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Care organisations role as intermediaries between the authorities and the marginalised in crisis management

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ABSTRACT

Social service providers work to alleviate social disadvantages, which may particularly loom during crises. These organisations have a close understanding of the needs of their clients. However, this knowledge is rarely taken into account in tailoring crisis measures, which may lead to increased vulnerability and create additional suffering. In this paper, we take a novel look at the role of care organisations as intermediaries between their clients and the authorities in representing the needs and capabilities of vulnerable people and explore the factors hindering or facilitating this representation. We focused on care organisations in Europe and collected data from 32 interviews, followed by 5 workshops and an international colloquium with 6 language-based discussion groups with participants from organisations offering care services to socially marginalised individuals. The results demonstrate the role these organisations had in advocating their clients' needs to the authorities to adapt the crisis measures accordingly ("bottom-up approach"), and communicating official information about the risks and government rules to their clients ("top-down approach"). We found effective mediation to stem from long-term, trusting client relationship to be able to reflect on clients' needs, while the lack of collaboration protocol and tradition can be seen as the main barrier to inclusive crisis management. Networking with social care services to bring their expertise into crisis management systems is essential to promote the resilience of the diverse society.

1. Introduction

Global policy frameworks explicitly recognise the need to include marginalised groups in crisis policies [1]; Paris Agreement, 2016; United Nations, 2015). The poor inclusion of the needs of these individuals in vulnerable life situation in disaster risk reduction initiatives is evident from the disproportionate harm they bear [2–6] due to individual factors and/or when (public) support struc-

tures fail in general or in considering their various needs [7]. Existing studies highlight significant shortcomings in the practical implementation of principles of accessibility and continuous exclusion of vulnerable individuals from disaster risk reduction (J.-H [3,4,8–10]. In particular, communication between crisis management authorities, (local) governments and marginalised groups has been described as lacking, which in turn, undermines adequate crisis response and reduces trust in crisis governance [11–13]. Specifically, deficiencies in disseminating guidelines (e.g. evacuation orders) and general crisis information (e.g. infectiousness of the virus) from crisis leaders to the marginalised often have unwanted effects like misperception of risks and inappropriate protective behaviours. Insufficient awareness about the needs and capabilities of the diverse society (e.g. not considering visual impairments) by the decision-makers exacerbates previously existing vulnerabilities and creates new disadvantages [11,13].

Based on the above, it is important to understand what hinders and what facilitates the translation of official crisis messages to vulnerable people and what are the obstacles to authorities' understanding of the needs and capabilities of marginalised groups in coping with crises. This study aims to clarify the role of care organisations as intermediaries between individuals in vulnerable situations and authorities in crisis management during the COVID-19 pandemic. Using the umbrella term 'care organisations', we integrate a wide range of institutions, as they all provide services and support to people in vulnerable situations. Included here are associations of individuals with impairments, soup kitchens, day centres, night shelters and long-term accommodations like rehabilitation centres, organisations working with people experiencing homelessness, immigrants or victims of violence, and care homes.

We defined two key aspects related to care organisations' role as an intermediary. First, care organisations represent the needs of their clients in communication with the authorities, facilitating "bottom-up" communication. Second, care organisations mediate official guidance and assistance to their clients, facilitating "top-down" communication. Focusing on the functioning and interactions of the state and social care system supporting marginalised individuals in disaster risk reduction, our four key research questions are.

1) To what extent were the needs and capabilities of vulnerable people taken into account by the authorities during the COVID-19 pandemic?
2) What was the impact of the level of consideration for the coping of vulnerable people?
3) What were the mediating activities undertaken by care organisations?
4) What factors impeded and facilitated care organisations' mediation of a) needs of their clients to public authorities and b) crisis information to clients.

We employed rounds of interviews, workshops and a colloquium with representatives of care organisations in Belgium, Czech Republic, Estonia, Finland, Germany, Hungary, Italy, Lithuania, Norway, Portugal, the United Kingdom and the Netherlands to explore care organisations' experiences during the COVID-19 pandemic. The paper follows the structure where we first scope the existing research on how crisis information is mediated to and from marginalised groups and what are the factors influencing this mediation. Thereafter we explain the methodological approach and discuss the findings on what hinders and what facilitates mediating crisis information to vulnerable people and representing their needs to the authorities. We hope to contribute to the discussion on the inclusion of the needs of the most vulnerable in disaster risk reduction and the role of care organisations as intermediaries promoting this inclusion.

2. Theoretical framework

2.1. Current level of inclusion of marginalised groups in crisis management

Disaster studies have indicated particularly severe consequences of disasters for those already burdened by some form of vulnerability, and the cumulative nature of these disadvantages [2–6]. The worldwide COVID-19 pandemic added significantly to this research and directed the spotlight both to vulnerable people and care organisations supporting them through this long-term crisis [11,14,15]. This has raised the issue of exclusion of marginalised groups and their needs in the policy decisions around disaster risk reduction [16–18].

The Third UN World Conference on Disaster Risk Reduction 2015, held in Sendai, Japan, acknowledged that among the range of factors causing the disproportionate impact of disasters on certain groups (including but not limited to the poor, children and youth, persons with disabilities, older persons and ethnic minorities) are their exclusion from decision-making processes and their limited access to information [19]. The Sendai Framework for Disaster Risk Reduction made remarkable progress towards recognising the needs of the diverse society and incorporated explicit recommendations for implementing concepts of inclusion and accessibility, and firmly established these vulnerable people and their advocacy organisations as legitimate stakeholders and actors in international disaster risk reduction policies [10]; United Nations, 2015).

Despite the foundation laid by the Sendai Framework, studies show that in practice, marginalised and vulnerable people are not sufficiently included into crisis management processes and their needs and views are not heard [3,5,20]. Evidence on the lack of communication between different parties of disaster management, including representatives of vulnerable people, the authorities, the crisis managers, local governments and NGOs is compelling (e.g. Refs. [11,21,22].

The role of social work in disaster management has historically been seen as engagement in the response and recovery activities, focusing on psychological interventions and knowledge and skills of social workers post-disaster [23–25]. More recently, emphasis on the planning and preparedness phase of crisis management has been pointed out to improve the inclusion of vulnerable and marginalised groups [18,26,27]. The COVID-19 pandemic has highlighted the importance of social work even further and brought about recommendations to expand its role to provide more awareness about how to communicate with vulnerable populations during disasters [16]. For example, although generally pre-existing policies and channels facilitate better outcomes [28,29], in response to the pandemic, efficient new partnerships were created to support marginalised groups (H. S. [30]; Orru, Nero et al., 2021).

