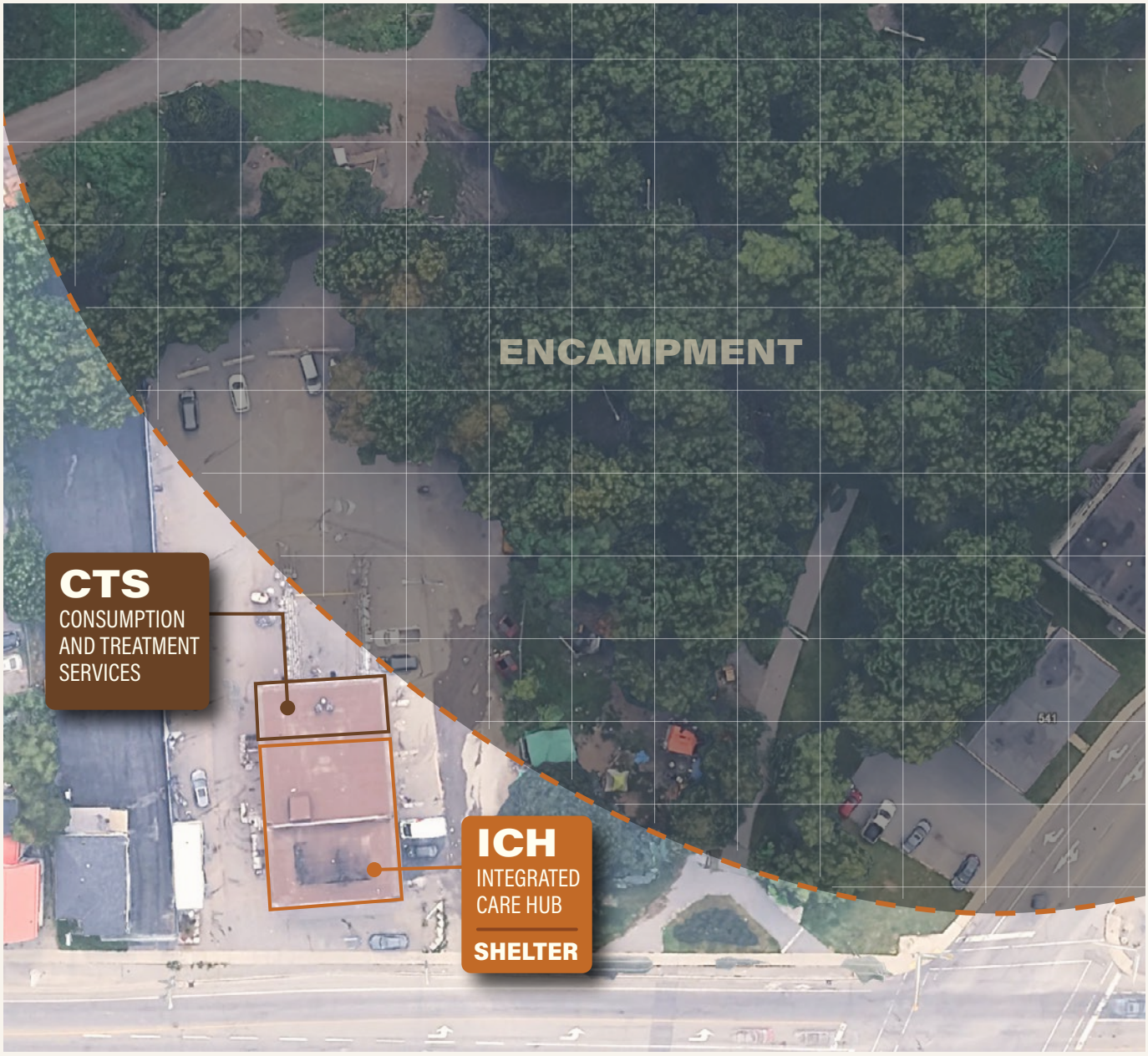
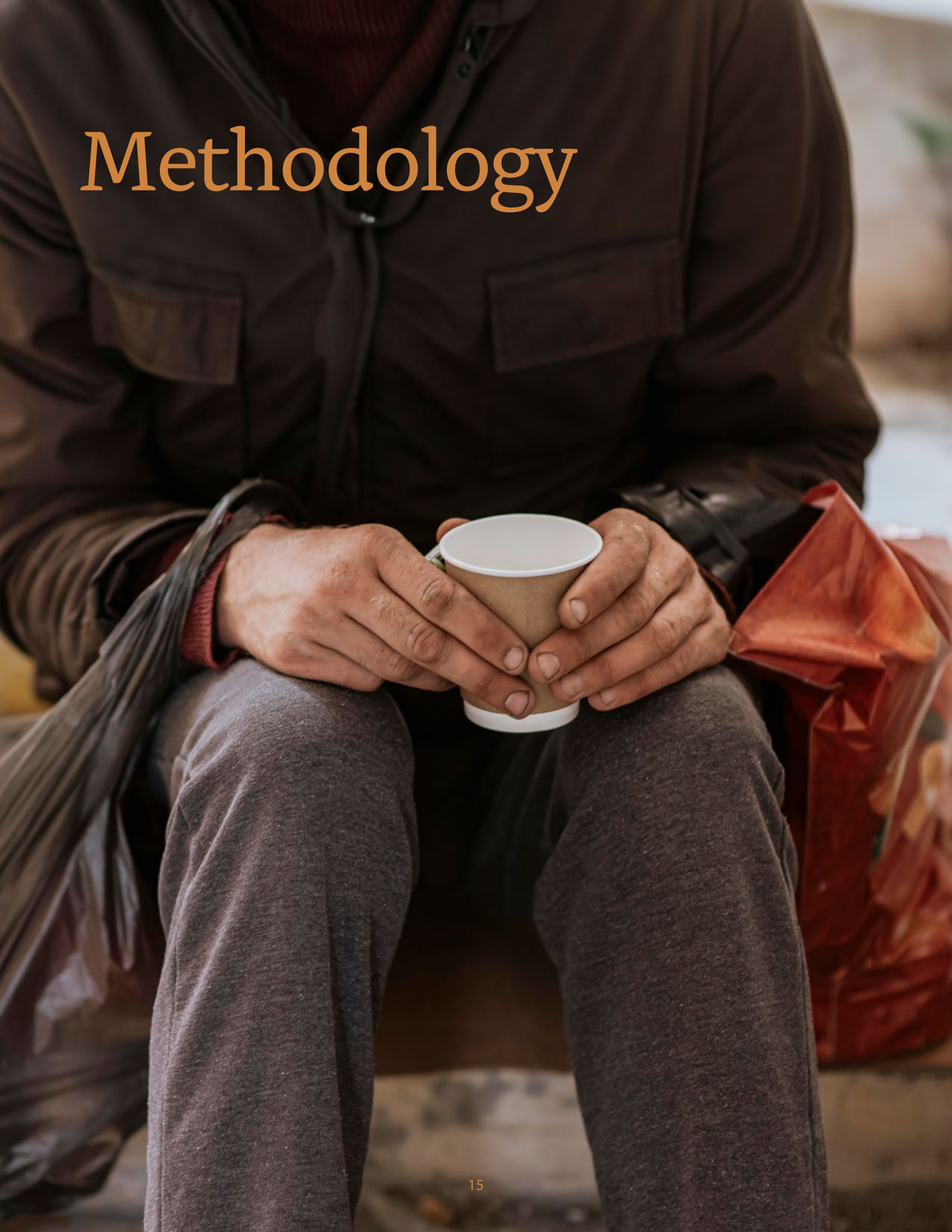
Figure 3

ICH, CTS and Encampment Locations



Methodology



To explore our research question, we conducted a critical narrative inquiry, a methodology that aims to understand the narratives of a group of participants using a critical lens [45]. This methodological approach acknowledges that humans recall their experiences through storytelling, and recount these experiences in ways that follow a narrative structure [46]. In using narrative inquiry, we can reconstruct the narratives of a group of participants by recounting their stories though a single narrative in the form of themes as they evolved over time [47]. As such, our findings are presented as a story, with a beginning, middle and end.

