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EVIDENCE-BASED AND COMMUNITY-ENGAGED PANDEMIC RESPONSES FOR CALGARY

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SUMMARY

To optimally support the health of families, interventions provided by community organizations must be evidence-based. As well, strategies should be locally informed to ensure relevancy of interventions and smooth incorporation of research within existing systems. While research attracts awareness to particular community issues, there is often a disconnect between research collection and subsequent translation into community-level policies. Greater focus on evidence-based and community-engaged interventions are necessary to mobilize research into practice, and ultimately improve outcomes for families who rely on services.

COVID-19 has highlighted the pre-existing political, economic, and structural impediments to knowledge mobilization that community organizations contend with. To better understand existing evidence on the role of support, communication, and funding approaches that facilitate knowledge mobilization from a community engagement perspective, a scan of the literature was conducted and summarized. These findings were then contextualized to understand the specific priorities and issues in Calgary using the Nominal Group Technique (NGT) to engage diverse stakeholder groups. Five NGT groups were held over the course of two weeks to generate ideas surrounding barriers to evidence-based service provision throughout COVID-19, as well as solutions that have the potential to address aforementioned challenges.

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Though the engagement process, focus group members of community-service organizations identified barriers to evidence-based service provision, including the inefficacy and practicality of virtual service delivery, a lack of clarity and consistency among various government pandemic protocols, staffing and scheduling challenges, and the effect of short-term funding structures on collaboration within the sector. These difficulties are heightened by pre-existing vulnerabilities, as vulnerable families are most likely to be adversely impacted by the COVID-19 pandemic and the ensuing public health restrictions implemented.

To improve the ability of organizations to deliver community-centred and evidence-based services for this pandemic, and to prepare better for future emergencies, common themes included person-centered policy and program approaches and reciprocal partnership development. Findings led to three policy approaches that could be considered towards evidence based, community engaged pandemic response: (1) education and consultation with community organizations, (2) subsidy and grant provision for community-based research, and (3) formalizing a local network of researchers, community organizations, and policymakers.

GLOSSARY OF RELEVANT CONCEPTS

Vulnerable family: Families that face hardships caused by inadequacies in the social structures they rely upon for daily functioning (Raising Children Network 2018).

Evidence-based practice: Treatments or service options that incorporates patient values and practitioner experience with the best available evidence from recent studies (Melnyk et al. 2010).

Evidence-based policies: Policymaking that relies upon research to inform new policies, to improve existing policies, or to encourage future policies and programs that are based in evidence (EBPC 2016, 2).

Knowledge mobilization: A process wherein academic research is shared with people, organizations, and government to advise policies and programs (UWinnipeg n.d.).

The Non-Profit Starvation Cycle: A chronic cycle where low overhead expectations on behalf of funders cause non-profits to underreport overhead budgets (Goggins Gregory and Howard 2009).

Coronavirus disease (COVID-19): The disease initiated by the new coronavirus, SARS-CoV-2. Common symptoms include fever, cough, fatigue, loss of smell and/or taste, headache, and shortness of breath.

Community-level supports and services: These services and supports are based geographically within the community, housed in institutions such as schools, neighbourhoods, and organizations (McLeroy et al. 2003, 530).

Pandemic preparedness: incorporates general guidelines from central government to suit the specific needs of a particular program, institution, or event. WHO strongly encourages pandemic preparedness because of the unpredictability of pandemic occurrence and the ability for pandemic occurrence to create widespread economic challenges (WHO 2009, 5).

I. INTRODUCTION

While the consequences of global health crises, such as an influenza pandemic, are felt universally, not everyone is impacted equally. In the words of BC Chief Medical Officer Bonnie Henry, “We are a global community, and we’re all in the same storm, but we are not all in the same boat.” Indeed, pandemics unduly burden those who are already economically and socially disadvantaged by poverty, disability, marginalization, and other vulnerabilities (Uscher Pines et al. 2007, 32). Global pandemics increase disparities experienced by society’s most vulnerable, as inadequacies in systems-level protections make services challenging to access during emergencies (Buccieri and Schiff 2016, 1). Families are specifically at risk, especially if they experience economic and social disparity concurrently with the pandemic (Moore and Greeley 2020, 1).

To promote best outcomes for families, practices should be community engaged and evidence-based (Titler 2008, 1). Yet, community organizations are challenged by the

implementation of evidence-based practices (EBP) due to difficulties in knowledge application, staff reception to new models of service provision, reconciling the efficacy of EBP with traditional methods, and proving beneficial impact of EBP through outcome measures (Barwick, Peters, and Boydell 2009, 2). EBP implementation within the community has been limited (Ramanadhan, Crisostomo, and Viswanath 2011, 718). When it is achieved, the translation process can take decades (Southam-Gerow, Ringeisen, and Sherrill 2013, 2).

As a consequence of the COVID-19 pandemic, barriers to EBP access have heightened vulnerability in families and children. Community-level services such as disability supports, newcomers' centres, emergency food and shelters, prevention programs, counselling, and women's shelters help families mitigate risks (FCRC n.d.). During COVID-19, infection curtailment instructions such as physical distancing and stay-at-home orders have halted delivery of many of these vital services. Though these services have transitioned online, many social services do not have experience with digital provision and lack a substantive evidence-base to promote their efficacy (Peretti et al. 2017).

This study focuses on examining the way COVID-19 has exacerbated challenges to EBP implementation for community organizations in Calgary. Here we describe circumstances that make families vulnerable, the community organizations that support these families during the pandemic, and challenges with implementing EBP. To better understand policy barriers and facilitators as they relate to EBP access throughout the pandemic in Calgary, we conducted focus groups using the Nominal Group Technique (NGT) with diverse individuals representing local community organizations. Participants articulated the structural disparities that impede access to community-based EBP during the pandemic, and recognized potential solutions.

II. WHAT MAKES A FAMILY VULNERABLE?

Vulnerability is an ambiguous term that can pertain to various dimensions of risk susceptibility. Often, the term "vulnerability" refers to an individual or group's susceptibility to extraneous impacts of hazards (UNDRR 2007). Yet, deficits in the structures that help families navigate social risk factors reduce coping capacity during disasters (Nagamatsu n.d.). Families, in particular, experience vulnerability when they encounter obstacles to accessing structures that ameliorate impacts of adversity that pre-exist disasters. Such adversities include income variation, unemployment, adverse childhood experiences, food and housing insecurity, social exclusion, health care accessibility, gender, race, and disability (CPHA n.d.).