2.2. Consequences of lacking focus on vulnerable people in disasters

Poor inclusion may lead, on the one hand, to lack of awareness about and consideration of the marginalised individuals' needs, which has been identified as the inhibitor of adequate response to disasters and the cause of additional suffering due to the stigma, exclusion and lack of planning [5,13,21]. This was often the case during COVID-19 pandemic, when marginalised groups became even more invisible, suffered from being stigmatised as spreaders of the virus and in some countries were even fined for being homeless. Furthermore, organisations providing care for vulnerable people (e.g. soup kitchens, day centres and night shelters) were forgotten in their effort to manage with increasing numbers of clients. Closing down the facilities left many clients without access to warm room, moving activities online left those with limited digital skills and devices cut off their usual support (Orru, Nero, et al., 2021)

Marginalised have different crisis experiences due to varied expectations on the care provision, the level of care provision and stringency of the COVID-19 restrictions (Orru et al., in this issue) Material impacts were particularly harsh on those working in black market, with temporary contracts, but milder on those receiving state pensions or other regular support [31]. While material impacts of the pandemic were similar for men and women, socially marginalised women experienced more severe mental impacts of the COVID-19 pandemic than men, including reporting significantly more PTSD-symptoms [32]. Migrants and asylum seekers, individuals with mental health challenges and those living at home were also more psychologically affected. Those having lower levels of social capital and living on the streets engaged less in self-imposed isolation [33].

On the other hand, poor inclusion may lead to official information being tailored in a way that disregards the specific communication needs of the vulnerable people. Inhibited access to information, poorly presented information and vulnerability to information disorder has been highlighted as some of the triggers of vulnerability to crises [34,35]. Deficiencies stem from creating communication without considering people burdened by visual or hearing disabilities, lack of (local) language skills or illiteracy, cognitive or mental challenges, insufficient digital skills or means, cultural barriers etc. Thus this vital information might be misunderstood, misinterpreted or not received at all [4,10,12,21]. Even worse, challenges with receiving and/or understanding the provided instructions evoke new and exacerbate existing vulnerabilities, for example causing panic and inability to implement protective behaviours or evacuate [11–13]. This was evident also during the COVID-19 pandemic, when marginalised groups presented high levels of scepticism in regard to getting infected or suffering serious consequences of the virus (Nero et al., forthcoming). Given the increased risk of getting infected or hospitalised and higher mortality rates that individuals with socioeconomic disadvantages actually faced [21,21,52,52] and critical role of risk perception in adopting measures to contain the spread of the COVID-19 virus [36,37], failure to reach vulnerable people with the right information hampers their situation.

2.3. Mediation of crisis communication with vulnerable people

Effective crisis communication has been identified as the key challenge in risk governance, determining its success. It requires various actors from different backgrounds to interact meaningfully in the face of uncertainty, complexity and ambiguity [38]. To achieve this, intermediaries may be necessary to serve as a "link between two or more cultures and social systems" [39]. Mediating implies to purposefully intervene into the act of communication [40] and embraces a wide range of actions (linguistic, cultural translation) and roles with the goal of helping people from different backgrounds to access information, communicate and gain mutual understanding [41].

Top-down crisis information is directed towards vulnerable people by (local) governments and crisis management institutions that provide instructions and regulations on how to respond to a disaster situation. In order to benefit from this guidance, people with vulnerabilities (e.g. with disabilities, inadequate infrastructure or support, lack of resources) need to access the information (e.g. be able to read) and understand it [34]. On the other hand, authorities leading the rescue activities and shaping crisis policies require knowledge to make well-informed decisions. Bottom up communication is essential to foster this awareness as people in marginalised situations and their representatives or care organisations are the best experts on needs and also the capabilities of the diverse spectrum of community members [4,6,19,27].

So far, (inter)national and local authorities and crisis response institutions (the so-called golden trio of rescue, police and medical care) have been recognised as the main stakeholders in crisis management. It has been argued that alongside with health care systems, social services could significantly contribute to disaster risk reduction and contingency planning [16,23,42]. Social workers and care organisations present a sense of mission and deep motivation to support their clients [15,43,44]. Their understanding of human behaviour, social systems and available recourses provide a basis to advocate the needs of those vulnerable and marginalised to different levels of disaster governors to ensure their social protection [16,17,26].

Existing research has highlighted the contribution of social workers to communicating the official crisis information to their clients [16,17]. This mediating role has been described not merely as disseminating, but as educating, fighting misconceptions about the situation and making sense of it, thus promoting appropriate behaviours in disasters [4,16,45]. During the COVID-19 pandemic, with long-term and devastating effects on people who were already vulnerable, the care organisations and social workers rose to the occasion to adapt and keep on providing support and distribute reliable information to those most fragile [14,16,17,44,45].

2.4. Factors facilitating or hindering mediation of the crisis communication and needs of the vulnerable

2.4.1. Factors hindering mediation

People with disabilities and other marginalised groups are often treated as 'inherently vulnerable' and rarely experience invitations to contribute on an equal footing [26]. In a similar vein, organisations acting on their behalf are not regarded as equal parties in disaster management [22]. This is rooted in the prevailing notion of marginalised as pre-determined groups. Recent theoretical understanding of the nature of vulnerability reflects its dynamism, suggesting that everyone can become vulnerable as a result of inter-

dependent and intersectional factors stemming from human agency, technological functionality, individual coping capacity or societal support structures [46,47]. Ongoing representation of marginalised social groups as 'vulnerable groups' limits the abilities and potential of their own and their representative organisations in disaster risk planning and programs [48]. Concomitantly, there is a general lack of recognition of social workers' role in coping with disasters [25,49,50].

Hand in hand with the outdated understanding of intrinsic and static characteristics of 'vulnerable groups' goes the assumption of the homogeneity of these communities. In fact, individuals discussed in the context of vulnerability or marginalisation in crisis research involve homeless people, women, children, elderly, indigenous people, LGBTQIA+, people with physical and mental disabilities, ethnic minorities, migrants, people with sensory, intellectual or cognitive needs, pregnant women, people with temporary health conditions, low literacy, limited language skills, few resources, food insecurity, those from religious, racial and ethnically diverse backgrounds, owners of animals etc. Paternalistic views about supposed vulnerability and incapacity of certain groups, viewing them as liability, 'objects of charity' or 'special' prevents their inclusion into disaster management [5,26,51].

