Caring Community: expanding integrated community care in partnership with people experiencing homelessness during the COVID-19 pandemic

Final project report

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Canada Research Chair in Patient and Public Partnership

Centre intégré universitaire de santé et de services sociaux du Centre-Sud-de-l'Île-de-Montréal

Québec

caring community

Taking care of one another

Foundation for Advancing Family Medicine

Fondation pour l'avancement de la médecine familiale

PROJECT REPORT

PROJECT TITLE

Caring Community: expanding integrated community care in partnership with people experiencing homelessness during the COVID-19 pandemic

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Project Webpage

Peer support in homelessness

Context

The COVID-19 pandemic disproportionately affects people experiencing homelessness, both in terms of health and psychosocial impacts [1]. The importance of building trust and collaborations with healthcare services and community resources are paramount to mitigate these consequences of the pandemic, especially in heavily affected urban areas across the country. Montreal was one of the early epicenters of the pandemic, including in the Center-South borough of Montreal one of the most socially disadvantaged neighborhoods of the city, with high rates of homelessness, drug use and social isolation.

Peer-support workers (people with significant lived experience of a social or health condition and demonstrated abilities to listen and care for others) **offer a unique perspective in supporting those experiencing homelessness**, through shared experiences, role modeling, linkages to health and community resources and social support [2]. Peer-support programs have been associated with improved sense of empowerment, quality of life, reduced substance use, and increased access and use of primary care services [2-5].

Internationally recognized as a model of integrated community care [6], **Caring Community** positions peer-support at the heart of community care, by helping people connect with clinical and community resources to achieve their own goals as citizens. In contrast to disease-specific peer-support programs, the Caring Community model adopts a community-wide perspective on health, bringing together peer-support workers, clinicians and community members with a range of experiences and expertise, making it particularly relevant for people facing complex issues such as homelessness [7]. Funded as part of the Foundation Co-RIG Phase 1 program, our team aimed to implement the Caring Community model to address the direct and indirect impact of the COVID-19 pandemic on people experiencing homelessness, our specific were as follows:

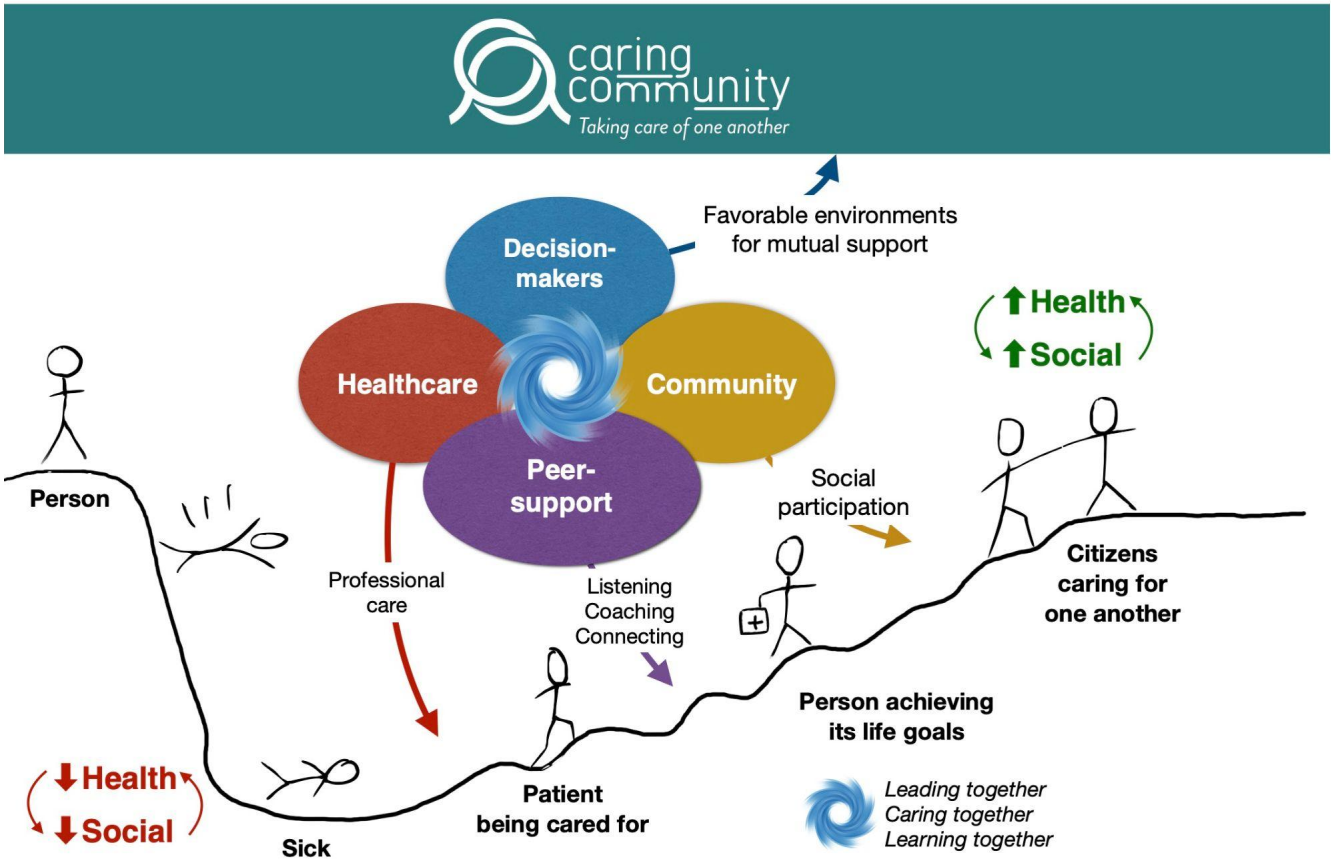
Objectives

1. **Adapt** the Caring Community model to the context of homelessness during the acute phase of the COVID pandemic;
2. **Integrate** one peer-support worker within a community-based primary care team to offer practical support, coaching and care navigation for people experiencing homelessness;
3. **Assess** the feasibility, acceptability and perceived impacts of peer-support in the context of homelessness during COVID.

Adapting Caring Community to Homelessness

Caring Community (Figure 1) recognizes that patients and citizens are the first caregivers in society. It positions peer-support workers as a bridge between health and community care. Designed and piloted in primary care with members of our research team, the Caring Community project has shown promising results for people presenting with complex medical and social issues [7].

Figure 1: Caring Community Model



In order to adapt the Caring Community model to homelessness, our team has been active in **building partnerships with local clinical and community collaborators**. During the first 3 months of the project, we held over 16 action research team meetings (~30 hours) and held approximately 25 meetings with local clinical and community partners, under the leadership of our clinical lead, Dr. Mathieu Isabel.

1. These meetings allowed us to to **identify key stakeholders, and appreciate the depth of local expertise in peer-support interventions in other sectors in Montreal**. We have learned that peer-support workers are well established within mental health teams, as well as within substance use treatment programs. This consultation process with local experts helped us adapt our research and intervention plan, and created opportunities for mentorship and support by local, experienced peer-support workers.

2. We have uncovered a **high level of enthusiasm to extend peer-support models to address the challenges of homelessness**. Clinical managers, health professionals and community partners perceive the Co-RIG action research project as a key opportunity to move the peer-support model forward and address the needs of people experiencing homelessness, by mobilizing their practical and experiential knowledge and offering a model of hope.
3. **Research was seen as essential to practically support innovation during times of crisis**. While local partners were convinced of the importance and potential value of peer-support, the COVID crisis put a high strain on clinical and community teams, making it difficult to lead any new implementation of practice innovations (build partnerships, support recruitment and role clarification, ensure ethical and institutional oversight). Research leadership during the early phase of the project was therefore seen as valuable practical support, and a key facilitator in the initial experimentation on the ground.