Community-level supports and services help families navigate their specific vulnerabilities in a proximate context. Directing services to the unique circumstances of vulnerable populations within a geographical community can improve accessibility, efficacy, and longevity of outcomes (Chazin and Glover 2017). The ability to provide "the right service in the right place at the right time" is vital to ensure community-based organizations reduce vulnerability to populations at risk (Khanassov, Pluye, and Levesque 2016, 1; Bhatt and Bathija 2017, 1272).

While community-level supports and services help families navigate risk, multiple barriers prevent families from optimally accessing services within their local community. Main challenges include the non-profit starvation cycle, staff retention in the non-profit sector, lack of coordination between ministries and organizations, and slow knowledge mobilization (Lasby 2020; Phillips and Hernandez 2018, 1; Children's Cabinet Network 2010). These systems-level gaps exacerbate vulnerability in families who are already experiencing need, as they delay the implementation of evidence-based research within practice. Resultantly, interventions received by families and children are not necessarily the best practices available (Shields and Evans 2012, 254).

III. COMMUNITY ORGANIZATIONS AND PANDEMIC PREPAREDNESS FOR VULNERABLE FAMILIES

Private sector and not-for-profit pandemic preparedness includes coordination with central government frameworks to create a plan for service continuity that minimizes risk to customers and workers (City of Calgary 2018). WHO recommends all central governments take leadership in providing frameworks for pandemic preparedness, create communication plans to disseminate these frameworks, and coordinate the implementation of the framework across levels and sectors of government (WHO 2009, 11). A community-wide approach is necessary to reduce the far-reaching impacts of pandemics, particularly for communities that support vulnerable families.

Adequate pandemic planning must equip institutions supporting vulnerable families with the knowledge to safely navigate readiness, response, and recovery (Buccieri and Schiff 2016, 2). In addition to communicative disease control, effective pandemic preparedness must also respond to systems-level and societal factors that impact families, such as housing conditions, health care access, income supports and services and technological infrastructure (Oshitani, Kamigaki, and Suzuki 2008). Yet, government directives often narrowly focus on transmission prevention, which provides insufficient guidelines pertaining to service continuity for businesses, organizations, and infrastructure (Canada 2018). Pandemic preparedness must identify the most disastrous service continuity implications and create standard operating procedures to address these implications (Hogan and van Dillen 2020).

Service continuity planning is difficult for many community organizations, as evidence-based practices, such as counselling, behavioural therapy, rehabilitative services, and newcomer settlement agencies, offer in-person services to optimize outcomes (Buccieri and Schiff 2016, 59). Furthermore, there are organizations that inherently must deliver services face-to-face, such as women's shelters, homeless shelters, and addiction treatment centres. While some of these interventions, such as counselling, have literature to support implementation of evidence-based practice, many service providers were unfamiliar with digital modes of delivery prior to COVID-19 (Torous et al. 2020, 4).

Throughout the duration of the pandemic, the Government of Alberta has implemented policies and programs that support community organizations in service continuity planning. In April, the Government of Alberta announced \$30 million of available

funding for civil society, and an additional \$5 million for food banks (Alberta 2020b). \$9 million of the \$35 million was allocated to Calgary Family and Community Support Services for dispersion (Alberta 2020c). On April 21st, the Government of Alberta stopped accepting applications, and dispersed funding to 460 of 600 organizations who were able to apply for the emergency funds (City of Airdrie n.d.).

Besides increasing funding, the Government of Alberta has also procured PPE for vulnerable populations. Disability service providers do not have to source or finance their own PPE and can have PPE delivered by the province by filling out a request form (Alberta 2020d). Similarly, the Government of Alberta procured and distributed non-medical masks, hand sanitizer, and thermometers to schools before commencement in September (Alberta 2020e). These policies ensure PPE is provided to people who may not have the disposable income to access masks independently, reducing vulnerability in the context of transmission.

It is not clear whether the programs provided throughout the pandemic to promote healthy families are evidence-based. In fact, the recency of COVID-19 and impacts, combined with slow knowledge mobilization, implies evidence-based practices are not yet available. The evidence available in the literature largely addresses best practices to reduce infection rates and lacks specific focus on structural inadequacies. Resultantly, policymakers have limited data, which means programs are a patchwork of environmental scans, previous strategies, and intuition (Dissanayake 2020).

IV. EVIDENCE-BASED PRACTICE FOR COMMUNITIES SUPPORTING VULNERABLE FAMILIES

Evidence-based practices provide the safest, most effective outcomes for families by implementing research within practice, improving the availability and accessibility of comprehensive services (Henriksen et al. 2005; Kazak et al. 2010, 86). However, slow knowledge mobilization creates challenges in access to EBP for community organizations that serve families and children (Trocome et al. n.d.). While plenty of research exists on practices to mitigate social risk to families and children, evidence-based interventions are not swiftly being translated into community-level services due to inefficient knowledge mobilization (Trocome et al. n.d.).

When research does not translate into policies and programs, it fuels an ongoing degree of mistrust, frustration, and unwillingness to enter into future academic partnerships (Pinto, Spector, and Rahman 2019). It is necessary for academics to include organizations within research frameworks in order to inform evidence-based service delivery within the community. Furthermore, political inaction results from “ivory tower” research – research that is detached from the practicality of daily life for the purposes of publication in academic journals that are only accessible to other academics (Hoyt and Hollister 2014, 129). Research conducted in this siloed manner prevents translation into policy and practices that families rely upon (Hoyt and Hollister 2014, 129).

Effective collaboration between academic researchers, community organizations, and policymakers is vital to translate research into community-level, evidence-based policies and programs (CST, 2008). Collaboration in the form of co-creation models prioritizes the input of relevant stakeholders and facilitates the adoption of evidence-based practice within the local community (Greenhalgh et al. 2016, 393). To enhance the benefits of collaborative research, academics, organizations, and policymakers need to first identify and address the challenges that occur when engaging in partnerships. Often, knowledge mobilization is inhibited by a obstacles, such as silo effects in social policy, political intervention as a habitual response to focusing events, failure to share findings back with community organizations, power imbalances between organizations and researchers, and academic pursuit of traditional research mobilization avenues, such as journal publication or conference presentation (Reardon, Lavis, and Gibson 2006, 3; Jenson and Fraser 2015, The Council 2020, 14). Through discussions with focus groups (see appendix for methods), this paper aims to identify key policy barriers and facilitators in accessing and implementing EBP during the pandemic for community organizations supporting vulnerable families in Calgary.