Factors facilitating mediation. Successful translation of vital crisis information benefits from the support of the appropriate mediators. Qualities and values possessed by social workers to reach the vulnerable people are their awareness of social context, human behaviour, and available sources [16] and trust built by long-term relationship with their clients [15,24,50]. For example, during the COVID-19 pandemic, living in the care organisations' facilities with daily support from social workers protected marginalised groups from underestimating virus-related risks, whereas low trust in authorities' information was related to COVID-19 scepticism (Nero et al., forthcoming).

Care organisations need funding, raising their crisis-related competence and self-confidence of their staff, and external support form crisis management to be empowered for increasing awareness and influencing policies through advocacy on an institutional level and enhancing their communities' preparedness for crisis [27].

The education and training of social services in the disaster management have been highlighted as a foundation for representation of needs and mediating crisis communication [23,42], such as including social services in emergency management exercises [42]. But among other activities, this requires integrating crisis-related competencies into social work education [52,53]. [25] call for formal recognition of the term "disaster social work" (as is, for example gerontological social work) and proposes a relevant competence framework [25].

3. Methods

We used qualitative case study design [54] to investigate the extent to which the needs and capabilities of marginalised groups were taken into account during COVID-19 pandemic and what impact this had on their coping. Going further in depth, we explored the mediating activities that care organisations took on to address deficiencies in considering their clients' situation and elicited the factors impeding or facilitating this mediation.

The data was collected in three consecutive clusters: personal interviews, country-based workshops, and finally, international colloquium mixing joint and language-based discussions that generally followed the first, second and third wave of the COVID-19 pandemic in Europe (Table 1). We involved care organisations providing support to individuals with coping difficulties, people experiencing homelessness, migrants, victims of violence, the elderly, people with drug or alcohol addiction and individuals with impairments. These include charity-based, volunteer- and municipality-financed, and private organisations. Broad spectrum of services these organisations offer include food and clothing aid, day centres (counselling, hygiene facilities etc.), short-term accommodation in night-shelters and refuges (clients can't stay during the day), 24/7 long-term accommodation (rehabilitation for addiction, resocialisation). Main activities of the associations of individuals with impairments include counselling and information for their members and advocacy work like interacting with public authorities, cooperation with other associations. The associations of individuals with impairments may not traditionally fall under the classification of 'care organisation', used as an umbrella term here, but are referred as such for the ease of reading. When something is specific to only one type of organisation or relevant to certain individuals, they are pointed out in the text.

Table 1
Data collection and participants.

	Period of research	Data collection method	Types of organisations represented by the staff or managers.	Number of participants	Countries covered
1	May–July 2020 plus additional interviews in Portugal April 2021	Semi-structured expert interviews	Soup kitchens, night shelters, day centres, residential facilities for addiction rehabilitation, resocialisation centres, day centres for homeless, migrant, people with coping difficulties	32	Czech Republic, Estonia, Finland, Germany, Hungary, Italy, Lithuania The Netherlands, Norway, Portugal
2	June–September 2021	5 national online workshops	Soup kitchens, addiction rehabilitation, day centre, night shelter, resocialisation centres, centre for migrants	52	Belgium, Hungary, Estonia, Norway
3	January 2022	International online colloquium with 6 language-based break-out rooms	Soup kitchens, charity organisations, migrants centres, associations of individuals with impairments, care home, home care provider, services for the elderly, psychological first aid centre, support for victims of violence, social first emergency aid 24 h	42	Language-based groups in English, Estonian, Finnish, German, Italian, Norwegian

Proceeding of the research and main themes of questions and discussions are presented in Table 2. The preliminary analysis of the data was conducted in each stage of the research and introduced to participants of the next stage, enabling to develop questions on the basis of emerged themes, facilitate the discussions and collect participants' reflections. Additionally, participants were presented with the preliminary results of the parallel study conducted by the research team. A total of 313 clients of care organisations in Europe were surveyed to broadly open up the pandemic experience of marginalised groups. Initial analyses of the survey allowed for its results to be embedded in discussions with care organisations to get their feedback and explore in depth pandemic experience of the marginalised groups [33]; Nero et al., forthcoming; Siimsen et al., Orru et al., Olson et al., in this issue).

We used purposive sampling strategy, expanding the circle of participants based on the information gathered in the previous stages to ensure the representation of the diverse individuals in marginalised and/or vulnerable situation. Participants signed the written consent and the study design was approved by the ethics committees of the involved research institutions. The ethical consideration on doing research on the disaster experiences of the marginalised is reflected in Schobert et al. in this issue.

After the final colloquium, the data collected during the 1.5-year period was analysed. A qualitative content analysis [55] was carried out sequentially between the stages as described above. Such an iterative data gathering and analysis process enabled to validate the findings of previous phases and assess the developments that took place during this long-term crisis. However, in using a combination of methods and such a wide spectrum of care organisations and the vulnerabilities their clients represent, there is a risk of some superficiality and generalisation.

4. Results

4.1. Inclusion of care organisations into crisis management during the COVID-19 pandemic

Results of our study (Fig. 1) reveal that organisations supporting or representing marginalised groups were not involved in tailoring crisis measures and in many cases they initiated contact with the authorities and (local) governments to draw attention to their clients. Despite this active advocacy work, inclusion of these organisations into COVID-19 response work groups was rare (Finland, Hungary), their involvement varied across countries and level of governance. Constant exclusion from crisis decision-making was criticised by most of the participants of the colloquium. Several countries' discussion groups expressed that the consideration of their clients' needs is better (or efforts are made to improve it) in local and municipal level as opposed to regional and state authorities (Italy, Finland, Norway, Germany, Estonia). However, even when general collaboration between care organisation and local authorities was good during the pandemic, they were still not involved at the planning and decision-making processes related to crisis management. For example, interviewee from Italy said: "I have sent countless letters to the region, to the address of the region's health department, but we have not even been invited to a meeting."