Recruitment

After receiving ethics approval from Western University in London, Ontario, Canada, we recruited service providers and policymakers who had knowledge of the critical incident described in the introduction section of this paper. We recruited service providers, advocates, policymakers and organizational leaders from agencies that provided social service and mental health supports to individuals experiencing homelessness throughout the affected community. Such organizations included shelters, drop-in centres, and community mental health services. To recruit participants, we: 1) sent emails directly to leaders of health and social care organizations detailing information about our study and requested their participation; and 2) presented to shelter and case management staff within relevant organizations and encouraged interested individuals to contact the research team directly.

Inclusion and exclusion criteria

We included participants who had been employed as service providers, policymakers and as leaders in organizations whose work involved providing direct service, or influenced municipal or organizational policy regarding individuals experiencing homelessness in the affected community. We only recruited individuals who had been affected by, or who had direct exposure to the critical incident. Individuals who were over the age of 18 and who had at least one month of experience in practice, advocacy, or policy regarding homelessness, were included as participants in this research.

Procedure

Interviews were conducted between July 22, 2025-November 17, 2025. We arranged suitable times and dates with individuals meeting the inclusion criteria to facilitate the conduct of interviews. Once these interviews were arranged, we sent a link to a survey developed in Qualtrics [48] that included a letter of information and informed consent followed by brief demographic questions (gender; time engaged with the low barrier shelter and CTS in months; profession; role; years of experience in practice or policy related to homelessness; highest level of education).

Three members of our team (CM, BW, LSJ) were involved in the conduct of semi-structured interviews using a qualitative interview guide. Questions posed to participants followed a narrative structure, asked participants to recall their experiences before, during, and after the critical incident, and to describe their perspectives on the decisions made throughout this experience by a range of social actors. All interviews were conducted virtually via Zoom [49]. The qualitative interview guide used during these interviews is presented in Table 1.

Table 1

Semi-structured interview questions

1. Tell me about the closure of the consumption and treatment services (CTS) and co-located shelter in Kingston and the events that led up to its closure.
2. What was the initial impact of the closure on the community? On your colleagues? On people who used the CTS/shelter?
3. During the closure, what impact did this have on people who use substances and/or experience in the community?
4. As the closure continued, what did you see happening in the lives of persons who use substances and/or experience homelessness?
5. As the closure continued, what did you see happening in the community and in local services?
6. Since the CTS has re-opened in October, what changes have you noticed in the community as a whole? For persons who use substances and/or experience homelessness? In services that support people who use substances and/or experience homelessness? a. Since the shelter has re-opened, what changes have you noticed?
7. If the CTS and shelter were suddenly closed again in the future, what do you think might happen in your community? What about other communities where there is a possibility of sudden CTS and shelter closures?
8. What do you think we need to do as a community to support the interests of people who use substances and the community as a whole in relation to CTS services and shelter programs when community crises occur?
9. What would you recommend to policymakers regarding responses to future community crises that involve services for individuals who use substances and/or experience homelessness?
10. Is there anything that we have not discussed today that you think is important to mention with regard to how we respond to community crises involving persons experiencing homelessness and substance use services in the community and beyond?

Analysis

In conducting our analysis, we have assumed a constructionist epistemology wherein research findings are co-constructed with participants through the conduct of interviews, and following analysis as participants reflect on their own narratives and the narratives of others [50]. A constructionist approach acknowledges the contributions of the researcher to the research, and the ways in which knowledge is created through an interaction with participants [50].

Consistent with critical narrative inquiry, we analyzed our data by coding transcripts abductively, using a critical theoretical orientation [45,47]. We coded our transcripts using Dedoose, a cloud-based qualitative data management program that facilitated the organization of our data [51]. Several members of our research team engaged in this process (BW, LSJ, EJ) and coded statements pertaining to the research question. Once all transcripts were coded, we arranged codes into a narrative structure identifying participant narratives before, during, and in the aftermath of the critical incident under study [46]. We identified themes within this narrative structure, and the principal author (CM) then wrote this structure into a narrative incorporating participant quotes and themes identified. As a constructionist approach, we engaged in a member checking process wherein we presented the reconstructed narrative back to the participants, and requested their input, which was used to refine our written narrative. Once our findings were analyzed and written, final feedback was provided by all study authors on the analysis presented, and was subsequently refined further.

Trustworthiness

Trustworthiness was established using criteria identified by Lincoln & Guba [52]. Strategies used included: (a) prolonged engagement with the population of interest, which was achieved through extensive experience by several members of our research team as researchers and practitioners in the area of homelessness, and pre-existing relationships with the recruitment organizations; (b) peer debriefing, which involved continuous debriefing among several members of the research team involved in data collection and analysis; (c) recording interviews; (d) accurate transcription; (e) intercoder consensus; and (f) use of a computer program to organize data (Dedoose), which contributed to the dependability of our analysis.

Reflexivity and Positionality

Combined, the principal investigator and members of our research team have decades of experience in conducting research related to homelessness, and practicing in health and social care professions with individuals during and following homelessness. All research team members identify as cis-gendered, with all identifying as women. Our team represents a range of races. Two members of our research team immigrated to Canada after living in other countries. At least one member of our team has lived experience of poverty. We recognize the impossibility of setting aside these prior experiences in the analysis of our data. As such, we have embraced this knowledge as a strength in informing our analysis by actively drawing on these experiences during the process of interviewing, coding and analysis. We discussed our positionality throughout the process of analysis by engaging in in-depth discussions during the coding, theme generation, and writing process.

Findings

A total of 22 service providers, advocates, organizational leaders and policymakers participated in this study. Of these, 15 (68%) identified as women, and seven (32%) identified as men. Participants had interacted with the ICH and CTS for 2-8 years (24-96 months; m=56.5 months; sd=25.3 months) before participating in this study. Participants represented a range of professions including occupational therapists (n=2; 9.1%), registered nurses (n=2; 9.1%), social workers (n=2; 9.1%), child and youth worker (n=1; 4.5%), kinesiologist (n=1; 4.5%), harm reduction professional (n=1; 4.5%), paramedic (n=1; 4.5%), and peer support worker (n=1; 4.5%). Half of participants did not provide their profession when responding to this question (n=11; 50.0%). The roles that participants occupied included leaders in a healthcare or social service agency (n=10; 45.5%), direct service providers (n=6; 27.3%), advocates (n=3; 13.6%), and policymakers (n=3; 13.6%). Participants were educated at the high school level (n=1; 4.5%), had completed some college or university (n=2; 9.1%), had completed a college or university diploma or degree (n=13; 59.1%), or had completed a master's or PhD (n=6; 27.3).