V. FOCUS GROUP FINDINGS

Five focus groups revealed three thematic categories of policy barriers and two thematic categories of facilitators as they relate to EBP access throughout the pandemic in Calgary. Appendix A highlights the Nominal Group Technique (NGT) methodology used to structure the focus groups, and discusses the analytic methods employed to uncover these five themes. Three prominent barriers described by participants included revenue loss, transition to online service delivery, and inadequate communication and collaboration with government. Policy solutions emerged under two themes: person-centred policies and programs, and reciprocal partnerships. Table 1 can be viewed below, providing a summary of the focus group themes and subthemes. The following section will elaborate upon the findings encapsulated in Table 1 using the qualitative data collected in each of the five NGT focus groups.

Table 1: Emerging Themes and Subthemes from NGT Focus Groups

BARRIER THEMES		BARRIER SUBTHEMES	
Reduced Revenue Streams		<ul style="list-style-type: none"> • Funding and Grant Focus • Funding Structure • Income Loss 	
Transition to Online Service Delivery		<ul style="list-style-type: none"> • Access to Hardware and Software • Digital Literacy • Staff Capacity 	
Inadequate Communication and Collaboration with Government		<ul style="list-style-type: none"> • Insufficient Guidelines • Lack of Sector-specific Guidelines • Inconsistencies Between Health and Regulatory Bodies 	
SOLUTION THEMES		SOLUTION SUBTHEMES	
Person-centred Policies and Programs		<ul style="list-style-type: none"> • Equity Lens for Policies and Programs • Evidence-based Policies and Programs 	
Reciprocal Partnerships		<ul style="list-style-type: none"> • Intergovernmental Collaboration • Sector Alignment • Equal Partnerships Between Academia, Community Organizations, and Government 	

REDUCED REVENUE STREAMS

Reduced revenue streams, as a theme, was prioritized as the most important barrier across all five NGT focus groups. Throughout COVID-19, community organizations have experienced reductions in general revenue streams for a variety of reasons. The three main causes articulated by participants included funding and grant focus, funding structure, and income loss.

According to participants, the pandemic has created an emergency funding and grant focus that carries implications for long-term sector sustainability. Participants described funding as short-term, with many funding and grant agencies prioritizing COVID-19-specific programming over long-term programming and planning. These specific priorities may not always align with organizational and staff capacity needs as funding is not exclusively or readily available for long-term planning needs such as service continuity. Additionally, participants noted there has been a lack of supply-side funding provided during the pandemic. Because COVID-19 rendered worldwide economies inactive, the supply-side shock has been answered by demand-side compensation, such as CERB (Canada Emergency Reponses Benefit), CEWS (Canada Emergency Wage Subsidy), and CESB (Canada Emergency Student Benefit). These programs do little for community-based organizations who need to fund daily operations beyond the impacts of COVID-19.

COVID-19 has certainly introduced the need for funding that supports staff sick leave, digital service provision, the work from home transition, and the procurement PPE, but there are still funding needs within social and community services beyond COVID-19 specific needs. Yet, many funders and grants are awarding dollars to community-based

supports within a COVID-19 context. Many participants expressed concern regarding what the emergency funding focus implied for sector sustainability, and for their ability to comprehensively reach new and existing clients with the evidence-based practice they rely upon.

In addition to the focus of funding and grants, participants described challenges to evidence-based service provision caused by insufficient coordination of funding, universal lags in receiving funds, and competition for funding between organizations. Some participants noted a lot of COVID-19-specific funding was available for community organizations but lacked coordination between government departments and funding agencies. Confusion surrounding funding sources creates unnecessary delays in getting funding to community organizations during a time of great need. Such confusion also taxes staff and organizational capacity, as this capacity is misallocated toward grant proposals and funding applications.

Many participants also spoke about the way funding structure creates competition between community-organizations, ultimately thwarting a client's ability to receive the best services to meet their needs. Combined with temporary project-based funding from government and private funders, community organizations feel pressure to compete with one another for funding and grants (Scott 2006, 28). As one participant said:

"I think that when we're in financially hard times, we get very territorial as organizations. I think that we get worried, and I think that we don't play nice together. And I think that when we don't play nice together, we don't share resources, we don't share support, we don't team up together, and then we don't support each other."

In a stressful context, such as a pandemic, community organizations may be fearful about losing clients and thus losing revenue. Organizations may be hesitant to recommend other programs or services their clients may benefit from out of fear of losing that client to another organization. Ultimately, this reduces the client's ability to access programming that would optimize their outcome.

General income loss was also noted by the majority of participants. Overall income loss was attributed to many pandemic-related factors. Namely, participants spoke about an inability to fundraise, client hesitation to access virtual services, and a loss of direct billable hours. Participants described additional income loss due to client hesitation to use restructured services. While some participants noted that digital service provision has made services more accessible than ever, others described new methods of service delivery as a barrier to continuing or beginning services from a client perspective. Some of this hesitation was said to result from privacy and confidentiality concerns. Other participants described hesitation as stemming from the client's perception of virtual service efficacy. As one participant noted:

"Data, in many ways, supports tele-practice... But there's still a perception it's a 'less than' service. So, I'd like to know to what degree it is, or isn't."

Participants in all NGT groups reported a desire of clients to return to in-person services and reported that clients expressed reduced interest in accessing virtual services due to privacy and efficacy concerns.

Participants also mentioned a reduction in direct client hours, which causally reduce funding or billing for one-on-one hours. Other organizations that bill direct hours experienced a decrease in these hours resulting from the transition to online service delivery. In some cases, these service hours remain limited depending on the type of service provided. For clients receiving intensive therapies, service hours could not be provided as rigorously through online platforms. In this manner, restructured forms of service delivery have changed funding for direct hours, as well as ability to bill hours.

TRANSITION TO ONLINE SERVICE DELIVERY

With Calgary's declaration of state of emergency, only essential services were allowed to keep physical premises open. While some community organizations, such as food banks and emergency shelters, were deemed essential, most participants in this study needed to close their doors to clients. All of these participants engaged in service continuity through online delivery platforms, such as Zoom and Google Hangouts. Participants encountered challenges to restructuring services due to access to hardware and software, digital literacy, and staff capacity.