Local partner consultation was complemented with a **review of the published literature on peer-support intervention and evaluation within the context of homelessness**. Key findings from our review include:

1. the **complexity and diversity of peer-support** interventions and models;
2. the importance of considering **institutional, professional and practical barriers** to implementation [8];
3. the **challenges of conducting research** with a homeless population because of issues of trust (e.g. fear of being "monitored"), loss to follow up, and research literacy (e.g. barriers with traditional methods of research and ethical consent);
4. the **need for co-building and adapting** the intervention and evaluation with peer-support workers, community partners, and clients.

We have learned from consultations with our partners and from the literature that **tangible support and mentorship by experienced peer-support workers is essential**. In addition to the established support with our lead patient partner from the Caring Community program (Ms. Ghislaine Rouly, co-investigator on the Co-RIG project), we have successfully established collaboration with two additional peer-support organizations and experts: 1) the Quebec Association for Peer-Support Mentors (AMPAQ), a not-for-profit organization supporting the training, recruitment and integration of peer-support workers in mental health teams. We have partnered with AMPAQ to support recruitment of a trained peer-support worker within our project; 2) the Integrated Health and Social Services Authority of Center-South Montreal (CIUSSS Centre-Sud) has several years of experience integrating peer-support workers into its community mental health and substance use teams. We have partnered with CIUSSS Centre-Sud to identify a peer-support worker with over 10 years of experience (Benoit St-Pierre) to act as peer-support mentor.

Integrating peer-support in community care

We **identified a conducive site to host our intervention** at the CLSC des Faubourgs homelessness clinic, a community-based primary care team in Center-South Montreal. Clinicians and their community partners expressed eagerness to integrate peer-support workers within their practice, based on previous experiences in mental health teams. For them, peer support "fits" with their shared mandates around client autonomy, psychosocial support, and rehabilitation. This alignment of professional culture facilitated the integration of peer-support workers within this practice setting. Peer-support programs were also strongly supported by high-level managers of the CIUSSS Centre-Sud local health authority (in which CLSC des Faubourg is integrated). The selected setting thus offered both professional and institutional support.

We have successfully **engaged with three local clinicians to act as liaison with our peer-support worker**. In addition to our clinical lead, Dr. Mathieu Isabel, Ms. Joelle Boivin, a social worker, partners with our peer-support worker Daniel Turgeon in providing direct client care, doing outreach visits, and introducing him to community workers and potential clients. Ms. Monica Weber, also a social worker with peer-support intervention experience and knowledge, supported the integration of the peer-support worker with the clinical team. We arranged 2 preparation meetings with the CLSC des Faubourgs clinical team (physicians, social worker, nurse, managers) to introduce the peer-support worker's role, identify potential barriers and facilitators, and discuss practical implementation strategies (e.g. access to an office, sharing of information, reference criteria, and the evaluation's purpose and methods).

We have **successfully recruited a peer-support worker** to join our action research team. Following an identification of potential candidates with our partners from AMPAQ and CIUSSS Centre-Sud, we held interviews with our intervention team (Dr. Mathieu Isabel, Ms. Ghislaine Rouly and Ms. Monica Weber). We hired Mr. Daniel Turgeon to join our action research team. Formally trained as a peer-support worker by the Quebec Association for Psychosocial Recovery, Mr. Turgeon conducted a peer-support internship within a community-based mental health team. Mr. Turgeon formally started his paid work with our team in December 2020 and has requested to work 2 days a week (rather than 3 days a week, as originally planned in the grant) with our team, due to previous commitments.