Table 2

Participant Demographic Characteristics (n=22)

DEMOGRAPHIC CHARACTERISTICS

GENDER

WOMEN	MEN
15 (68%)	7 (32%)

PROFESSION

OCCUPATIONAL THERAPIST 2 (9.1%)	HARM REDUCTION PROFESSIONAL 1 (4.5%)
REGISTERED NURSE 2 (9.1%)	PARAMEDIC 1 (4.5%)
SOCIAL WORKER 2 (9.1%)	PEER SUPPORT WORKER 1 (4.5%)
CHILD AND YOUTH WORKER 1 (4.5%)	OTHER 11 (50%)

ROLE

LEADER IN A HEALTHCARE OR SOCIAL SERVICE AGENCY 10 (45.5%)	SERVICE PROVIDE IN A HEALTHCARE OR SOCIAL SERVICE AGENCY 6 (27.3%)
ADVOCATE 3 (13.6%)	POLICYMAKER 3 (13.6%)

HIGHEST LEVEL OF EDUCATION

HIGH SCHOOL 1 (4.5%)	SOME COLLEGE/ UNIVERSITY 2 (9.1%)
COLLEGE/ UNIVERSITY COMPLETED 13 (59.1%)	MASTER'S/ PHD COMPLETED 6 (27.3%)

LENGTH OF TIME IN A ROLE RELATED TO HOMELESSNESS IN YEARS: 2-36 (m=11.4; sd=9.1)

LENGTH OF TIME INTERACTIN WITH THE SHELTER AND CTS IN MONTHS: 24-96 (m=56.5; sd=25.3)

Qualitative findings

Interviews ranged from 37-66 minutes in duration (m=49.3). The narrative that we have identified through our analysis reveals the polarization in the community under study, and particularly regarding concepts of harm reduction and the rights of individuals experiencing homelessness who use substances. This narrative is organized as a story, beginning with the perceptions and experiences of participants before, during, after, and in the aftermath of the closure of the ICH, clearing of the encampment, and closure of the CTS that is the subject of this paper. The overall sentiment of our findings was that participants described this incident and the reaction to it as *"a perfect storm"* [Andy].

CONTEXT PRIOR TO THE INCIDENT: *"they were done before it even started"*

Before the incident began, participants discussed a high level of tension that formed a foundation for the community and municipal response to this event. This included the ongoing frustration of community members living around the shelter, encampment, and CTS, and the municipal policymakers who were often tasked with mediating this frustration:

> *I think there was some political motivation that the CTS and ICH wasn't truly supported. It was more tolerated. And I think...there was some stronger political factions within the City of Kingston that wanted it closed. Not on an evidence basis, but wanted it closed on an ideological argument. And I think there were certainly community members wanting the same. And folks that live close to the CTS or ICH, they work ...very hard to build those community relationships. And I think sometimes those get strained.* [John]

> ***"there was some stronger political factions within the City of Kingston that wanted it closed. Not on an evidence basis, but wanted it closed on an ideological argument."*** **[John]**

Participants highlighted that the municipal government in Kingston had engaged in previous actions to control the encampment surrounding the ICH. These tensions ebbed and flowed, but overall, remained significant in the years leading up to the closure of these services. Robin highlighted several attempts by the municipal government to legally evacuate the encampment surrounding the shelter, a decision that had been overturned through a judicial review process in November 2023 [53]:

> *I'll just map out a couple of specific things. The city went to court in the summer of 2023 to try to evict the Belle Park encampment. You know, the court case happened in the fall of 2023 where a judge decided that people had the right to stay overnight in the park. And then post-winter, in the spring of 2024, the City of Kingston was signalling that they were going to try to enforce some type of daytime [camping ban] in Belle Park which they had already been doing in other camps.* [Robin]

In addition to these political tensions, participants described that high demand for services, combined with a population of service users that was described as increasingly complex led to service providers feeling strained and morally distressed.

> *...there's more of a mixed demographic among the folks that are being served at a number of organizations now, sort of post-pandemic...And so, you've got people with some very complex mental health needs. You've got people with substance use related challenges, including maybe some behaviours that come out, because of their substance use, or because of mental health issues. And people who are sort of new to this side of the community...And so, there's this balancing act that places are trying to do, where they're trying to meet everyone's needs, but it's difficult.* [Jill]

In this context, participants described how the roles of service providers who are supporting unhoused people who use substances often lack agency to change the system. They lack agency while at the same time face the disdain of policymakers and the general public because the problem of homelessness continues to persist. Participants found that educating others about these experiences was important for promoting community understanding:

> *They're trying to do the best they can within a system that I don't think works particularly well. And they don't always get to make the decision. You can be a staff member and write a report. It may never go anywhere, right? So oftentimes, we have advocates saying, "They're so dumb they don't know what they're doing." There's this whole narrative out there that, "Who are we employing?" Meanwhile, that causes injury to the people who we need to do the work to get moving forward. So, you've got injured staff. You've got, the public who's injured...when you start explaining this to other people, they go, "Oh, I didn't think about that."* [April]

Participants described how the intensity of this work resulted in a situation where when the incident that is the subject of this paper occurred, that service providers were so weakened by the work, that they had little

emotional capacity to manage: *"The moral injury of having to work with people who are dying...who are palliative and dying...they also were in rough shape and not in a place where they could rally and make the best of a situation. They were done before it even started"* [Andy]; and: *"lots of moral injury going on. I've been in the field a long time. I have never seen the rate of burnout that I have seen in the last five or six years. Never, never. I have never seen so many workers go off work due to stress. Sick leave, PTSD. They are literally just throwing us out to the wolves and expecting us to fix all the problems."* [Emily]

Participants felt abandoned by municipal policymakers prior to the incident. They felt as though city officials should have sought to correct this narrative with the public. Rather, participants described their perception that the municipal government had allowed the blame for the presence of homelessness, violence, and substance use in the city to rest with the organizations who were tasked with addressing these social problems. They described how the public was apprised of little information about the important role they played in addressing the impacts of structural violence in their community:

> *We should have had our City Council stick up for us in regards to the media and the portrayal of the people that we serve. They should have stepped up and talked about the 4,000 overdoses we've responded to. The countless violent assaults that have happened to people...*[directed towards the unhoused] *community. How many times we've reported this and reported that, how many times we sheltered people when police dropped them off to us in the middle of the night or the hospital sent them in a cab, in a hospital gown, with their colostomy bag dragging on the ground in the middle of winter. They should be accountable, and they should have stepped up and said, "We should have done better." I'm still waiting for my apology in regards to that.* [Emily]

Within this political and service environment, there were differing views on the shelter, CTS and encampment, and how they were designed, supported and operated.