Multiple participants made the distinction between access to hardware and access to software to emphasize that both are necessary for program participation. Participants explained that having one device for a family does not suffice in the context of virtual service provision. To maintain appropriate levels of service, it is essential that families have more than one device per household. However, not all families can afford multiple devices for parents and children. Even if families do have sufficient hardware within the home, software access poses an additional problem to client participation. A few participants raised concern around wireless internet access challenges for clients living in rural and remote areas. Despite owning devices, client connectivity issues may create a barrier to meaningful engagement. Further, even in urban areas, entire families rely on the same wireless connection to complete work, to attend school, to speak with friends and family, for entertainment, and for program access. Families may lack the gigabyte usage to allow all members of the household to adequately engage in work, school and other activities.

Alongside access to hardware and software, clients and staff need to be equipped with technological comprehension and comfort in order to access services. A few participants spoke about the "digital divide" – a divergence between those who can access and use technology, and those who cannot – as a challenge to evidence-based service provision (Bezuidenhout et al. 2017). In our digital age, many people have access to hardware and software, but are not necessarily comfortable with technology. Participants identified that particular demographics were more likely to require skill-building for digital literacy. These demographics included seniors, newcomers, low-income families, and people living in rural, remote, and Indigenous communities. To obtain optimal outcomes from current services, clients do not just need access to

technology; they also require skills to effectively engage with a novel digital world in the context of COVID-19.

Clients may feel more comfortable with digital service provision if staff are digitally literate and well-versed in the ethics of digital citizenship. Staff have needed to transition to digital service delivery, which has favoured younger, digitally literate staff. Participants identified a need for organizations to be patient with staff, and perhaps alter performance evaluations for staff who experience greater challenges navigating digital service provision. Organizations also need to incorporate digital citizenship into staff training as it is now the primary method of service delivery. Digital citizenship encompasses elements such as digital rights and responsibilities, consideration of digital risks, and digital privacy and security (Ribble 2015, 17). A client's perceived loss of privacy and security may deter service access. Participants expressed that clients' perceptions of security could be enhanced if organizations have codes of ethics in place guiding digital responsibility.

However, participants reported that staff capacity was too taxed to engage in opportunities such as re-training because of pandemic-related factors. Participants noted unique staff challenges relating to technological service provision, including availability in staffs' schedules, and the need for staff to re-invent service delivery.

Some participants spoke to the impact of changes to staff scheduling on their ability to deliver virtual services to clients. COVID-19 has altered the work schedules of many staff members, especially those who have dependents and children requiring care during work hours. Participants reported that service delivery is not always flexible outside of work hours, and that COVID-19 has highlighted difficulties for staff who are balancing childcare with work. Work from home requirements impeded staffing availability, and subsequently, client access to their familiar service workers.

Other participants describe staff exhaustion from using capacity to re-invent service provision in a way that resonates through virtual platforms on tight timelines. As agencies rapidly needed to change their mode of service provision to meet client needs, staff and agency needs became an afterthought. Staff experienced burnout resulting from the need to take in-person services and translate the lessons behind these services onto virtual platforms. As a participant illustrated:

"I have to re-imagine, "what is this thing that I'm trying to teach you? What am I trying to get you to learn? What are the other ways that I could get you to learn that? How can I then do that within this virtual platform?"

Other participants noted staff do not have experience with creatively re-structuring service delivery. Organizations may not have staff with the skills to take in-person content and deliver the same message through virtual services. If organizations lack the staff capacity to translate face-to-face, evidence-based services onto online platforms, families may not be receiving the services they need to optimize outcomes.

INADEQUATE COMMUNICATION AND COLLABORATION WITH GOVERNMENT

Three notable areas factor into participant concern surrounding inadequate communication and collaboration with government. Participants cited insufficient guidelines, lack of sector-specific guidelines, and inconsistencies in advice from health and regulatory bodies as areas contributing to confusion surrounding practice implementation. As a result of ambiguities in protocols and procedures, organizations have experienced challenges crafting health and safety guidelines essential to their re-opening.

When asked about current barriers to providing evidence-based practice in this stage of Alberta's recovery, participants cited multiple inadequacies within government guidelines as an obstacle to re-opening physical premises. This included vagueness, inaccessible language, fluctuation, clarity, redundancy, inconsistency, English-only instructions, lack of transparency, and lack of support from government. Messaging was often too broad to be adapted to organizations' needs and was written in language that could not be easily understood by clients and families. As well, these guidelines changed rapidly as Alberta moved through recovery stages in ways that did not make staff and families feel safe. Confusion surrounding how to safely return to in-person services prevented return from occurring.

For many organizations, general COVID-19 health and safety guidelines did not fit client, staff, and service needs. Participants observed the lines between response and recovery phases of pandemic planning had become blurred, with many participants providing services the same way since March. Mostly, the decision to continue virtual service provision stemmed from a lack of sector-specific considerations. Some participants noted that sector-specific guidelines were only released weeks after a new phase, despite getting approval from government to re-open physical spaces. Multiple participants mentioned disability service providers were approved to re-open under Stage 1 of pandemic recovery but did not receive sector-specific guidelines until three weeks after the commencement of Stage 1. Even so, these sector-specific guidelines were not comprehensive enough to consider the unique needs of clients served by community organizations. For disability service providers, guidelines received from government failed to consider key barriers to persons with disabilities in relation to re-entry. For instance, the government recommendations for disability service providers include physical distancing between staff and clients with disabilities (Alberta 2020a). This recommendation does not wholly account for the hands-on support these clients require. Participants expressed that incomprehensive, sector-specific guidelines were impeding their return to in-person, evidence-based service provision.

Exacerbating this confusion, participants also discussed messaging provided by their regulatory body as contradictory to government guidance. In some cases, regulatory bodies seemed to be attempting to adapt government guidance to the unique situations of community organizations. In other cases, regulatory bodies did not provide timely updates to the guidance issued to organizations. The end result, in both situations, was a delay in provision of crucial information for organizations, and ultimately, a delay in resumption of evidence-based services. As one participant described:

“We got a set of directives from Alberta Health Services, and a set of directives from Children’s Services. They didn’t always match, and I found it took a while for Children’s Services messaging to catch up and align with Alberta Health Services. So, then we were in an awkward position of ‘well, which one do we follow?’”

PERSON-CENTRED POLICIES AND PROGRAMS

The prioritization of person-centred policies and programs instead of economic activity may provide community organizations with the support they need to reduce client vulnerability. Many participants agreed that, at the onset of COVID-19, the government released numerous person-centred policies and programs to quickly help people experiencing need. For instance, participants saw CERB as a person-centred program, as government acted swiftly to get funds to people who lost their job in the economic shutdown. However, participants also observed that messaging began to change as the economy started to re-open, and priorities shifted toward economic ignition and away from person-centredness. The two overarching solutions proposed by participants to uphold person-centredness included the use of an equity lens to craft policies and programs, and the implementation of evidence-based policies and programs.