Accordingly, the lack of understanding of needs and capabilities of vulnerable people by authorities was described by all discussion-groups of colloquium. Estonian group of participants pointed out their concern that there is not enough knowledge among crisis decision makers of who are vulnerable in crisis and what their needs are, and this seems not to be a priority. As for the mechanisms of representing the needs of the vulnerable on official grounds, the participants argued that, while there is an impression of plethora of institutions involved in crisis management, the feeling is still that every individual is responsible for themselves. "It felt like the city

Table 2
Proceeding of the research and analyses.

|	Stage	Discussion themes	Process	Outcome
1	1st stage Personal interviews (approx. 60 min each)	- impact of the pandemic on the organisations - impact of the pandemic on their clients - what hindered and what helped coping - who became most vulnerable - who coped well - lessons learned	Interviews and their analyses were conducted by native speakers from the research team	Country reports
2	2nd stage National workshops (90 min online events)	- what hindered and what helped when giving aid to clients - differences with the first wave experience - support from the public authorities - identifying and reaching the most vulnerable - tackling misinformation - advocatory role, collaboration with authorities and other partners.	1. Presentation of the results of the first stage and the survey among the clients of care organisations conducted by the research team 2. Reflections on the presentation 3. Discussion on the topics of the workshop, developed based on the country reports	Workshop reports
3	3rd stage International colloquium	- experiences of the pandemic (biggest challenges, sources of help, interaction with national and local authorities, differences between the phases of the pandemic) - previous experiences and current situation with considering the needs and capabilities of marginalised groups and individuals with impairments - vision of the "ideal world" (how can vulnerable people's voices be heard and considered better, how should care organisations be involved in crisis management)	1. Presentation of the results of previous stages of the study and the survey among the clients of care organisations conducted by the research team 2. Language-based discussions in break-out rooms 3. Joint discussion and wrap-up. Discussions were led by the moderator and equipped with the note-taker	Colloquium break-out rooms' and joint discussions' reports
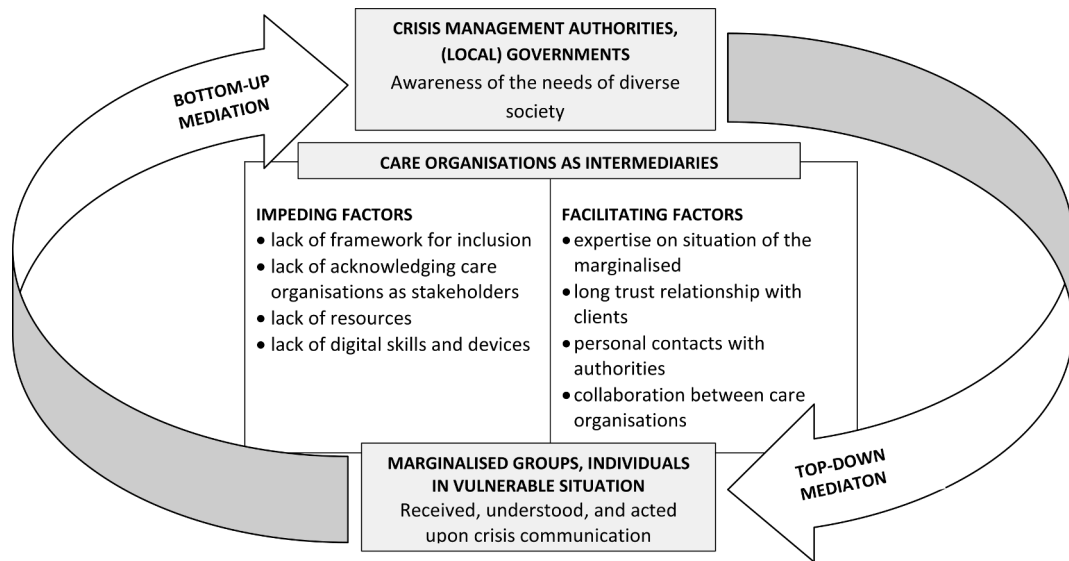
Fig. 1. Care organisations as intermediaries, facilitating and impeding factors.

had forgotten us", a Finnish social worker illustrated the inconspicuousness of care organisations and their clients in the crisis (Helsinki, June 09, 2020).

4.2. Coping of marginalised groups during the pandemic and the impact of low level of considering their needs and capabilities

Interviewees, participants of workshops and colloquium reported serious consequences that lack of awareness of their clients' situation and of the peculiarities of these organisations had on the pandemic experience of vulnerable people. Most striking example of not considering the marginalised groups was criminalisation of homelessness and fining people who couldn't "stay at home" in some countries (Czech Republic, Hungary). Interviewees from the care organisations described that their clients had become even more invisible during the pandemic, when authorities' capacities were overloaded with the general population: "We had to fight to show that our clients exist, that there is many of them" (Interview in Tallinn, June 30, 2020). Workshop in Norway revealed the inequality in how certain population groups are treated due to having different ID numbers: 'There are parallel communities living in society'. For example, temporary ID number deprived migrants from access to the same services as others during the crisis. Deportations happened continuously, and homeless and migrant communities were targeted since they were viewed as spreaders of the virus.

People experiencing homelessness or socio-economic disadvantages were hit hard by the social isolation regulations when many care organisations were obliged to close down their facilities. Implementation of these restrictions cut off the services that they usually relied on. One interviewee described their clients' difficulties to understand why they cannot access day centres and soup kitchens as 'shock, feelings of confusion and in some cases anger as they felt rejected by the society' (Interview in Tallinn, Estonia, May 29, 2020). Restrictions made warm rooms of day centres inaccessible, blocking use of showers and toilets, possibility to cook or make tea, wash clothes or watch TV and read newspapers for those living in deprived conditions. Not less important is the social venue these establishments usually provide – interaction with other clients and staff, counselling and often several supportive social services.

These consequences of crisis measures on care organisations and thus on individuals in vulnerable situations were generally not addressed by the authorities but by the care organisations initiative. Day centres (incl. Those for migrants and addicts) made effort to reach their clients outside of the premises, contacting them by phone, going out on the streets to find those in need and offering digital services. Finding creative solutions to keep up the services while following the government restrictions was vital for the coping of vulnerable people.