> ***It was really like, for lack of a better word, it was like a circus whenever you went over there.*** **[Decker]**

While many participants were sympathetic to the way in which the shelter and CTS were run, others expressed significant concerns about an overall lack of safety within and in the vicinity of these services: "it was becoming very unsafe...*It was really like, for lack of a better word, it was like a circus whenever you went over there"* [Decker]. Participants discussed how different the ICH was than other shelters in the city, specifically in how it radically embraced harm reduction and took a far more laissez-faire approach to service, which was seen by many as a problem. To try to reconcile the differences, some participants recognized that perhaps there was a need for this approach in the community from a trauma and violence informed lens:

> *...it was night and day. The atmosphere and the environment at the ICH versus the other shelters available in the community...There was that kind of clash in policies that way, and it made it difficult. I worked really hard to try and bridge the gap between the two organizations as to helping our people understand, "OK, people are in trauma right now. Let's just maintain here...and...you know, we're not, we're not kicking people off the property for using outside and, you know, they're coping with, dealing with trauma."* [David]

One participant had raised concerns in the week leading up to the incident, as he had received reports of violence in the encampment by neighbours: *"I had actually contacted police the week before, because [the neighbours] had been sending me images, photos of a person in the encampment with a gun walking around"* [Craig]. These divisions were strongly felt by participants, and led to a lack of cohesion that was seen as essential for promoting resilience in the

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face of critical incidents. Just prior to the incident under study, this cohesiveness appeared to be at an all time low:

> *And then what happens is we're all non-profit organizations. So, this is the part of the non-profit sector that's so sick that you're constantly pitted against each other to say, who does what better, and who can provide what service better? And so, there's no cohesiveness, ever... and that's why, when this first happened, there was no communication, and it was absolute chaos, because we don't do that already.* [Emily]

There was political division as well, which was specifically focused on harm reduction services. This event occurred during a particularly intense federal election in Canada, where federal candidates were using harm reduction as a key point in their political platforms. Participants discussed how a Conservative Party candidate openly engaged in: *"demonization of CTS...There was like change of government in the air...like how what Pierre Poilievre was saying about CTS...like 'drug dens'"* [Lila]. These divisions between individuals who were concerned about these services and those who were in support of them grew until it reached a crescendo just before this critical incident began:

> *Things were building. Things were bubbling. I thought this divide and this clash between opposing views about how best to approach this population were bubbling in our community. Were bubbling between service providers who... worked with these people. And then...I remember at the time, Pierre Poilievre was doing his big drug den talk, and so this was simmering under the surface. I think this was the catalyst that really caused kind of an explosion.* [Andy]

> ***Things were building. Things were bubbling. I thought this divide and this clash between opposing views about how best to approach this population were bubbling in our community. Were bubbling between service providers who... worked with these people.*** **[Andy]**

DURING THE INCIDENT: *"It was like a war, like a bomb had been dropped"*

In describing their experience of this incident, participants remember the event as chaotic. While media reports linked the incident with the ICH and CTS, participants were careful to note that the event occurred in a location that was in the vicinity of these organizations, rather than on the property itself. Further, these media reports, which were being published swiftly in local and national media, characterized the alleged assailant as a member of the unhoused community, which they noted was inaccurate. In fact, the alleged perpetrator of the crime was a housed individual. Participants described service providers, advocates and policymakers springing into action as soon as the incident occurred. Doe described how he responded:

> *So, I went flying, I went down to the ICH right away. They had it all blocked off. There must have been a dozen, dozen and a half police cruisers on every corner. They had drones flying. They had officers, the tactical team, the emergency response vehicle. They had just about every police officer in the City of Kingston kind of blocking off this corridor. So, I wasn't able to drive into the ICH, obviously. But there were conflicting reports as well. I'd had a couple texts from other people, and I reached out to some people. The news was saying that it was on Integrated Care Hub property, which was incorrect. It was actually in the field of Belle Park, so it was off their property.* [Doe]

> *we had to respond really quickly…I always say I walked in a lot of darkness, so I understand the realities of keeping people safe. So we actually were seeing community members who had felt safe coming to our centre, running across the road, which was very, very unlike their behaviour typically. They're pretty baseline. Like very calm people. And so I had opened up the doors. I had yelled at staff to lock the doors, and I had said, I'm staying out here to monitor and to get people inside…So it was definitely a really scary day…It was a day that I felt like it was like a war, like a bomb had been dropped in our little piece of the city. And it was complete chaos.*
>
> **[Ann-Joe]**

This event immediately shook the community. In the moment, service providers, advocates and policymakers noticed the toll that it was taking on the unhoused community, and tried desperately to ensure the safety of everyone involved:

> *I was having a meeting outside when these events were happening. And we had to respond really quickly…I always say I walked in a lot of darkness, so I understand the realities of keeping people safe. So we actually were seeing community members who had felt safe coming to our centre, running across the road, which was very, very unlike their behaviour typically. They're pretty baseline. Like very calm people. And so I had opened up the doors. I had yelled at staff to lock the doors, and I had said, I'm staying out here to monitor and to get people inside…So it was definitely a really scary day…It was a day that I felt like it was like a war, like a bomb had been dropped in our little piece of the city. And it was complete chaos.* [Ann-Joe]

Accurate information was difficult to obtain, and participants described how people relied on social media, media reports, phone calls and text messages to figure out what was going on, and to inform what measures they would need to take to keep staff and service users safe:

> *I have to say that…the lack of information…was concerning in the moment…Again, people were trying to share information, but also be confidential about some stuff, notably the police activity. And so, the initial information was that they had not caught the* [alleged] *assailant, and that he was on the loose in the neighbourhood. And so, all the buildings went into lockdown and there was a lot of concern about that. And then there was confusion about* [how] *the police actually had the* [alleged] *assailant within sight. But there was some confusion about where that was. Was it down by the* [river]*? Was it up by* [name of organization]*? It was hard to get that information.* [George]

Participants described chaos in the communication and coordination of services during this time as well. They described that there was little direction provided by a single entity. Because they felt as though there was no one leading heath and social care organizations on how to proceed, they tried their best to support each other and individuals using their services in the best way they could with existing resources. Overall, this incident was deeply felt by all involved:

> *…the day that it had happened, I was here at another shelter…and we had started – clients started coming through the door. Phone calls started coming in. What can we accommodate, what* [could] *we do within our shelter to try to help within the situation….the outreach team… they were out on the street and we asked them to go over and provide support to the individuals there as well. It was chaos. It was scary. It was the unknown. We knew all the individuals involved. And so it had a huge impact on our clients. On our staff. On our teams.* [Lisa]

This situation was made more chaotic by what was perceived by participants as poor communication within the municipal government and between the municipal government and community organizations that was a problem prior to the incident. Participants felt that this was one of the reasons why the response seemed so uncoordinated:

> *I think the city staff were doing their very best to try to coordinate a response. But I know, historically working with the City, that communication between departments… is not great. And now put that into that scene that unfolded in September. It was a very high-pressure, high-profile situation, and I don't think that the internal communication was very well handled within the city. That's my take on it, but I know that the intention was constructive.* [George]

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Further complicating these problems in communication was a particularly toxic narrative that was being perpetuated online in real time while the incident unfolded on social media platforms. Emily described how she noticed a neighbour filming the incident with his cell phone to share on social media. He responded with little compassion for the unhoused community: *"Our neighbour was recording it all happening in the middle of the street. And then when somebody tried to approach him to tell him to stop fucking recording, he said, 'I don't give a shit. I hope they all die'"* [Emily].