Participants in all five focus groups emphasized the way COVID-19 exacerbated existing structural gaps. Many participants expressed that intersectional approaches were necessary to mobilize equitable recovery. Some participants acknowledged that a blanket approach to recovery would likely intensify pre-existing social and economic inequalities. When asked to elaborate on operationalizing equitable policy as a solution, one participant said:

“Understand[ing] that different groups have different, unique needs. And to really understand that, instead of just providing a ‘one-size-fits-all.’”

Participants spoke about great need for representation and consultation when crafting policies and programs that affect identifiable, vulnerable demographics. Such consultation must include sufficient representation from communities experiencing need. Client circumstances intersect in a variety of ways with distinguishable structural disparities. An equity lens is necessary to create policies and programs to help clients navigate deleterious impacts of intersectionality throughout the pandemic.

Alongside equity-based policies, and programs, participants expressed the need for evidence-based policies and programs to create a person-centred approach that mitigates the pandemic’s impact on client outcomes. Some participants described a lack of evidence-based policies as the biggest hurdle to person-centred service provision. Participants suggested open access to publications and research, as online access to peer-reviewed journals is often exclusive to other academics. Participants also noted, however, that the COVID-19 pandemic is unprecedented. The novelty of this pandemic’s impact means an evidence-base does not exist for community organization COVID-19 preparedness, response, and recovery. To address this, a participant suggested releasing white papers (concise government reports about contemporary, complex issues) alongside other emergency preparedness research to situate past policy and program recommendations within the current context. Many participants

expressed that policies and programs based in objective research, rather than ideology, would help support community organizations and clients.

RECIPROCAL PARTNERSHIPS

Almost every participant supported bidirectional collaboration as an ideal way to interact with government and support clients. Such collaboration was described as necessary between government departments, between community organizations, and between community organizations and policymakers. Multiple participants also valued academia as a necessary contributor to these partnerships in order to bring evidence-based practices to fruition. Participants acknowledged collaboration within and between community organizations, government, and research as an effective way to provide best outcomes for clients and families.

Intragovernmental Collaboration

Participants commonly mentioned a lack of collaboration between ministries as a barrier impeding evidence-based policy and program provision and proposed intragovernmental collaboration as a solution to redundant and inconsistent guidelines. While participants noted COVID-19 had increased intergovernmental communication between municipal, provincial, and federal levels of government, they also expressed provincial ministries had become more fragmented. One participant speculated the silo effect stems from competition created by top-down funding allocation.

“I think even from a systemic level, the fact that Education doesn’t talk to Health who doesn’t talk to Community and Social Services in times like this is really ridiculous. And I think they have siloed more during this time because dollars matter.”

Participants iterated that all ministries addressing the concerns of families and children must collaborate to best support outcomes for this population. A holistic, comprehensive, family-centred approach would maximize the coordination of programs that service children and families.

Participants also revealed dissatisfaction with the fragmentation of local community and social services and expressed a need to form a united front when interacting with government. Participants reported the lack of cohesion contributed to difficulties in efficiently communicating to the appropriate area of government, to redundancy in communication with government, and to a “watering-down” of a consistent voice. Other participants identified a need for efficient, cohesive feedback to policymakers in a way that encompasses sector concerns without repeating priorities. One participant mentioned that a sector-wide lobbying mindset may help organize sector aims and streamline communication to the appropriate ministry or level of government. Across all NGT groups, participants spoke to a need for unity in consultation with government.

Most participants reported a great need for research-based, community agenda setting. Many identified that collaboration with government was often ineffective due to an inability to provide direct, streamlined feedback to policymakers. One participant noted

service provision would likely improve if there were a professional way to “funnel advice” back to policymakers after the implementation of political and social guidelines. A few participants mentioned the need for real co-design solutions that involved community organizations, government, academia, and funders. Participants used terms such as “equal”, “bidirectional”, and “transparent” to describe the ideal dialogue to characterize these partnerships. Participants stressed the need for thorough community engagement where all voices contributing are weighted equally. Many of the participants who offered this idea spoke to a lack of public trust, and a need for trust-building in relationships to eradicate power dynamics from reciprocal partnership.

A few participants identified the information being released by government as it pertains to children, families, and service provision throughout COVID-19 has been over-abundant and non-cohesive. These participants also reported families have been confused about where to locate the best guidelines to suit their circumstances. The creation of a localized webpage containing all guidelines for service provision for families and children was suggested as a means of easing this overwhelm. Participants proposed this localized, online platform consist of government recommendations and guidelines, as well as research promoting evidence-based service provision during the pandemic. In this manner, families and organizations may have an easier time locating critical information as it relates to their unique circumstances.

VI. DISCUSSION

The major themes uncovered in the research, as they apply to barriers to evidence-based service provision, included reduced revenue streams, access to technology, and lack of collaborative communication within and between ministries, as well as sectors. Proposed solutions to these barriers included person-centred policy and program approaches and reciprocal partnerships. Holistic, family-centred approaches have long been proposed as a remedy to systems-level disparities, and subsequently, as a remedy to familial vulnerability. Many of these themes were extensively discussed in the literature.

REDUCED REVENUE STREAMS

Revenue has been cited as a barrier that organizations face when providing evidence-based services (McCambridge and Dietz 2020). In particular, insufficient funding from agencies and government is commonly concerning for long-term sustainability. While funders may be willing to provide dollars for direct service delivery, organizations have always experienced challenges in financing infrastructure and core operations, thus restricting growth capacity (Geofunders 2015). Community organizations report reducing overhead spending to qualify for funds and grants that do not offer adequate support for operational costs (Goggins Gregory and Howard 2009). Further, in Alberta, this concern has been particularly longstanding. Non-profits often rely on three main funding sources: donors, income from services, and funding from government (CCVO 2019, 15). Provincial organizations were competing from this small, undiversified pool of funds prior to the onset of COVID-19, and were recognizing the need for long-term funding contracts that could flexibly contribute to overhead as well as programs (CCVO 2019, 15).