More cases of poor representation and understanding of the needs of the most vulnerable among DRR officials were brought up by the umbrella organisation for people with impairments, who highlighted accessibility of information and services (incl. Mandatory procedures) to them as a serious problem. For example, they have difficulties to book vaccination appointments or to get the results of COVID-19 tests, and no service of testing at home is provided. From the positive side they stated that national broadcast reacted quickly and equipped official press conferences and pandemic news with translation into sign language (Estonia).

Governments' not providing accessible information was a general shortcoming stemming from insufficient awareness of the diverse needs of society. The officially distributed guidelines from the government were often not translated to other languages (Norway, Estonia, Germany, English-speaking group); illiteracy and need for plain language was not considered (Norway) and there was a lack of materials in Braille (Estonia). As described in the colloquium: "The government had the assumption that everyone will just watch the news" (English-speaking group). With chaotic and large amount of information, it was difficult for vulnerable people to identify what was relevant to them (English-speaking group). Communication barriers and lack of digital skills and means increased loneliness of vulnerable people and amplified fear and anxiety especially among individuals with mental health problems. As many

clients have no social networks and rely only on the interaction with their representing care organisation, not being able to communicate with them due to closed facilities or inability to use digital means left them without support.

Representatives of care organisations unanimously pointed out confusing guidelines received from the authorities, which did not take into account the specifics. Uncertainty and changing rules challenged their operation, especially in the first wave of the pandemic. In some cases, the authorities not involving social workers' expertise led to misinformed decisions regarding marginalised groups. For example, Lithuanian food bank expressed regret that they were not consulted when the Lithuanian government distributed vouchers of supermarket to people in vulnerable situation. They considered this measure a waste of money which could have been more effectively used by the care organisation. In the words of an interviewee: "if government would communicate more with NGOs, we could share our expertise in the fields and, working together, we could be more efficient. For example, we know well that with 1 euro from a voucher you can buy a few products in the supermarket, but, as a food bank, for 1 euro we can save 7.5 kg of food that can be then distributed to those in need" (Interview in Lithuania, July 08, 2020).

4.3. Care organisations acting as intermediaries in crisis communication

Communicating the needs of vulnerable people. Advocacy work of care organisations and associations of people with disabilities to raise the government authorities' awareness of their clients' needs and capabilities was repeatedly pointed out by participants of all stages of our study. As a result, some success was made, for example in producing accessible instructions of hand hygiene or improving accessibility of official crisis websites for individuals with visual impairments (Estonia). In many cases, care organisations succeeded in applying for additional living facilities for the homeless or for more material support from governments and when raising donations from the public (Lithuania, Portugal, Hungary, Czech Republic, Norway, The Netherlands).

In some cases, awareness campaigns were launched to facilitate understanding of vulnerabilities and marginalised groups among general public, publishing articles in newspapers and giving interviews in the media. For example, a care organisation carried out a communication campaign "I would like to stay at home" throughout Italy, which yielded the support of civil society.

The long duration of the pandemic gave time for development, for communication to take place between different parties and collaboration to enhance, processes to be optimised and worked in. The general assessment was that the situation has improved. Part of the issues with accessibility of information was solved, for example providing information leaflets in several languages. Care organisations hope for a continuous improvement of considering the needs of vulnerable people and including their representatives into decision-making processes. However, intensification of collaboration with (local) authorities was not the case in all countries.

Communicating crisis information to the marginalised. Care organisations in all of the studied countries took on the role of mediating the crisis information to vulnerable people when they witnessed it not reaching from authorities to people in vulnerable situation. They made remarkable efforts to mediate the government guidelines and other relevant crisis information to their clients and promote their health protective behaviour. For example, care organisations printed out regulations and rules from the official websites, translated them if necessary, posted on the doors and walls, and distributed leaflets directly in the hands of their clients. For organisations supporting migrants and asylum seekers, translating guidelines from the country's official languages was especially extensive and resource-demanding. Estonian discussion group described that care homes and providers of home care for elderly or disabled people disseminated relevant information to them; leaders of associations of individuals with impairments assisted their members with developing new digital skills.

Intermediary role of care organisations is particularly important for reaching marginalised groups in the most fragile condition with crisis information. Life experience of vulnerable people has often closed them to lead an isolated life from the outside world. Pandemic can feel like just another challenge to them (English-speaking group). Addiction to drugs or alcohol impedes understanding of the seriousness of the crisis and implementation of protective behaviours. This can also apply to individuals with mental health problems, whereas in some cases the pandemic information causes them to feel anxiety and panic. In several cases, being disinterested or reluctant to receive guidance was described related to the above (Estonia, Finland, Lithuania). One of the interviewees referred to process of communicating with their clients that they – "explained, explained and explained again" (Interview in Tallinn, June 30, 2020), trying to make these guidelines and the overall situation understandable to their clients and to refute false information that otherwise inhibits implementation measures protecting them from the virus.

4.4. Factors influencing mediation

On the side of care organisations, lack of resources challenged their ability to act as mediators between their clients and the authorities. The staffs of care organisations were over-burdened and funding was often insufficient. While demand for their services increased or even multiplied, the personnel were also affected by the virus, implementation of new services and novel tasks (e.g. digital communication). Activities to mediate government information to marginalised groups added significantly to this workload. Similarly, overwhelming set of tasks that crisis management authorities and (local) governments faced during the pandemic and lack of (human) resources affected their ability to reach out to vulnerable people and to develop awareness of their needs. In some cases, it was difficult for the organisations to communicate rules because they didn't understand themselves why they were put in place. Incoherent understanding and acceptance of the rules among the staff added to the challenges of communication – wearing masks and, especially vaccination was a subject of different opinions in some care organisations. Managers of these organisations described that their workload had increased by the need to create and enforce appropriate regulations (e.g. mandatory vaccination for the care organisations' personnel) (Estonia).

On the side of authorities, there seemed to be a lack of framework or official coordination mechanism to facilitate the inclusion of the vulnerable people's needs in crisis planning and training, as was repeatedly expressed by the participants of our study (Estonia, Finland, Germany). For example: "there is no guideline, no plan … Often we manage to create projects because we work through a

network, on contacts on building relationships with institutional figures, but there is no common and homogeneous standard practice throughout the country' (Italy). Generally, it is the care organisations that approach the (local) governments to draw their attention on their clients' situation and the impact of crisis measures to them and rarely vice versa (e.g. in Hungary). This improved during the pandemic and several cases were described where authorities kept up the established collaborations for consultations (Estonia, Hungary, Portugal, Czech Republic).