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Overall, participants expressed concerns that the municipality was going to use this event as an opportunity to close the encampment, in the context of a situation where service providers were already stretched thin emotionally:

> *I was already feeling really demoralized...my first thought when I was in the encampment was like this is so terrible and upsetting and the city's going to weaponize this. They're going to punish the encampment because of what happened here, which happened immediately. And that punishment went further than I even expected...* [Robin]

These concerns and feelings of demoralization were compounded when the Kingston Mayor posted his perspective on social media as the events unfolded. This was immediately seen by service providers, advocates, and policymakers, and was largely regarded as politically opportunistic. Participants described how this post unnecessarily politicized this incident while it was unfolding. It was also predictive of what was to come. The post read as follows:

> *It's clear the safe injection site and the ICH need to close immediately. It is no longer safe for people to use the CTS and we need to respond. We as a city have been talking about the dangers of this encampment in and around the safe injection site for almost three years. There are community partners and advocates who have fought the city on every attempt we've made to clear this encampment and ensure public safety for those living there. I will not stand by and wait until more people die - enough is enough. We need to clear the encampment, close this safe injection site and the ICH until we can find a better way to support our most vulnerable residents and work with the province to provide treatment and housing solutions.* [54]

These statements had a serious impact on service providers, both because of the timing of the message, and also because they were at a tipping point before this incident began:

> *The community was already divided about the ICH, and it [the social media post] contributed to further division. It was like a line had been drawn in the sand for people who agreed and people who didn't. The mayor made a very public statement saying enough is enough. And I remember that being really just further traumatizing for a lot of the staff, who felt like they were working 24 hours a day and doing some of the hardest work that you can do.* [Andy]

> *The community was already divided about the ICH, and it [the social media post] contributed to further division. It was like a line had been drawn in the sand for people who agreed and people who didn't.* **[Andy]**

IMMEDIATELY FOLLOWING THE INCIDENT: "We saw people spread out through the city"

Following the incident, the ICH, CTS and the surrounding encampment were evacuated while a police investigation ensued. A steel fence was erected around the perimeter of the property, and well beyond the vicinity where the encampment has been located. Due to the loss of shelter beds at the ICH, additional shelter beds were made available across the city. These shelter beds, however, did not meet the needs of all who required them:

> *When the city said, 'Oh, we opened up shelters, and they can just go there.' No, they can't. They couldn't go there. They had pets. They had partners. They didn't allow that at the time...Also, the people were too sick to go there, because they* [staff in other shelters] *would say, 'Oh, their behaviour problems.' There were* [people]*...having psychotic breaks. And they would call it, 'Oh, they're behaving badly.'* [Kamala]

This lack of shelter drove some individuals deeper into wooded areas around the outskirts of the city. Others erected tents on the property of another shelter. Services changed to be more accessible to individuals who had been displaced, while also acknowledging that the needs of unhoused individuals had changed. The loss of community was one of the most significant losses for unhoused individuals at this time, at a time when community was needed most:

> *...staff were traumatized. But the population was also traumatized. They saw their friends get murdered... and their community locked down. Their community* [the encampment]*, while rat infested and unsafe, was still their community. And now, all of a sudden, that community was gone, and they couldn't find the workers who made them feel safe, or their friends who made them feel safe. So I think it was likely a very lonely time for a lot of people.* [Andy]

Participants described feeling frustrated with the city's response to close the ICH and CTS without offering other immediate responses that would replicate what was offered within these programs. They described this approach as consistent with previous strategies implemented that kept people in a constant state of precarity: *"You can't just take something away from someone and expect them to just be okay with it. And that's back to... how this community, unfortunately, has decided to deal with the people who are unhoused. Just take things away. Make it*

hard for them to survive. Like that's going to help?" [Alice]. Other participants pointed out that the response to this situation would be different if it affected people in the broad community: *"If you had a fire in a house, don't you wrap them around with, 'What do you need? Do you need counselling? Do you need food? Do you need whatever?' Instead of that, this time we just dispersed them. 'Out you go!'"* [Barbara].

> *You can't just take something away from someone and expect them to just be okay with it. And that's back to... how this community, unfortunately, has decided to deal with the people who are unhoused. Just take things away. Make it hard for them to survive. Like that's going to help?* **[Alice]**

Individuals who were unhoused and displaced by this incident sometimes went deeper into the woods, but some were sleeping in various other places in the community, particularly the downtown area. In response to this, community members who had historically opposed the presence of the ICH and CTS began advocating for a re-opening as individuals who were unhoused were now loitering around their businesses: *"...we had the Business Association calling us saying, 'Please reopen. Please. We don't...want these folks downtown, to the extent that they are. Or sleeping in, [or] on church property and things like that.' Had we reopened, we could have mitigated a lot of that"* [Concerned Advocate]. These calls for a re-opening were countered by voices who wanted the services to remain closed, which was illustrative of the polarized perspectives on homelessness and substance use in the community:

> *We saw people spread out through the city. So, it was interesting to hear over the weeks, because there was this kind of dichotomy of opinions on what should happen. And there was some political opinion that was pretty adamant that* [the] *CTS not open again. And then there was a lot of frontline stores and frontline community members saying, 'there's people sleeping in the entrance of my shop. Or my stairs to the apartment or house.' Because everybody spread out and didn't have places to stay other than on stoops or business fronts...So, we had community members saying, "When are you going to open up the hub and CTS again? Because clearly, people need those services, and will stay around the hub...in order to access those services.* [John]

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CTS staff transitioned to an outreach model where they would locate people who were displaced and who had been known to use CTS services to provide harm reduction supplies, and offer naloxone administration kits: *"staff transitioned to being outreach workers, so they all just went out and about and brought Naloxone and dealt with overdoses, but like on the streets in the community"* [Andy]. While many worried about the risk of increased overdose in their community during the closure, there was no significant changes in the number of overdoses or emergency department visits for opioid toxicity during this time compared with previous months or the prior or following year [55]. This may be attributable, in part, to the efforts of service providers during the closure.

Organizational leaders and policymakers immediately met to collaborate on a strategy that included the organization that operated the ICH, CTS, and other community partners who had been historically involved in informing its operation. Participants were proud of this collaboration, and recall it as an example of the community coming together: *"our organizations came together. We were on the telephone every morning; we set up meetings every single morning, and we had all the five consortium members...we came together and we offered support to each other"* [Sally]. The purpose of these meetings was to prepare and plan for a suitable re-opening plan. For some participants, the process was far too slow, and they believed that it placed people in their care at risk:

> *It was a very collaborative meeting with all the partner organizations...We were advocating for...safe consumption* [because it] *was so important because we know that people were unsafe...And so the reopening, we had very, very strong direction from the City of Kingston. Our funders certainly...we had many opinions...I feel we should have opened right away. Had it been up to me, I would have gotten a construction trailer or something and provided some sort of immediate support in some kind of way. I found it deeply frustrating and saddening that we weren't able to do that...It was very convoluted, which I*

understand is challenging for everyone, but I feel that we could have done a better job. Had we had the autonomy, we would have found a way to reopen in some way to save lives...that's what we're in the business of doing. [Concerned Advocate]

Participants recognized how the closure of the ICH and CTS and clearing of the encampment was something that the city was hoping to do for a long time, as they had not approved of how it was being operated: *"...this was the incident that sparked that. It felt, leading up to this event, it kind of felt like they were hoping...I don't want to say hoping that this would happen, but they didn't want the ICH run the way that it was being run"* [Doe]. Participants described how they believed that in part, the slow speed of re-opening was largely related to the stigma of substance use, and a backlash against harm reduction as a philosophy: *"I think if our community and society had a better understanding of the value of harm reduction, we would have opened much more quickly"* [Concerned Advocate].