Participants reported applying to a variety of funding sources and grants due to short-term funding contracts, which is referred to as a “piecemeal” approach to funding in the literature (Porter and Kramer 2002). This short-term funding focus creates concerns surrounding sustainability. Participants noted that, amidst the pandemic, almost all funding has been provided on short-term contracts without knowledge of renewal due to a collective, sector-wide experience of need. To this extent, the structure of funding and the absence of a strategy prevents long-term systems planning that promotes best outcomes for clients.

TRANSITION TO ONLINE SERVICE DELIVERY

In the context of COVID-19, access to technology was introduced as a challenge impeding organizations’ ability to support families. This theme did not appear directly within a pandemic context in the literature, as the emergence of tele-practice for all forms of service provision is a novel externality of COVID-19. Much of the research concerning digital access and literacy relates to healthcare. However, healthcare literature echoes the sentiments of participants in the group: insufficient access and skills to use technology impedes optimal service use (Kennedy and Yaldron 2017).

Even in fields with established modes of digital service delivery, this format is not widely considered best practice. Telerehabilitation, teletherapies, and teleprogramming are very new fields of telemedicine that do not have large evidence bases (Peretti et al. 2017). The little research that exists shows both advantages and disadvantages to digital service provision. Advantages include the ability to reach clients in remote areas, convenience in client scheduling, and cost-effectiveness for providers (Novotney 2017). Disadvantages may compromise the quality and spirit of services, including the lack of face-to-face content with a provider, non-optimization of service due to capacity constraints, and ethical considerations (Peretti et al. 2017). A lack of capacity significantly limits virtual care options. Access to technological infrastructure (phone and broadband internet), support, and the degree to which families are educated on its use, is of great importance to the success of virtual care delivery and is a limiting factor, particularly in rural and remote communities (Roerig et al. 2020, 10)

INSUFFICIENT COMMUNICATION AND COLLABORATION WITH GOVERNMENT

In research that examines past emergency preparedness planning at the community level, organizations emphasize the need for community collaboration to inform consistent, clear, and sector-specific guidelines (Buccieri and Schiff 2016, 107). Participants described guidelines as being insufficient in numerous ways: guidelines were too general, used convoluted language, fluctuated, were unclear, were English-dominant, and differed from what was provided by regulatory bodies. Literature for sound pandemic planning emphasizes community involvement to equitably target and plan for the circumstances of vulnerable populations (Stevenson et al. 2009). Connecting the valuable experiences from a wide range of organizations within the sector is necessary to scale out coordinated efforts (The Council 2020, 14).

Largely, insufficient and inadequate sector-specific guidelines could be mitigated by involvement from community organizations and researchers within planning processes.

For instance, physical distancing guidelines were challenging to implement within emergency shelter spaces (Buccieri and Schiff 2016, 90). If community-based homeless shelters were consulted about pandemic planning, government may better understand capacity concerns pertaining to physical distancing. As well, these organization would have the opportunity to work with government in producing specific emergency shelter guidelines that maintain integrity of practice.

PERSON-CENTRED POLICIES AND PROGRAMS

Research also validates the solutions proposed by participants as viable. The two themes recurring as proposed solutions included person-centredness and reciprocal partnerships. Robust bodies of literature support the efficacy of both ideologies.

Person-centredness is commonly used to describe ideal care in healthcare policy, practice, and research (McCormack and McCance 2010, 2). This ideology is a holistic, integrative approach that considers an individual person's circumstances, needs, and preferences (Barnett 2018). Participants described person-centred policies and programs as being both equitable and evidence-based.

Equitable pandemic policies and programs, as they appear in the research, are often framed in terms of medical and vaccine access (Fidler 2010). However, some recent literature urges policymakers to consider policies that will reduce social and health disparity in recovery stages of COVID-19. Globally, researchers have observed the pandemic's exploitation of existing structural inadequacies (Alberti, Lanz, and Wilkins 2020). Recent research notes increased stigmatization of Asian populations, differential exposure, and school closure impacts on low-income children (Alberti, Lanz, and Wilkins 2020; NAACP 2020). Participants noted that policies addressing recovery should be needs-based to ensure those experiencing exaggerated hardships receive proportional policy guidance and support.

Grey literature also signals to specific systems-level economic, political, and social inequities highlighted by pandemic affects. Racial minority, elderly age, incarceration, homelessness, and low-income are reported as risk factors for morbidity and mortality from the virus itself (NAACP 2020). In tandem with by-products of COVID-19, such as stay-at-home orders, the impacts of the pandemic have illuminated inequities affecting these vulnerable people. Some of these disparities include housing insecurity, inaccessible childcare, inadequate institutional models of care, lack of space in prisons and homeless shelters, insufficient sick leave policies for front-line workers, and emergency food distribution (NAACP 2020). Recent academic and grey literature supports participants' call for person-centred policies to address social and health inequity as Alberta continues moves through stages of recovery (Carlos, Lowry, and Sadigh 2020).

Participants also highlighted the role of evidence-based policies in promoting person-centred approaches to provincial recovery. Research that addresses particular circumstances created by COVID-19 is scarce. A lack of current research results from the recency of the pandemic, as well as the time it takes for evidence to mobilize (Dissanayake 2020). However, past pandemics, such as H1N1, have revealed a need

for more a more extensive evidence-base surrounding pandemic planning at all levels of government (Lipsitch et al. 2011). Policymakers have limited data, which means policies are rooted in jurisdictional success, past strategies, and intuition (Dissanayake 2020). This means that decision-making throughout the pandemic is, and has been, experience-based and ideologically-based rather than evidence-based. While literature notes the exaggeration of various health and social inequities throughout the H1N1 pandemic, there is minimal research addressing how to translate evidence from prior pandemics into policies and programs. Participants and the literature alike identify a need for a more robust evidence-based surrounding pandemic policies promoting effective planning, response, and recovery.

RECIPROCAL PARTNERSHIPS

Reciprocal partnerships may be a mechanism to alleviate the research-to-practice gap throughout the current pandemic and mobilize person-centred policies into practice more quickly. Participants reported a need for more effective collaboration at a variety of levels, including intragovernmental collaboration, partnership between organizations, and formalized connections between policymakers, academia, and community organizations. Literature supports faster knowledge mobilization occurs through partnerships within and between each of these bodies.