While existing peer-support programs in mental health tend to consider peer-support workers as "professionals like any others" (e.g. being hired and paid by the healthcare institution, having direct access to medical files, etc), the Caring Community model places peer-support workers in a **bridging role between clinical teams and the community**. We have made this distinction explicit in our description of roles and responsibilities and communications with clinical and community partners. This had several practical implications:

1. **Peer-support services are provided in the clinic, in community organizations or directly in the street**. Regular on-site visits in community shelters have been established during Phase I. Some clients were also approached directly by the peer-support worker in the streets or in their temporary residence.
2. While the peer-support worker had access to the clinical team offices and team meetings, we worked with **confidential peer-support intervention notes that are distinct from medical files**. This allowed the sharing of relevant information to facilitate co-interventions, while protecting

confidential information that clients may only want to share with the peer-support worker or health professionals, as long as the safety of clients or others were not at stake (e.g. sharing of suicidal or homicidal intentions);

3. **The peer-support worker is a partner rather than an employee of the healthcare institution**, hired by the research team rather than the clinical institution, in order to protect the peer-support worker's independence.

Under the leadership of Dr. Nadia O'Brien (postdoctoral researcher with expertise in community-based participatory research) and Gwenvaël Ballu (research assistant with psychology background), we have **designed a set of evaluation tools for tracking the implementation process and outcomes** of the project, including:

1. An **Implementation Log** to keep track of all significant steps conducted by the team to implement the intervention (barriers, facilitators, meetings, field preparation, activity tracking);
2. A **Participant Log** linking individual research participant anonymous identification number with their contact details (patient contact information, date enrolled and withdrawn from intervention);
3. A **Visit Log** completed by the peer-support worker to track his interactions with clients and colleagues (number, duration and nature of the intervention, type of support provided);
4. Use of a **Goal Attainment Scaling** instrument, to be completed with participants during their follow-up with the peer-support worker (to document the type of life goals being self-defined by participants and their perceived degree of achievement);
5. A **pre-post questionnaire**, integrating standardized instruments: the Social Provision Scale (SPS), Patient Activation Measure (PAM) (knowledge, skills and confidence), and Perceived Self-Improvement Questionnaire (PIQ);
6. Three **semi-structured interview guides** (patients, peer support workers, stakeholders);
7. We have revised our existing **research consent process with an ethicist** to adapt it to the needs of people experiencing homelessness, with a special attention given to the design of short plain language information material to address literacy issues.

Assessing feasibility, acceptability and impacts

Our Phase I project was successfully implemented in Montreal under the harshest conditions. The peer-support worker joined our team in December 2020, during the peak of the COVID-19 second wave. The homeless population was directly hit by this second wave, with large outbreaks and high death rates in the homeless populations, state enforced curfew measures during the cold winter months, and the dismantling of community shelters and primary care teams, including reassigning professionals from the CLSC des Faubourgs community homelessness clinic towards hospitals and other Covid-dedicated units.

Integration of peer-support in homelessness took longer than expected. A common saying in collaborative research endeavours - a wisdom shared by Elders at the annual Hotiì Ts'eeda research gathering in the Fall of 2020 - is that for action research to be ethical and sustainable over time, one must “move at the speed of trust”. Linkages with clinical and community partners - which were not integrated in our original timeline - have required two extra months of preparation work but allowed critical adjustments in the intervention and research plan. As a result, we requested and obtained from the Foundation a no-cost extension of the project from 7 to 9 months (see Revised Project Timeline). These collaborative research activities were essential to establish a solid foundation for the acceptability, successful implementation and sustainability of the project. Such flexibility and co-building are hallmarks of successful participatory action research projects [9] and have important implications for research funders and teams.

Integration of peer-support proved to be **feasible, acceptable and highly valued** by all stakeholder groups:

- **Clinical integration** of the peer-support worker **as a full member of the team** was quick and significant. Although not a formal employee of the clinic, Daniel was provided with a dedicated office and an access card card upon his first week of work. These represent a symbolic recognition of his role that we have not yet achieved in four years of peer-support integration in another local primary care clinic supported by our team. Furthermore, Daniel was prioritized by the clinical team to get early COVID vaccination as a front-line worker as early as February 2020, during a period where access to vaccination was highly restricted among healthcare workers. Co-interventions and referrals were initiated early with clinicians of the team.
- **Community integration** highlighted the **bridging potential** of peer-support workers. Although he was initially introduced by healthcare professionals from CLSC des Faubourgs, Daniel was quickly recognized as a unique contributor to client support by community organizations. Regular on-site visits were made at three local community sites serving the homeless population: Accueil Bonneau (and its day centre at le Grand Quai), Old Brewery Mission, and Mission Saint-Michael. One community organization took the initiative of posting a description of the peer-support workers’ role to facilitate linkages with potential clients and Daniel was present on-site half-a-day per week. Links with the peer-support worker were maintained, even during critical periods of the COVID outbreak, where relationships with health

professionals from CLSC des Faubourgs were strained or interrupted because of the drastic decrease in clinical activities resulting from the relocalization of many professionals from the team.

- **Client integration** demonstrated the potential of peer-support to **build trustful relationships** with people experiencing homelessness. In a debriefing focus group with CLSC des Faubourgs clinical team in March 2021, a clinician shared the story of a client who was reluctant to accept care for years, but recently reconnected with the clinic after building a trustful relationship with the peer-support worker.

Hope, bridge, meaning: unpacking the benefits of peer-support in homelessness

Echoing the Caring Community slogan of "caring for each other", we documented **reciprocal benefits for all those involved**, including clinical team members, the peer-support worker himself and people living with homelessness. In March 2021, we held a focus group with team members to reflect on their experience of integrating a peer-support worker within their team. Three key findings emerged from discussions:

1. Peer-support offers a model of **hope** for people experiencing homelessness, through the embodied example of a peer who built a new life beyond his experience in the streets. "You don't get it, unless you've lived it" reflected a team member;
2. Peer-support acts as a **bridge**, helping to establish trustful relationships with people experiencing homelessness despite social stigma and suspicion toward public institutions. It practically helps to connect with a number of resources in the community and healthcare system. Health managers described the value of peer support, explaining: "it's not the services that are lacking, it's the navigation".
3. Peer-support brings a sense of shared **meaning** among team members, reconnecting them with the purpose of their work during the darkest days of the COVID crisis. Team members explained that during the pandemic, services were shut down and staff reassigned, exhausted and demoralized, and that the integration of a peer-support worker "grounded our services", that it "brought us back to what we really wanted to do as a team, it brought us back to our mission, it resonated". Peer-support also prevents compassion fatigue by supporting care providers in addressing their client's psychosocial needs: "there is something very healthy about sharing the care intervention. . . it does me a lot of good to work as a team".

Through his first formal experience as a peer-support worker, Daniel Turgeon reflected on the fact that the project also brought direct benefits in his own recovery journey, helped consolidate his sense of self-confidence, provided an opportunity to reintegrate the workforce and to transform a difficult life experience into an asset that can help others (Box 1).

Box 1: Daniel Turgeon's experience as a peer-support worker

"My name is Daniel. I have had a mental diagnosis for 25 years. Six years ago I was homeless with severe addictions. Now I use my own life experience to show that homelessness does not have to be permanent but a better quality of life can be achieved.

Working with the Co-RIG project has given me confidence in myself that I can be an integral part of the team and contribute portions of my life to help others recover from being in a situation of homlessness.

One of the most important elements that I can offer my clients is a shared life experience. Many times my clients have lost trust in the health system and being able to communicate and share common experience can lead to fostering a relationship of trust. As a peer helper, I am trained but not in the same clinical perspective as a social worker. I believe I bring a more human approach and bring it directly to them.

I must say the team went out of their way to make me feel as an integral part of the team. From allowing me to join in regular meetings to even have my own cubicle name tag. The social workers and I work as a team to offer strategic approaches to the problems of customers.

My hopes for the project is to demonstrate that having a peer helper can help in many ways. From better trust from clients, a new way to offer existing services and programs, reducing client hospitalizations and reducing workload for clinical teams. With this pilot project and its proven track record even during the many limited situations during COVID (closing of refuges, curfew, etc) that the role of a peer helper becomes an integral part of the team that services this most disfranchised and isolated portion of society."