> *I think if our community and society had a better understanding of the value of harm reduction, we would have opened much more quickly.* **[Concerned Advocate]**

> *So my staff were burning out left, right and centre, because they were just tired of seeing people suffer and not have access to the programs that they utilized.* **[Emily]**

IN THE MONTHS FOLLOWING THE INCIDENT: "it just went on for so long"

As the months wore on, some staff were laid off from their positions, and others remained working in health and social care organizations supporting people in a range of shelters and in encampments that had spread through the city. This had a serious impact on the staff who were providing these services, as they watched individuals who were unhoused going without their needs met on a daily basis for months on end. This was recognized by organizational leaders who were tasked with supporting these staff as they provided care to individuals who did not have access to needed services: *"So my staff were burning out left, right and centre, because they were just tired of seeing people suffer and not have access to the programs that they utilized"* [Emily].

As the ICH and CTS re-opened, participants discussed how they were pleased to see the services resume, but grieved the loss of a service approach that was seen to be more welcoming and less restrictive before the closure. Participants discussed how the feel of the new service model represented a transformation into something that was nearly unrecognizable from the previous service approach. This was described as more 'institutional' and overly controlled:

> *I just think we've created an institutional looking place which wasn't an institution. The whole beauty of the way it was set up was that it was there for anyone in whatever stage of mental health, substance use, life. They were welcome there and that's not the case now. It definitely looks like a sore spot when you drive by, because...there's been no attempt to make it look or feel like a welcoming place.* **[Barbara]**

I just think we've created an institutional looking place which wasn't an institution. The whole beauty of the way it was set up was that it was there for anyone in whatever stage of mental health, substance use, life. They were welcome there and that's not the case now. It definitely looks like a sore spot when you drive by, because…there's been no attempt to make it look or feel like a welcoming place. [Barbara]

It looks like a skeleton to me, and it looks like it's institutionalized and it's far from what it was. There's positives to that. I know that there's positives to that. But I think the fact that there's a fence…It's more manageable. But it is a very institutional feel and there have been times I stopped visiting because…I don't want to even be there… what I would hear from clients, as well, is the same – the same feeling. [Ross]

For other participants, while the differences in the service delivery approach were initially difficult to adapt to; Over time, they recognized that these differences brought some positive changes. One of these changes was a reduction in the number of program participants served at a given time:

There was some really, really big changes, and some of them were changes to capacity. It was one of the big dramatic differences that we noticed. You know, the drop-in was often like overflowing with individuals [before the closure]. *But we had reflections from staff around like just getting to have like meaningful conversations with people. People they had known for years and now know in such a different way. Because with things slowing down, they were able to have different conversations with people. They weren't just in crisis management mode all of the time. And so, people talked about like getting to know people differently, and having just that more dedicated time and space to have conversations.* [Jane]

The incident and the events that followed were traumatizing for participants and the people who used services in the city, and this lingered in the months during and following the re-opening of services. Several program participants and service providers had witnessed the homicides that had occurred in the encampment. As the services gradually re-opened, there was a need to account for this trauma as they supported one another, and the people who hesitantly re-connected with their services:

…we met so many, people who were just deeply scarred about what they witnessed, and they were just terrified to go anywhere close to the hub. Yeah, it took just a lot of unlearning and listening to these experiences because it wasn't because they were afraid of The Hub. It was just because you go there and it was like an immediate trauma response for a lot of people. [Alice]

Participants discussed finding ways to heal together as a community, as they collectively knew one another and the victims of the crime. As they described this, the individuals who were murdered, the person who was critically injured, and the alleged assailant were all identified as victims: *"…it was a really difficult day for everybody involved. It was difficult for all the staff who knew him* [the alleged assailant] *and who knew the individuals who were murdered. And it just went on for so long…I'm actually doing some psychotherapy now with some of the police officers who were there on site"* [Andy].

> *You send them into unsafe places, deeper into the woods. To trap houses. To shelters that have bugs. All of these things. And you're just like, "No, they're fine."...God forbid anything like this were to ever happen again. It's like, don't do it like that. Don't take things away from people when they've already lost a friend or a family member and they're grieving. They lost the services that keep them alive...It's just like, how do you expect people to just say, "You know what this makes me really want to do? Attend that housing meeting and go and be very serious about finding housing. And you know what? While we're at it, I'm going to stop doing drugs, too.* **[Alice]**

MAKING MEANING OF THIS INCIDENT IN THE AFTERMATH: "If you housed people appropriately… this is all preventable"

Reflecting on this tragic incident, participants discussed how the events that unfolded in their community, and the response to it, are symptomatic of much greater structural problems that transcended the city of Kingston, such as growing poverty and attitudes regarding what people who experience homelessness and who use substances deserve. They described how people who are unhoused and use substances are treated as an 'other' group that is distinct from the broader society. Participants observed the presence of a problematic and persistent belief that people who are unhoused and use substances *can* and *should* live with less simply because of the health and social conditions they occupy. Participants identified that these attitudes created fertile conditions for events such as the one under study to occur in the first place. They highlighted that by taking away resources, we create greater complexity and greater precarity in a person's life rather than helping them leave homelessness and heal:

> *You send them into unsafe places, deeper into the woods. To trap houses. To shelters that have bugs. All of these things. And you're just like, "No, they're fine."...God forbid anything like this were to ever happen again. It's like, don't do it like that. Don't take things away from people when they've already lost a friend or a family member and they're grieving. They lost the services that keep them alive...It's just like, how do you expect people to just say, "You know what this makes me really want to do? Attend that housing meeting and go and be very serious about finding housing. And you know what? While we're at it, I'm going to stop doing drugs, too."* [Alice]

Given the inadequate living conditions in which many people who are unhoused and use substances are forced to live, participants predicted that similar events to the one that is the subject of this paper could happen again, within or beyond the steel perimeter fence that still stands erected at the time of writing this report: *"we have to keep in mind that this original incident didn't really happen on the CTS or* [the] *Hub's property. I mean, it was immediately adjacent to it. So could it happen immediately adjacent to it again? I think so...maybe the boundaries are a little bit further away, but all the circumstances people [live in] are relatively the same"* [John].

Participants discussed the lasting impact of this entire ordeal on all involved, and how these events continued to affect them at the time of the interviews, which occurred months after the re-opening of the ICH: *"... people are still traumatized. People are still hurting"* [Andy]. Many participants discussed how they viewed this situation as preventable by just meeting the basic needs of all people in our society: *"I started to feel very bitter and very angry, because I was like, 'This was all preventable. If you house people appropriately, this was all fucking preventable'... It's like they just didn't want people to exist"* [Emily].