Intersectoral collaboration has been proposed as a means of reducing systems-level gaps experienced by families as they navigate a variety of programs that promote children's outcomes. Coherent organization between ministries has notable benefits for children and families (Friendly 2008, 40). In 1995, the state of Maine combined five departments that serviced children and families in diverse ways: Education, Health and Human Services, Corrections, Public Safety, and Labour (Children's Cabinet Network 2010). The combination of these departments, now known as the Children's Cabinet, cohesively work together to uphold one comprehensive vision, focused on school success, workplace readiness, health and safety of families, and family-centredness (Children's Cabinet Network 2010). Noteworthy benefits since this initial collaboration include leveraged funding from federal and private sector sources, alignment of programming to stimulate benefits across multiple dimensions of child health, and the creation of an Educare centre (Children's Cabinet Network 2010). Maine's Children's Cabinet is considered a nationwide exemplar of cross-ministry collaboration. Collaborative models such as children's cabinets are research-supported methods of comprehensively coordinating policies and programs that support best outcomes for families.

Collaborative partnership is dominated by community participatory capacity in the literature. The literature demonstrates that evidence-based policies mobilize quickly into the local community when organizations collaborate with academics and policymakers in conducting research (Fourie 2003, 33). Reciprocal relationships between academia, community organizations, and policymakers produce effective legislative progression (Brockway 2005, 1). Partnership between these three bodies, however, can be challenging to coordinate and implement (Jenson and Fraser 2015). While provincial ministries such as the Ministry of Community and Social Services (MCSS) claim to have transparent, open door ideologies, such ideologies, have failed

to effectively respond to the needs of community organizations and families during COVID-19 (Alberta 2017a; Alberta 2017b).

Community organizations are valuable resources for informing research questions, as they navigate daily operations of the research interest (Wallerstein and Duran 2010). Research partnerships have the ability to broaden policymakers' perspectives, increase scope and range of the content investigated, and minimize replication of similar research (Green, Daniel, and Novick 2001). Within the context of COVID-19, an important advantage of these partnerships is fluid knowledge mobilization that can promptly inform evidence-based decisions (Shields and Evans 2012, 255). Issues noted by participants that may be eased by such partnership include uncoordinated and insufficient communication from government, access to technology, digital literacy, and funding competition between agencies.

Though much of the literature surrounding reciprocal partnerships speaks to ministerial partnership and community-government engagement, there is some research supporting organizational alignment as a knowledge mobilization catalyst (German, Urquhart, and Wilson 2008, 4). In the literature, this concept is referred to as "interorganizational collaboration" (Karlsson et al. 2019). Interorganizational collaboration has positive implications for tailoring cooperative effort to client outcomes, to advance evidence-based practice, and to allocate resources (Karlsson et al. 2019, 241). However, as participants mentioned, economic downturn often makes community organizations insecure and competitive (Taylor 2017). It can be challenging to entice organizations due to fear-based perceptions around scarcity of funding access (Taylor 2017). During the pandemic when funding is short-sighted and scarce, sector alignment may be challenging to organize.

VII. LIMITATIONS

There are a few notable limitations within the NGT used to structure the focus group; namely, pressured consensus, minimization of more traditional discussion, and restriction of idea generation to a single topic (CDC 2018). The highly structured and digital nature of the NGT may encourage participants to direct most of their ideas toward the researcher and dissuade participants from speaking directly to one another. In traditional focus groups, communal discussion is encouraged between participants in order to flesh out group feelings, thoughts, and experiences surrounding interview questions (Gibbs 1997). Structured NGT methodology may deter a more in-depth collective discussion. In the same manner, the single-topic structure also may discourage the sharing of emotions, ideas and experiences unless they specifically align with the research question. This decision, however, was made with acknowledgement to these trade-offs in order to reduce potential power imbalances and to get a prioritized list of barriers and solutions from participants.

Other limitations existed within this particular study, mostly as a result of this project's short timeline. The methodology and writing for this project were completed from May to September of 2020. Participant recruitment only began at the start of July, and NGT groups were conducted within a two-week window. As well, NGT groups were held in

the middle of summer during Alberta's Stage 2 of pandemic recovery. Many contacts during the recruitment stage expressed the desire to participate, but were unable due to childcare arrangements, vacation, or lack of availability due to the pandemic.

The pandemic introduced a virtual element to this research that is less developed in the literature than traditional in-person qualitative research. Digital qualitative research has its advantages and disadvantages. Some of the limitations resulting from hosting the NGT groups on Zoom are as follows: less fluidity in conversation, microphone issues, unfamiliarity with Zoom, and perceived convenience to come late or leave early. Speaking to the latter limitation, six of 24 participants withdrew from the focus group prematurely due to other engagements, and two participants arrived late for similar reasoning. Zoom meetings have become a new standard of normal throughout the pandemic. Convenience is cited in digital qualitative data collection research as a key advantage from a participant perspective (Archibald et al. 2019, 4). However, in this research, the convenient access to attendance led some participants to overscheduling on the day of participation.

VIII. POLICY RECOMMENDATIONS

EDUCATION FOR AND CONSULTATION WITH COMMUNITY ORGANIZATIONS

The majority of participants in this study reported feeling unsafe, confused, or overwhelmed by nonspecific directives for service continuity. Provincial leadership is necessary to sufficiently engage community organizations in the creation of sector-specific pandemic documents, to build trust, and to establish clarity around service continuity. There are a variety of ways the Government of Alberta can provide education and leadership during this time. Participant concerns and the literature identify a need for hazard awareness, technological assistance, and improving staff abilities (Bardach 2012, 148).

SUBSIDY AND GRANT PROVISION FOR COMMUNITY-BASED RESEARCH

Above all other themes, and across all five NGT groups, participants consistently prioritized reduced revenue streams as a barrier to evidence-based service provision. Funding focused on long-term outputs, rather than short-term outcomes, is a growing priority for organizations and families. Subsidy and grant provision for community-based research can shift focus toward long-term sector sustainability, can catalyze creation of evidence-based programs that promote client outcomes. As well, this focus for subsidies and grants may incentivize reciprocal partnership between community organizations and researchers.

A FORMALIZED, LOCAL NETWORK OF COMMUNITY ORGANIZATIONS, RESEARCHERS, AND POLICYMAKERS

Participants disclosed great difficulty in navigating service provision throughout the pandemic due to the siloed operation of research, community organizations, and government ministries. Collaboration between these bodies can lead to tangible

public and social policy innovation, and subsequently, improvements in service delivery. More importantly, improved service delivery means families and children will be able to access evidence-based services easily, in their communities, when such services are needed.