In some countries, including care organisations into crisis planning is required by law. However, according to the Italian discussion group, in practice, this rarely happens. They see lack of tradition to collaborate as a reason for this and feel that there is not enough will to involve their organisations (Italy). In the Estonian discussion-group, care organisations expressed their feeling that their involvement into round-tables and discussions with authorities have sometimes been formal, done to "tick a box".

The importance of personal contacts and networks with authorities was stressed as a factor facilitating the communication of the needs of the care receivers. These lines of communication were often based on pre-pandemic relationships, but additionally many new connections were built that participants hoped to become long-lasting. Getting to know responsible officials helps to bring the shortcomings to the attention of those in charge. In some cases, non-profit organisations gave mutual support and guidance to eachother and collaborated their actions, their cooperation made their voices easier to hear by the authorities (Italy, Estonia, Finland). Future collaboration in the pre-crisis phase, coming together around one table and in trainings was emphasised by all participant countries to raise mutual awareness and establish strong networks that can be activated in crisis. To fulfil the valuable task of conveying vulnerable people's messages to the authorities, care organisations are best equipped, because they 'speak' the language of the authorities (Finnish discussion group).

Other fundamental facilitating factor of mediation was defined as the work culture of care organisations and their long-term experience with people in the vulnerable situation. These organisations have built trustful relationship to approach marginalised groups that can be used to reach them with correct crisis information and promoting health protective behaviours. For example, interviewees described the willingness of their clients to accept the pandemic measures due to trusting that care organisations' decisions are made for their benefit. Care organisations' expertise on the life situation of their clients is important in understanding vulnerable people's needs and capabilities. Particularly if individuals have difficulty articulating or expressing them.

Receiving information from care organisations or government officials was often impeded by limited access to other media like TV, radio or newspapers and lack of digital devices and skills Without the devices or ability to use them, marginalised groups were cut off from outside world when the day centres were closed or home visits stopped and many services and information moved to the web. While lots of attention was paid in the media to providing computers for distance schooling, people with disabilities facing the same problem were forgotten. Finnish care organisations described another barrier of communication when they couldn't reach elderly people living at home as they were kept in isolation by their families, so-called 'kidnapped' and denied access to the information the lockdown restriction were lifted. Similar obstacles were pointed out by English-speaking group in regard to reaching victims of domestic violence.

	FACILITATING FACTORS
IMPEDING FACTORS	●expertise on situation of the marginalised
●lack of framework for inclusion	●long trust relationship with clients
●lack of acknowledging care organisations as stakeholders	●personal contacts with authorities
●lack of resources	●collaboration between care organisations
●lack of digital skills and devices	
MARGINALISED GROUPS, INDIVIDUALS IN VULNERABLE SITUATION	
Received, understood, and acted upon crisis communication	

5. Discussion

5.1. Insufficient consideration of the needs and capabilities of vulnerable people by the authorities during the COVID-19 pandemic

Recent disaster research highlights the need to understand what makes individuals vulnerable in crises and how to address these vulnerabilities, to mitigate negative impacts and support coping. Based on a social vulnerability analysis framework, both individual factors (e.g. health, beliefs, skills) and societal/structural factors (e.g. lack of support networks, poor access of functionality of social care) interplay during disasters, mutually amplifying or compensating their impact and interplaying with situation-specific dynamics of the vulnerability [7,47]. Care organisations need to be supported during crises to ensure necessary services to the marginalised, which can downplay individual factors of vulnerability.

Our study on the inclusion of the marginalised groups in disaster risk reduction showed that vulnerable people were not sufficiently taken into account when tailoring pandemic response. This refers to continuous exclusion from decision-making and limited access to information revealed in existing studies [20–22]. Although global disaster risk reduction policies call for involving marginalised groups and their representative organisations as stakeholders [56,57] and increasing academic recognition of the role social services should play in crisis management and contingency planning [16,23,42], care organisations had to take the initiative to make their clients' voices heard by the authorities. Collaboration improved as the pandemic progressed and many problems were solved, yet participation in decision making remained unavailable for representatives of the marginalised.

5.2. Negative impacts of lacking consideration of vulnerable people on their coping

COVID-19 challenged the care organisations with a surge in demand for their help, stopping or limiting their services and closing down facilities (see Ref. [58] for a comprehensive overview), which led to increased negative impact of the pandemic on their clients.

Measures to mitigate spread of the virus that did not take into account situation or marginalised groups (e.g. closing down the premises of care organisations, restrictions on being in public places for the homeless) severely hampered coping of those already disadvantaged.

Crisis information was often inaccessible to individuals with impairments or mental health problems and migrant groups. Not knowing local language, illiteracy, lack of information in Braille, not having access to TV and official media (e.g. due to closing down day centres), not understanding complicated wording of guidelines were common barriers. Poor inclusion and communication have repeatedly been highlighted as a cause for inadequate disaster response and exacerbation of vulnerability [21,34]. Limited access to information has been generally acknowledged as cause for disproportionate impact of disasters to certain groups of population [19]. Our research revealed cases of additional sufferings to individuals with disabilities, who became lonelier due to communication barriers. Measures to mitigate the spread of the virus strongly affected vulnerable people's access to support and information services when services were rearranged, digitalised or closed altogether. Marginalised groups without the digital skills or devices were cut off not only from official information, but also often from care organisations' consultation and personnel, even further exacerbating isolation from the society for the homeless and other vulnerable people.

5.3. Social care organisations initiatives to acting as intermediaries

As unanimously highlighted by our interviewees, workshops and colloquium participants, mediating crisis communication to vulnerable people and advocating the needs of these individuals to the authorities became one of the most important and time-consuming tasks of these organisations during the pandemic. Care organisations took the initiative to support vulnerable people and started to provide them guidance necessary for coping with the pandemic, and to advocate their needs to the authorities. This behaviour confirmed the integral role of social workers in distributing official information to those who might otherwise be unaware of safety measures and mitigating fear and rumours that has been pointed out in other COVID-19 studies [16,17]; Nero et al., forthcoming).

Bottom-up mediation. 'Focusing on raising awareness for their clients' situation, care organisations' own initiative was a key factor: "we had to take the first step" (Estonia). Communities that had experienced disasters before had stronger pre-developed lines of cooperation. In many cases, new relationships were developed during the pandemic as indicated also by Ref. [30]; and existing collaboration grew stronger and more personal between the organisations themselves and with the authorities.