> *I started to feel very bitter and very angry, because I was like, 'This was all preventable. If you house people appropriately, this was all fucking preventable'...It's like they just didn't want people to exist.* **[Emily]**

Many interviewees discussed the sheer complexity of the problem of homelessness, and the need for a complex and orchestrated response. They discussed how there is a need to educate the public about CTS sites, and how such supports are a crucial part of the array of services needed for all people in society, including individuals experiencing homelessness. With so much misunderstanding about the needs of unhoused individuals, particularly people who use substances, and how politicized this issue has become, the need for effective education is more important than ever before:

> *I would say that this incident that happened is a good example of how it is. The whole thing is so complex. It is so complex. It wasn't just about an incident...I would encourage anyone that would like to have an opinion about it, just to*

> *How can we help inform people? How can I help inform you in a really judgement free way, what happens at a CTS? What happened there in that particular situation, and why most of what we hear is just not - it's just not true. And it's not that it's upsetting to me that people don't know all the details or understand this, the nuances, and the complexity of it. If you really want to know, then we can help people understand...how complex of an issue it is.* **[Kari]**

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Participants recognized that with limited resources to support the people that they were providing services to before the incident, that something bad was eventually going to happen. Reflecting on this incident, they expressed bitterness about being characterized as responsible for not adequately managing homelessness, and creating a problematic service environment, when they were actually just overwhelmed with trying to manage a growing and complex group of people who were denied basic rights to permanent housing and adequate supports:

...it was the perfect storm for something bad to happen. And we knew that. We predicted that. We screamed that from the rooftops to a bunch of different people...We are not contractors. We're not city officials. We're none of these things, but we were expected to fix the encampment, slash homelessness, slash the overdose crisis, slash Covid, slash everything else that was wrong. [Emily]

Many participants discussed how homelessness cannot be solved with simple solutions, and that closing a CTS site will not remove the problem or it's corollaries from our communities. They discussed how we can keep changing services, move them around, or call them by different names, but this won't ultimately alleviate homelessness. Participants described how people who experience homelessness ultimately lack power, and face the ire of the public. This ire and lack of power converge to enable political actors to offer only inadequate solutions for this growing problem because people who experience homelessness and use substances are so weakened by their health and social circumstances that they are unable to ultimately rise up, ask for more, and be regarded as worth listening to:

The simple solution of closing a CTS is not going to fix a problem. The simple solution of moving it to whatever distant street, where it's out of sight, out of mind, is not going to...fix the problem...I think we really need to put our heads together. And it's multiagency, probably even multiple levels of government that all need to get together. And not just within Kingston, but every city where this is an issue, and figure out what to do. And it's such a big problem, and there's so much stigma attached to it, I think it's just one of those things that is more easily swept under the rug. And because these folks don't have the political clout or connectedness or means to make meaningful advocacy to move things forward, I feel like we're stuck in this perpetual treating the end problem rather than making meaningful upstream preventative measures that we don't ever get [to] the solution. [John]

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Discussion

We conducted this study to understand the perspectives and experiences of service providers, organizational leaders, advocates, and policymakers in the aftermath of a tragic event in one mid-sized city in Ontario Canada. We also sought to engage in a process that would enable community members to process and more fulsomely understand how the events unfolded from the perspectives of participants to ultimately inform policy responses in the event of future such incidents. Our findings highlight the increasing polarization that exists in our society related to poverty, homelessness, and mental illness, and how ideologies have come to inform policies regarding unhoused persons in our communities. This study represents one city in Ontario, Canada, but could easily be any city in Canada or beyond.

Our findings particularly reveal divisions in the community in which we recruited related to the use of a harm reduction approach with individuals who experience homelessness. Participants in this study were largely supportive of a harm reduction philosophy, but recognized that others in their community were not, and this created barriers in how they could deliver services. There were ongoing, acknowledged problems with the way in which the ICH and CTS were operated as described by participants, and the differences in opinion around how these services operated seems to have centred around criticisms of harm reduction as a philosophy. This resistance against harm reduction is not isolated to the community that is the subject of this study. In other research, investigators interviewed 35 harm reduction practitioners in an Appalachian community, an area of the United States that has been particularly affected by the opioid epidemic, and found that practitioners needed to continuously engage in community education or limit the information shared with their community in order to continue to operate harm reduction services [56]. In another study conducted in San Francisco, researchers found that harm reduction in services for persons experiencing homelessness were highly stigmatized and politicized, resulting in limited funding being provided to organizations who operated their programs using a harm reduction approach [57]. These researchers described some social conditions they termed "socio-economic multipliers" that exacerbated stigma in their community, including income inequality, lack of housing affordability, gentrification, increased public substance use, increased substance trafficking, and homelessness [57]. That is, when income inequality and its corollaries are greater, the stigma of substance use can be higher, thereby placing unhoused individuals living with substance use disorder in a precarious social position where their healthcare needs can go unmet.

In Canada, and many other high income countries across the globe, the cost of living continues to rise, and many are feeling overburdened financially [58]. People who have never thought they could be at risk of homelessness are increasingly concerned about their ability to sustain their housing, feed their families, and pay for their basic needs with no end in sight, and in countries that are some of the wealthiest in the world [59,60]. This situation has particularly affected individuals who were already living in poverty when this affordability crisis began [61]. In the face of scarcity, it is common for people to maintain their survival by isolating themselves from others to ensure that the basic needs of themselves and their families are met. We argue that classism and class divisions have deepened as this affordability crisis has continued and that these divisions function as a defense mechanism for managing fear and distress associated with the possibility of one's own economic precarity. Seeing people who are experiencing homelessness as an "other" group distinct from oneself, and believing that the actions of individual people who comprise this group are responsible for their own distress, enables all of us to find comfort in believing that "it" (homelessness) cannot happen to "us." Stigma, homeism, and sanism are allowed to thrive in times of uncertainty, and only serve to foster ongoing division in an already divided society. Further, the belief that unhoused individuals are unhoused because of some *action* or *inaction* that caused their respective situations, or because of a health problem that they have failed to address, only leads to inappropriate and ineffective solutions to addressing this serious and growing social problem. Trying to fix mental health and addiction problems instead of fixing a broken housing and income support system is a tragic example of a flaw in logic that appears to be influencing policymakers to emphasize that substance use and mental illness should be the most suitable focus of policy intervention. This approach is being taken without recognition that lack of access to a dignified life is often the cause or a complicating factor in the high rates of mental illness, including substance use disorder, observed in the unhoused population.

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Policy Implications

Policymakers are tasked with making complex decisions in the midst of a growing situation of poverty in their communities, and this is particularly the case for municipal policymakers who are increasingly addressing issues related to homelessness. This study reveals the extent to which homeism and sanism can influence the development of policy, and impose profound effects on communities. The lack of shelter beds and permanent supportive housing in Kingston, and most other communities across Canada [62] prior to the critical incident described in this study is an issue that transcends this one city, yet is an example of how the needs of people who experience homelessness and use substances are frequently neglected. The lack of urgency with which policymakers have acted on the crisis of homelessness in Canada, for example, demonstrates how homeism influences how policy unfolds. As highlighted by participants in this research, if someone in the broad community lost their housing due to a fire or some other event, the supports provided would likely be vastly different than what is typically available to a person who is already unhoused, or who lives with mental illness or a substance use disorder. For unhoused individuals, the offer of housing is delayed by underfunding deeply affordable housing stock, then designed in such a way that one needs to fulfill specific criteria established by policymakers to demonstrate that they are 'housing ready' to gain access to this fundamental basic human need.