Daniel Turgeon, B.A.
Peer-support Worker & Research Assistant
Canada Research Chair in Patient and Public Partnership
Adult homelessness program, CLSC des Faubourgs

Direct impacts on people experiencing homelessness

Direct peer-support interventions were provided during a 3-month period at the equivalent of 2 days/week. Interventions lasted on average 71 minutes (range: 5 minutes to 3 hours) and were provided at the clinic (45%), in community organizations (32.5%) or in outreach settings (12.5%).

The type of support provided included listening, providing practical advice, supporting navigation toward clinical and community resources, and coaching to define and achieve personal goals. Examples of direct support included:

- Addressing difficulties in implementing COVID prevention activities (eg. wearing mask in community shelter)
- Orientation with existing clinical and community resources;

- Providing advices on how to stay warm during the winter
- Prepare and accompany someone to court or to the hospital
- Identify an interest with art and orient with art-therapy program
- Support integration into a new apartment

These activities included **direct COVID-related peer-support**, including:

- Providing information and advices on COVID **prevention** (eg. explaining the rationale of wearing a mask in community shelters);
- Help in community **navigation** in the context of COVID-related closures and changes (eg. orienting clients who had been quarantined or hospitalized for COVID into community ressources that had changed during the meantime);
- Assisting in COVID **vaccination** activities (eg. orienting and accompanying clients from community shelters to vaccination sites, providing information about vaccination opportunities).

As previously reported in other studies [2], **quantitative assessment of impact proved difficult in the context of homelessness**. We realized with experience that a number of meetings between the client and the peer-support worker were necessary to consolidate the relationship before implementing the quantitative questionnaires. Some of the intervention settings (e.g. discussions in the street) also made it difficult to undertake formal surveys. In total, only 4 clients completed the baseline questionnaire (Social Provision Scale, Patient Activation Measure, and Perceived Self-Improvement Questionnaire) and none was followed for a sufficient period of time to complete a follow-up questionnaire. Published studies of peer-support in homelessness have required a minimum of 6 to 12 months of follow-up to document changes in similar outcome measures. An extension of the project beyond the pilot phase would allow further opportunities for quantitative impact assessment, and data collection is ongoing (see “Conclusion and next steps” section).

However, qualitative assessment suggested a number of potential benefits for clients. **Box 2 and 3 provide two (anonymized) illustrative examples of the impacts of peer support on people experiencing homelessness**.

Box 2: John’s story

John decided earlier this year to move to Montreal after facing severe harassment in his rural community. He wanted to start a new life and to find work. He suffers from anxiety and takes his medication regularly. He has no alcohol or drug addictions. He is in his late 20s and has never been homeless in the past.

Daniel initially met with John at Accueil Bonneau, a community shelter where he was lodging temporarily. The first contact with Daniel focused on orienting him to Montreal and showing him the eating and lodging resources. John’s first goal was to find work. Daniel accompanied him to get a cellular phone, an email address and to work on his CV to facilitate contacts by potential employers. John is now applying for work through a placement organization that specializes in adapted work for people living with a mental health condition. John’s next goal will be to find more stable personal living quarters.

Connection with Daniel during the early stage of his homelessness situation ensured that he could orient himself into the big city to meet his basic needs for food and shelter, provide a launching pad for his employment search, and orient him toward a more stable living situation. Sharing a common experience of homelessness and mental illness offered a living example for John that it is possible to move beyond his current situation.

Box 3: Mike's story

Mike has a long history of homelessness: it is all he has known for the past 10 years. He is reluctant to see professionals and to accept services offered by the government. He feels he has been betrayed by the system.

Daniel's role as a peer helper has been to gain his trust and help him understand that the clinical team is not against him but want to work with him. Three weeks after their first meeting, Daniel was able to work with Mike to receive 4 years in federal and provincial tax returns that he is entitled to but never asked for because of his mistrust. Daniel's relationship with him helped to break this cycle, and provided much needed money without compromising his autonomy.