Disability-friendly crisis websites, guidelines in Braille, accessibility of testing and vaccination were some of the main topics of concern to people with disabilities. Their representative organisations collaborated with relevant authorities to draw their attention to these needs and gave consultations for developing appropriate solutions. This value of the expertise of care organisations for individuals with impairments in disaster risk reduction has been emphasised in previous research [26,51].

Bottom-up communication has been highlighted as essential to raise authorities' awareness as marginalised groups and their representatives are the best experts of their needs and capabilities [4,6,27]. The pandemic has highlighted the advocacy role of these institutions [17,58]. However, our analysis shows that care organisations were rarely included into COVID-19 work groups and policy making.

Top-down mediation. Exploration of how care organisations mediated COVID-19 information and official guidelines to their clients and members highlighted that much of these organisations' work eventually involved disseminating and making sense of crisis communication. They took on this novel, time-consuming and challenging task when it became apparent that their clients were not receiving or understanding information about government guidelines and the pandemic situation.

Official information concerning the pandemic did often not reach marginalised groups and misinformation was widely spread. This is in line with studies indicating that poor communication might be misunderstood, misinterpreted or not received at all [4,10,12,21] and increase vulnerability to information disorder [34]. To address this problem, effort was required to explain the guidelines, support clients to follow them and correct misconceptions. Making the information accessible (language, simple wording) and understandable (meaning-making) for people from different cultural backgrounds and social systems and helping them communicate is the essence of mediation process [39,41].

The role of associations of individuals with impairments was somewhat smaller in top-down mediation as opposed to their importance in bottom-up contribution with their leaders more involved in consulting government authorities as described above. However, members of these associations supported each-other and helped to overcome challenges with accessibility, for example with using digital services.

5.4. Factors influencing the mediation of the crisis communication and needs of the vulnerable

The main inhibitors of considering vulnerable people in crisis response can be summed as the lack of legal or practical framework for including them in decision-making when preparing and responding to crisis. Individuals with impairments and marginalised groups as well as organisations acting on their behalf were not regarded as equal parties or invited to contribute in disaster management [22,26]. So far, there is no tradition of involving vulnerable people; care organisations and associations of individuals with impairments became active themselves and approached the authorities. Questions like "Who is responsible for crisis information to reach marginalised groups" posed by care organisations call for central coordination and governments' leadership in initiating collaboration. Research defining social workers and care organisations as integral stakeholders in crisis management is mounting [16,17,23,42]. However, our study brought out concerns of organisations who felt that their inclusion is sometimes primarily being done for "ticking a box". Experiences with round-table gathering without subsequent reflections or results have caused some scepticism about the perspective and motivation behind these events.

Funding and (human) resources are needed to enable vulnerability-participatory cooperation [21,27]. Fighting the further spread of the virus required additional finances. From the authorities' perspective, the need for human resources was more acute. Similarly, staff of care organisations faced a high workload with a surge in demand for their services, and the infection cutting their personnel and novel tasks introduced by the need to rearrange their services and act as intermediaries (see Ref. [58] for more detail).

To mediate information means to consciously and purposefully intervene into the act of communication [40]. During the COVID-19 pandemic, care organisations took the initiative to employ their knowledge and expertise with the aim to deliver crisis information to their clients, give meaning to it and promote their acting accordingly. Clients often showed feelings of gratitude towards people coming to support them in time of the pandemic and its risks, and this feeling of gratitude in turn encouraged receiving information about the government guidelines and acting upon them. Even more so, trusting care organisations promoted acceptance of crisis regulations and accepting information that they provide. This long trusting relationship with and qualities of social workers that make them valuable intermediaries to reach marginalised groups with crisis information and advocate their needs to the authorities have been highlighted in previous studies [7,15,24]. Living in the facilities of care organisation and having higher levels of linking social capital (i.e. trust in the authorities) are related to lower levels of COVID-19 scepticism (Nero et al., forthcoming).

5.5. Limitations of current study and prospects for future research

The focus of the study was to examine the care organisations role as intermediaries between public authorities and vulnerable people. The studied organisations represented and supported a wide range of marginalised groups and individuals with impairments in Europe. The focus of the study was not on the comparison between the countries or the types of organisations but on establishing the general factors hindering or facilitating mediation of crisis communication and needs of the care recipients. Future studies should be conducted to investigate the scope of the problem with more precision using a structured survey based on the factors revealed in this study. An even wider circle of organisations with insights into vulnerabilities emerging in disasters and individuals affected by these vulnerabilities should be addressed, to focus on questions such as what hinders and what facilitates coping in a crisis, who and why becomes the most vulnerable, and how to reach these people with crisis information.

5.6. Policy implications of the study

Increasing community resilience is grounded on considering all members of the diverse society and preventing falling through the safety nets of those in vulnerable situation. Based on the result of our study we propose to include care organisations in all levels (national, regional, local) and stages of crisis management. Public authorities need to take a lead and responsibility for initiating cooperation with care organisations. Collaboration needs to take place in all phases of crisis management – in preparing for, responding to and recovering from its impacts. Reaching vulnerable people with official crisis information needs to be prioritised to protect them from increased vulnerability caused by information disorder. Social services need to be considered as an equal stakeholder in disaster risk reduction and an essential addition to the golden trio of crisis management alongside with the rescue, police and health care services. Social work education will benefit from including disaster risk reduction competencies in its curriculum and involving care organisations in practical trainings.

6. Conclusions

The complex and dynamic nature of vulnerabilities, shaped by a combination of individual and structural factors that contribute to susceptibility to the negative effects of disasters, calls for a systematic assessment of the safety nets that can support people in crisis situations. Shortcomings in considering the needs and capabilities of vulnerable people in COVID-19 decision making and developing government measures to mitigate the pandemic led to increased vulnerabilities and additional suffering. Poor accessibility of services and information increased vulnerability to misinformation and misconceptions. The care organisations took on the task of mediating crisis communication and government guidelines to their clients. Their expertise on the situation of the marginalised and long-term trustful relationships with clients facilitated mediation of official regulations to them and mitigation of information disorder. Main challenge in raising the authorities' awareness about the needs of vulnerable people was lack of acknowledging care organisations as stakeholders in crisis management. To increase community resilience and avoid exacerbating consequences of crisis to those already vulnerable, care organisations' need to be involved in crisis management. Future research can elaborate on factors hindering and facilitating care organisations' intermediary role to foster better inclusion of marginalised groups to disaster risk reduction.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

The data that has been used is confidential.