Conservative ideologies, which tend to take a moralistic view of substance use, often emphasize the use of punishment and abstinence-based approaches [27]. During the critical incident that is the subject of this study, participants described how the municipal government, who had been critical of the harm reduction approach of these services prior to the incident, immediately took an opportunity to evacuate the encampment and close the ICH and CTS in reaction to this event. Instead of making the same services immediately available in another location while an investigation unfolded as advocated for by participants in this study, the municipality closed the CTS for a month without making another alternative location immediately available to people who required it. Harm reduction is a central philosophy of Housing First, an intervention emphasizing the provision of permanent supportive housing without preconditions [63]. In recent years, there has been considerable resistance to the implementation of Housing First, in the face of evidence demonstrating its effectiveness over treatment first approaches for promoting tenancy sustainment [64]. Instead, policymakers in many communities are returning to funding a system of transitional housing, a temporary housing solution that requires individuals to prove their 'housing readiness' prior to being offered permanent housing options. Transitional housing models tend to emphasize abstinence over a harm reduction approach in relation to substance use, and the increasing return to their use is suggestive of a backlash against not just Housing First, but also harm reduction. This is concerning as harm reduction is an approach that is known to be effective for reducing the harms of substance use, while also building a foundation that can support substance use recovery 26. Recent decisions by provincial and municipal governments in Ontario and beyond are also illustrative of this backlash against harm reduction. These include discussions about forced treatment for substance use disorder, the recent de-funding of CTS sites across the province while simultaneously funding HART Hubs, and implementation of the "Safer Municipalities Act." These are all actions on the part of our policymakers that lack evidence and are based on ideological arguments about what is "best" for people who experience homelessness and use substances.

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Policymakers are tasked with making decisions that represent all citizens in their communities, including individuals who experience homelessness and use substances. For this reason, it is critical that policy decisions are informed by evidence rather than ideology. Policymakers are encouraged to consult research evidence to inform their decisions, and to collaborate with researchers, who are knowledgeable about how to acquire information or generate evidence on the effectiveness of approaches that they wish to implement. When policymakers fund novel approaches where evidence is not available, they are encouraged to *require* as a condition of funding, the generation of evidence through a structured evaluation process which can inform future decision-making. This requires enhanced collaboration, and a movement away from policymaking that is largely informed by an ideological orientation. This is known to be a particular problem in the context of making decisions about complex social problems where policymakers are prone to errors in decision-making including the "tendency to fix immediate problems rather than employ long-term strategies" (p.1), and ideological decision-making, both of which lead to problematic policy approaches [65].

Research Implications

There is a need for future research exploring the ways in which stigma factors into the decision-making process of policymakers to inform how best to mitigate its impact on the lives of unhoused and precariously housed individuals. Conducting this research will highlight the ways in which stigma may be reflected in policymaking and help to identify a focus for approaches designed to lessen its negative influence on policy decisions. Researchers may also consider collaborating with policymakers, practitioners, and persons with lived experiences of homelessness and substance-use disorder to develop and evaluate frameworks to guide decision-making in times of community crisis to guide the decisions of policy and practice quickly, effectively, and ethically. Such frameworks should be trauma and violence [66,67], and evidence-informed. Finally, future research focused on designing and piloting approaches for addressing the stigma of substance use directed toward individuals who experience homelessness is needed for mitigating the oppression that it causes. It is clearly a problem that continues to persist and remains a serious barrier complicating the permanent transitions to housing following homelessness [68].

Practice Implications

Service providers and advocates work directly with people experiencing homelessness every day, and see the end result of ineffective systems. This has weakened services overall because the workforce in housing and homelessness services is experiencing profound moral distress and injury [69]. This situation has resulted in a system that is poorly prepared when tragic events occur, because the people who are working directly with unhoused persons are constantly overburdened and overwhelmed. Leaving people without housing, food, safety, and a dignified life, while starving the system that is meant to provide mental health and social services to individuals living with mental illness and substance use disorders may contribute, in large part, to the unfolding of such tragic events in the first place. In order to fortify the workforce in the face of limited resources, practitioners working with individuals who experience homelessness and use substances may consider finding ways of supporting one another within the context of the work they do. Advocating for benefits including 'mental health days,' and structured spaces to support the well-being of practitioners who are working in high-stress health and social care environments may help to build resilience among health and social care practitioners. Incorporating communities of practice in the workplace to problem solve through difficult cases, and build skills may help to increase capacity, and provide the emotional space for healing when health and social care staff encounter difficult and emotionally affecting experiences. These opportunities should include shelter workers, who are rarely incorporated into such opportunities in health and social care organizations. Finally, organizations who serve persons experiencing homelessness may consider finding ways for staff who provide direct services to contribute to advocacy efforts and decision-making to restore agency in the context of their work. Participants in this research highlighted how they are frequently thrust into social contexts where they have limited resources or control in changing the structural conditions in which unhoused individuals live. Providing direct service staff with opportunities to contribute to advocacy efforts may not only contribute their expertise to policy decisions, but may also help to mitigate the moral distress that they experience by restoring a sense of agency in influencing the structural conditions that so thoroughly affect the lives of the people who use their services.

Limitations

The most significant limitation of this research is that as a research team, we chose not to include the voices of persons with lived experiences of homelessness. While this event was deeply traumatic for the service providers, advocates and policymakers who were involved in this research, we were concerned in designing this study that individuals with lived experience may have experienced this event differently, and participating may have the potential to activate trauma in ways that may be felt more deeply. We recognized that many potential participants with lived experience may still be unhoused, and interviewing people about this incident while still living in a state of precarity may cause them to re-live the traumas that they experienced, and disrupt their ability to heal. Instead, we opted to take a more trauma and violence-informed approach to this work, yet in the process have limited our findings solely to the service provider, organizational leader, advocate, and policymaker perspectives. In addition to this limitation, our findings are subject to recall effects. The event under study was traumatizing for participants, and many discussed how this trauma interfered with how they were able to recall the events that unfolded accurately. This, combined with the fact that our interviews were conducted months to over a year after the initial event may have contributed to the presence of recall effects. Finally, while we recognize that our findings have relevance for informing practice and policy in other contexts, they represent a very specific and rare incident that occurred in a single city in Ontario, Canada, and cannot be generalized to other contexts.

Conclusions

Homelessness is a growing social problem across Canada and beyond, and its growth will only contribute further to existing divides, and ongoing polarization about this seemingly intractable social problem.

There is a need to invest in long-term, evidence-based, and effective approaches to address the problem of homelessness in our communities. Harm reduction is a philosophy that has faced considerable resistance in the face of evidence demonstrating that it is responsible for reducing mortality and providing a foundation for substance use recovery [26,32]. We cannot address the crisis of homelessness by "fixing" the people who experience it. Addressing homelessness begins with providing deeply affordable housing, followed by support to address the complex needs of people who experience it. This will require considerable investment in infrastructure and an expansion of services. We will never address homelessness by creating more precarity in a person's life, or restricting services to make it difficult to survive. This is the approach that we have taken for the past 40 years, resulting in the rapid growth of homelessness in our communities. Now that this problem has become severe, it will require considerable efforts to address. By drawing on the expertise of persons with lived experience, policymakers, service providers, organizational leaders, advocates and researchers, we need to come together and create a system that addresses the structural problems that have caused homelessness to grow, and ultimately commit to addressing this serious social problem.

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