L'Équipe de soutien clinique et organisationnel en dépendance et itinérance

EXECUTIVE SUMMARY

The Royal Victoria's COVID-19 isolation unit for people experiencing homelessness in Montréal: results from an implementation study

INSTITUT UNIVERSITAIRE SUR LES DÉPENDANCES

CREMIS
Centre de recherche de Montréal sur les inégalités sociales, les discriminations et les pratiques alternatives de citoyenneté

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EXECUTIVE SUMMARY – The Royal Victoria's COVID-19 isolation unit for people experiencing homelessness in Montréal: results from an implementation study is the result of a collaboration between the Centre de recherche de Montréal sur les inégalités sociales, les discriminations et les pratiques alternatives de citoyenneté (CREMIS) and the Institut universitaire sur les dépendance (IUD).

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CONTEXT

On March 11, 2020, the World Health Organization (WHO) declared a global pandemic due to the spread of a new coronavirus, SARS-CoV-2. Two days later, the Québec government declared a state of public health emergency (Government of Québec, 2020), introducing a series of measures to limit the spread of the disease caused by this coronavirus, namely COVID-19.

On the international level, various organizational models were implemented to address the needs of people experiencing homelessness (PEH) and public health issues during the first wave of COVID-19. For example, some medical services centres, shelters and hotels were repurposed to safely meet the needs of people experiencing homelessness and to provide care and services to those who were confirmed COVID-19 positive or were awaiting test results.

In Montréal, an isolation unit for PEHs potentially infected with COVID-19 was established in the former Royal Victoria Hospital from March 31 to June 12, 2020. This temporary living environment was supported and managed by medical and psychosocial professionals, most of whom are experts in working with people experiencing homelessness and people with substance use disorders.

The implementation study sought to document the different components of this unit designed to help people experiencing homelessness who are confirmed COVID-19 positive or are awaiting test results, and to determine the strengths, obstacles and implementation issues specific to this initiative from the perspective of participating administrators and clinicians.

STUDY OBJECTIVES

- To document the components of the isolation unit for people experiencing homelessness (PEH) who are confirmed COVID-19 positive or are awaiting test results.
- To determine the strengths, obstacles and implementation issues specific to the initiative from the perspective of participating administrators and clinicians.

METHODOLOGY

The implementation study drew its inspiration from the *Consolidated Framework for Implementation Research* (Damschroder et al., 2009). The present report is based on the process laid out in the Damschroder theoretical framework. More specifically, the methodology is divided into four parts:

1. Literature review
2. Program description
3. Operational data analysis
4. Collection and analysis of qualitative data (nine individual interviews with administrators and four focus group interviews with clinicians)

THE FORMER ROYAL VICTORIA HOSPITAL ISOLATION UNIT

Isolation Unit Mandate

- Voluntary isolation
- Basic health and social services for people experiencing homelessness who are confirmed COVID-19 positive or are awaiting test results
- Focus on a living environment approach

Isolation Unit Eligibility Criteria

- PEH living in or visiting the territory covered by the CIUSSS du Centre-Sud-de-l'Île-de-Montréal (CCSMTL)
- PEH confirmed COVID-19 positive or awaiting test results
- PEH whose medical condition does not require hospitalization, but for whom accommodation in an isolation hotel is inadvisable because of a substance use disorder

Isolation Unit Components

Resources

- ◯ Personal protection equipment
- ◯ Workspaces and individual rooms
- ◯ Safe drug use equipment
- ◯ Accommodation furniture and equipment
- ◯ IT equipment
- ◯ Medical supplies
- ◯ Medication and other psychoactive substances

Personnel

- ◯ Administrative officers
- ◯ Security guards
- ◯ Administrators
- ◯ Nurses
- ◯ Nursing assistants
- ◯ Psychosocial support workers
- ◯ Physicians
- ◯ Hygiene and sanitation workers

Services provided

PSYCHOSOCIAL SERVICES

- ◯ Recreational activities
- ◯ Liaison with the healthcare and health network services
- ◯ Management of social solidarity benefits
- ◯ Discharge arrangements
- ◯ Pet care