Acknowledgements

Appendix

Table 1
List of country reports

Nr	Country	Date
1	Czech Republic	July 29, 2020
2	Estonia	July 29, 2020
3	Finland	June 25, 2020
4	Germany	July 29, 2020
5	Hungary	July 29, 2020
6	Italy	August 06, 2020
7	Lithuania	July 29, 2020
8	Norway	November 20, 2020
9	Portugal	May 28, 2021
10	The Netherlands	July 29, 2020

Table 2
List of interviews for country reports

Nr	Time	Place	Institution/Organisation
1	May 29, 2020	Prague, Czech Republic	The Salvation Army (TSA), national coordinator for social services
2	June 24, 2020	Prague, Czech Republic	TSA social services centre
3	May 29, 2020	Tallinn, Estonia	TSA alcohol rehabilitation centre
4	June 08, 2020	Tallinn, Estonia	TSA day centre for material and social support for homeless and materially insecure individuals
5	June 16, 2020	Tallinn, Estonia	Department of social welfare, one of Tallinn district governments
6	June 17, 2020	Tallinn, Estonia	Welfare Centre, night shelter and resocialisation unit
7	June 30, 2020	Tallinn, Estonia	Tallinn Social Work Centre, resocialisation accommodation
8	June 01, 2020	Helsinki, Finland	TSA social service center, social counselling
9	June 09, 2020	Helsinki, Finland	TSA night shelter for homeless
10	May 28, 2020	Tampere, Finland	TSA day centre for material and social support
11	June 08, 2020	Cologne, Germany	TSA Territorial Social Programme
12	June 19, 2020	Hamburg, Germany	TSA homeless centre
13	June 26, 2020	Hamburg, Germany	German Red Cross day centre
14	July 03, 2020	Hamburg, Germany	German Red Cross, strategy department
15	June 24, 2020	Budapest Hungary	TSA, temporary shelter, rehabilitation hostel, day centre
16	June 19, 2020	Budapest, Hungary	Hungarian Red Cross, Department of Disaster Management
17	June 25, 2020	Budapest, Hungary	The Budapest Methodological Centre of Social Policy and Its Institutions, homeless services
18	July 01, 2020	Budapest, Hungary	The Hungarian Charity Service of the Order of Malta, Central Hungary
19	July 16, 2020	Bolzano, Italy	Day care centre for material and social support
20	June 05, 2020	Rome, Italy	TSA homeless centre
21	16.072020	Rome, Italy	Day centre, reception attendance services
22	July 23, 2020	Rome, Italy	24-h reception and care centre
23	May 28, 2020	Klaipėda, Lithuania	TSA day centre for material and social support of homeless
24	June 30, 2020	Klaipėda, Lithuania	Association of Social Workers
25	July 08, 2020	Vilnius, Lithuania	Food bank, collects and distributes food aid
26	June 09, 2020	Oslo, Norway	TSA housing facility for homeless people with drug or alcohol addiction
27	June 11, 2020	Oslo, Norway	TSA day centre for active users of drugs or alcohol
28	June 12, 2020	Oslo, Norway	Substance abuse care provision
29	March 31, 2021	Colares, Portugal	TSA, residential centre for materially disadvantaged
30	April 14, 2021	Lisbon, Portugal	TSA, centre for Homeless People
31	April 14, 2021	Lisbon, Portugal	TSA, centre for Families and Needy People
32	July 13, 2020	Groningen, The Netherlands	TSA day centre for material and social support of homeless

Table A3
List of workshops

Nr	Place	Date	Facilities
1	Belgium	September 30, 2021	The Salvation Army
2	Tallinn, Estonia	June 15, 2021	Social Welfare Centre (homeless night shelter, day centre, long-term rehabilitation centre); re-socialisation centre with 10 establishments (long-term accommodation, women's and family refuge, homeless night shelter, long-term rehabilitation centre for people with mental health challenges and alcohol abusers) (12 participants)
3	Tartu, Estonia	August 25, 2021	Soup kitchen, homeless soup kitchen, rehabilitation centre (homeless night shelter, day centre, long-term shelter), church charity (food and clothing) (5 participants)

Table A3 (*continued*)

Nr	Place	Date	Facilities
4	Hungary	September 20, 2021	The Salvation Army, Hungarian Red Cross, Hungarian Civil Protection Association, care for homeless people, soup kitchens, maternity homes
5	Norway	June 29, 2021	TSA migration centre, TSA food distribution centre, TSA drug and alcohol rehabilitation centre (7 participants)

Table 4
List of the organisations participated in the language-based discussion groups

	Name of the organisation	Key care services provided
English-speaking group	The Salvation Army, Loisto Setlementti	Housing services, support for individuals with disabilities, support for victims of honor-related violence, support for homeless people.
Estonian group	Estonian Association of the Blind, private home care provider, private long-term elderly care provider, care home for the elderly, Estonian Association of Associations of Women with Disabilities, Tallinn and Harju County Disabled Women's Association	
Finnish group	Suvanto ry - National organisation which purpose is to prevent and provide information on elder violence, abuse and exploitation.	Personal conversational therapy and peer support groups for the elderly, training professionals on the forms of elder abuse.
Germany group	General Secretariat German Red Cross (GRC), Arbeiter-Samariter-Bund/Workers' Samaritan Foundation Germany (ASB)	Psychosocial care; nursing basic care; ambulant care Voluntary services for Senior citizens; open care and group services; day care; Rescue service for senior citizens.
Italian group	(1) PsyPlus Onlus ETS, (2) Social Emergency Roma Capitale (Social Operations Room), (3) Associazione Psicologi per i Popoli, (4) ESPRI' (Emergency Social Psychological Research Intervention).	(1) provides social solidarity interventions, (2) provides social emergency interventions 24 h, (3) provides professional psychologists first aid, (4) Provides psychological and psychosocial first aid.
Norwegian group	The Salvation army	Services for active substance users, accommodation for active substance users, services for immigrants, person who is responsible for contact with municipal authorities.

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