Mike also had difficulties with the law. He had 4 pending court appearances and was at the point that he could get arrested and jailed. He was afraid of showing up alone in court and reached out to Daniel. They scheduled a meeting with his lawyer and a social worker from the CLSC des Faubourgs to ensure that Mike would be at the next court date and to prepare him. A week later, Daniel accompanied him for his court appearance. The outcome was favorable for Mike: he now has no warrants against him and the judge gave him a small fine that he could pay. While walking together from the court, Mike started sharing with Daniel his desire to stop using drugs and to explore programs to help him.

Relating with Daniel as a peer helped Mike reestablish trust with someone and slowly reconnect with public institutions (healthcare team, government, judiciary system) in a more productive way in order to achieve his own personal goals. It broke his isolation and gave him the feeling that he could work with an ally at his side.

Conclusion and next steps

Our Phase I project was successfully implemented in Montreal under the harshest conditions, during the peak of the COVID-19 second wave. **Peer-support offered** a model of **hope** for people experiencing homelessness, served as a **bridge** between health and community resources, and contributed to a sense of shared **meaning** and mutual support for care providers. Its implementation in primary care proved to be feasible and it generated strong support from clinical and community partners.

These achievements provide a solid foundation for the extension and sustainability of this project. Local partners have identified three priorities for the project's next phase:

1. **Expand** peer-support with women experiencing homelessness, given the fact that the COVID pandemic exacerbated drivers of homelessness affecting women (disproportionate job loss and increases in intimate partner violence);
2. **Connect** peer support in homelessness with other peer-support workers experiencing issues affecting the homeless population (e.g. mental health, substance use, chronic diseases, aging, grief);
3. **Sustain** peer-support in homelessness beyond the acute phase of the pandemic, to address long-term issues of care fragmentation for this population.

The Canada Research Chair in Patient and Public Partnership has dedicated internal funding to prolong the project (peer-support and its ongoing evaluation) until the Summer 2021, while actively exploring complementary funding for its extension beyond this period (including application to the Co-RIG Phase 2 competition).

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Project Plan and Timeline

Caring Community: expanding integrated community care in partnership with patients and citizens to support homeless populations during the COVID-19 pandemic

Boivin, Isabel, Rouly, & O'Brien | Revised Nov 30, 2020

Activity	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021	April 2021
Clinical and community partnership-building								
Reaching-out an linkages with community-based peer-support organizations								
Reaching-out an linkages with clinical partners and collaborators								
Expert and partners' consultation to consolidate and adapt research and intervention plan								
Recruitment, training and support of homelessness peer-support worker								
Recruitment of homelessness peer-support worker								
Initial training and intake of homelessness peer-support worker in Caring Community team								
Coaching by experienced citizen, patient partners and senior peer-support worker*								
Ongoing support by Caring Community team (family medicine teammate, ethicist, psychologist)*								
Intervention								
Follow-up of patients and citizens dealing with the psychosocial consequences of the pandemic*								
Weekly interdisciplinary meetings (case discussions, healthcare and community linkages)*								
Monthly Caring Community co-learning sessions (sharing expertise, learning to care together)*								
Evaluation								
Hiring of research assistant								
Review of litterature on peer-support intervention and evaluation approaches								
Adaptation of evaluation tools to best-practice recommendations on homelessness research								
Data collection* (project log and service use metrics, interviews and questionnaires)								
Data entry*								
Data analysis*								
Reporting, dissemination, knowledge exchange and sustainability support								
Interim and final reports								
Dissemination & knowledge exchange*								
Application for complementary action research funding with clinical and community partners								

* These activities will continue beyond the grant period with the support of Canada Research Chair funding held by Dr. Boivin.

Original timeline

Revised timeline

Overlap between original and revised timeline

Additional activities added in response to litterature review, expert and partners' consultation