A formalized network is necessary to leverage collaborative efforts between policymakers, researchers, and community organizations. This network should embed backbone support to ensure collective alignment, to maintain the mission of the network, to facilitate new partnerships, and to build capacity in the community (CIF n.d., 8). Such a network, in the form of a community-based research and policy hub, would facilitate alignment of community organizations, encourage partnerships for community-based research, and streamline findings back to policymakers for implementation into tangible outputs. Effectively, a hub would increase the speed of knowledge mobilization to quickly deliver evidence-based services to families in need.

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APPENDIX A. - QUALITATIVE METHODOLOGY

FOCUS GROUPS STRUCTURED BY THE NOMINAL GROUP TECHNIQUE (NGT)

To develop a comprehensive understanding of the perspectives and priorities for vulnerable families, five focus groups were undertaken virtually July 14th, 2020 until July 22nd, 2020. Using Zoom videoconferencing, the participants' names were changed to numbers in order to protect their identities from one another. To maintain consistency, all present participants were asked to have cameras on, or cameras off. Two of the groups were conducted with all participants' cameras off, while three groups were held with participants' cameras on.

The Nominal Group Technique (NGT) was used to structure the focus group. The NGT is a consensus method used to determine priorities across a particular demographic (McMillan, King, and Tully 2016). First used by Van de Ven and Delbecq, the NGT identifies critical problems faced by participants in relation to a research question, elaborates on and clarifies meaning, and parses out the most critical problems faced by a particular demographic (Van de Ven and Delbecq 1972, 341). This methodology offers unique advantages best suited to the research objectives. Firstly, the NGT is highly structured in a way traditional focus groups are not, which negates potential dominance from one or multiple participants (Khayat-zadeh-Mahani et al. 2019). The structure additionally ensures each participant gets equal say to offer contributions around the research question. As well, the NGT concludes with a ranked list of preferences immediately available for participants to view, which can validate personal experiences, thoughts, and feelings (Khayat-zadeh-Mahani et al. 2019; McMillan, King, and Tully 2016).

The use of NGT methodology encouraged participants to generate a variety of ideas surrounding service provision throughout the pandemic without unequal contributions due to power imbalances within the group, and without fear of offering an opinion that potentially differed, as stakeholders were quite diverse. The primary researcher used an adapted form of the NGT which included five stages: silent generation, round robin, clarification, categorization, and ranking. This adapted NGT was facilitated by the lead researcher.

In the first stage, the primary researcher allotted participants ten minutes to brainstorm ideas surrounding evidence-based service provision throughout COVID-19. In silence, participant noted as many ideas as possible. Next, in the round robin stage, the researcher asked participants to concisely share their ideas, in turn. The researcher recorded these ideas in a word document, which was screen-shared for all participants to view. Participants only offered up novel contributions or perspectives to items listed on the word document. In stage three, clarification, participants discussed their opinions and experiences with the listed items and elaborated in areas that necessitated clarification. Next, participants and the researcher categorized the listed ideas by thematic concept, ensuring all listed items could be sorted into one of the created themes. In the final stage, ranking, participants used the private chat function on Zoom to individually send the researcher a list of five themes, ordered from five to one, with five points reflecting their first preference, and one point reflecting their fifth

preferences. The researcher then concluded this stage by summing all scores, revealing the rankings of each theme, and providing the participants with immediate feedback on their collective contributions.

RECRUITMENT AND PARTICIPANTS

Researchers recruited participants from a variety of networks using both purposive and snowball sampling. Purposive sampling was employed by extending study materials to 47 people working within the disability sector, as well as 44 people representing diverse organizations in Calgary. The latter contacts were provided by a co-supervisor and were forged through working relationships as well as past experience participating in this area of research. Snowball sampling was also used as the researcher welcomed participants to extend study information and recruitment materials to anyone expressing interest within their respective networks.

Recruitment letters were sent to all 91 contacts, with 24 of these contacts returning consent forms and participating in the focus groups. The five focus groups took place on five different days with scattered time slots. Due to the context of the pandemic and the uncertainty it has introduced into daily schedules, participants assigned themselves to the focus group that worked best with their personal schedules. The average length of the NGT groups was 2 hours, 1 minute, and 46 seconds (min: 58 mins and 4 seconds, max: 2 hours, 45 mins, and 20 seconds).

In total, 24 participants attended the virtual NGT groups. The majority of participants were female, as 21 female participants and 3 male participants attended the virtual NGT groups. Participants were diverse, and consisted of front-line service workers, executive directors, research specialists, program leads, strategists, and coordinators. All participants represented numerous organizations within Calgary, with focus on areas such as youth homelessness, domestic violence, poverty, disability, early education, newcomers, mental health, addiction, and rehabilitation. Participants' experience in the non-profit and social service sector ranged from a few months to over 20 years. All participants drew upon personal experiences with vulnerable families to brainstorm and discuss challenges and solutions surrounding service delivery throughout the pandemic.

ANALYTIC METHODS

All NGT groups were held over Zoom videoconferencing. The focus groups were recorded and were saved locally to the researcher's computer for future analysis, as well as the meeting notes. The researcher coded the raw data to corroborate the themes generated by different participants across all NGT groups. Traditionally, NGT groups are not transcribed as the raw data provides a thorough summary of the themes reflected upon by participants (McMillan et al. 2014). However, in this case, the researcher did transcribe audio recordings verbatim to contextualize the themes prioritized by participants during the NGT groups. As the NGT inherently generates themes in the ranking stage of the methodology, the transcripts were used to add perspective and context to participant themes. All themes reflected opinions and experiences surrounding pandemic preparedness and evidence-based service provision in the context of COVID-19. The generation of themes were similar across all five focus groups.

About the Authors

Jessica Kohek is a graduate of the Master of Public Policy Program at the School of Public Policy and was a MITACS-Kids Brain Health Network Intern. Her research is concentrated in community engagement, knowledge mobilization, and disability. Jessica's recent work incorporates clinical experiences into advocacy and policy to improve systems functioning for individuals with autism.

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Dr. Katrina Milaney is an Associate Professor in Community Rehabilitation and Disability Studies at the University of Calgary. She has an interdisciplinary academic background that includes sociological and gender-disability theory frames and has several years in community-based research. Her research track record was established in communities where she spent several years on projects related to public policy development. Katrina is a qualitative researcher and she uses critical theory frameworks to study social determinants of health including disability, homelessness, gender, culture, domestic violence and mental health. Part of her critically driven research revolves around her interest in political and economic ideology and their impact on public systems and service delivery. Katrina currently serves as an Executive Steering Committee member for the Canadian Observatory on Homelessness.

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