HEALTH SERVICES

- ◯ Mental health counselling
- ◯ STBBI screenings
- ◯ COVID-19 symptom management
- ◯ Wound care

SUBSTANCE USE SERVICES

- ◯ Distribution of safe drug use equipment and PPE
- ◯ Distribution of naloxone
- ◯ Withdrawal management
- ◯ Tobacco and cannabis use management
- ◯ Supervised injection
- ◯ Innovative substance replacement options* (e.g. methylphenidate, cannabis, hydromorphone)
- ◯ Innovative wet shelter services (alcohol)
- ◯ Opioid agonist treatment (OAT)

**"Replacement therapy aims to replace substances purchased on the illicit market with pharmaceutical substances whose content is known and stable. Replacement therapy is based on harm reduction and safe supply principles and aims to reduce the risk of overdose and help people who use substances to respect isolation and physical distancing requirements in order to mitigate risks, both to themselves and to others." (Goyer, Hudon, Plessis-Bélair, et al., 2020)*

STUDY RESULTS

Selected operational data

- 77 stays were recorded between March 31 to June 12, 2020.
- 58% of stays were by individuals aged 45-64.
- Specialized services (psychiatry, occupational therapy, substance use management) were utilized by a minority of the PEHs admitted.
- At admission, 44% of the PEHs came from the street.
- Upon discharge, 12% of PEHs returned to the street.

Program characteristics: Clinician and administrator perspectives

Clinicians adopted a **living environment**, **harm reduction** and **individual support** approach, building on **shared experiences**. A range of innovative safe supply services were also provided to people with substance use disorders, including alcohol, tobacco and cannabis management programs, supervised injection, and substance replacement therapy.

> ***"We want a place for COVID-positive homeless people that feels like home."*** (Administrator 7)
>
> ***"Our mandate was to make it attractive so that they would be willing to come, and have something interesting waiting for them."*** (Physician-Administrator 3)
>
> ***"This was such a great opportunity for observations and interventions that could improve the dignity and living conditions of these people."*** (Administrator 4)

The program's internal context: Clinician and administrator perspectives

On the one hand, administrators and physicians expressed a positive appreciation of the co-construction process, communication framework and organizational support provided. They felt that their demands had been heard and acknowledged, and that this had helped them achieve their mandate.

> ***"It was a genuine co-construction from start to finish. We were in such a hurry that we couldn't impose anything because there were too many unknowns. No one knew how it was going to work. We did have some reference points to guide us—you don't forget what you've learned in such a situation—, but we also had to develop new ways of working, find new terms."*** (Administrator 9)

On the other hand, other groups of professionals were less positive. Many reported that there was a lack of information and that they felt that their demands were not heard or recognized.

> ***"In fact, we felt somewhat muzzled, given that there was a sort of structure that had established itself [...] In the end, everything we expressed had to go through them, but we had no idea whether it was actually passed on. You know, if the person didn't necessarily agree with what we were saying, we had no idea whether the information was being passed on or not."*** (Group interview, psychosocial workers)

The program's external context: Clinician and administrator perspectives

Several clinicians and administrators mentioned the loosening of structures and the unusually flexible nature of the health and social services network in the context of a public health crisis. With respect to partner relations, some complained of liaison issues and communication problems. Others reported a positive experience with partners and said that they had mobilized networks of contacts and professional relations that were already solid prior to the pandemic.

> ***"I think it's a question of opportunity. In a crisis situation, there are new opportunities, new ways of doing things that do not necessarily fall within a usual framework of approval, process, etc., which may have facilitated things [...]"*** (Administrator 5)

Professional practices: Clinician and administrator perspectives

Several comments reflected the perceived experience of mutual support, collaboration and familiarization with each other's work, although there were some reports of individual and inter-professional friction.

> ***"Everyone brought their own colours to the table, and for sure this sometimes resulted in friction, but other times the exchanges were very rich. And everyone had a different, complementary solution."*** (Administrative officer interview)

While many clinicians and administrators mentioned a confusion of roles, especially for psychosocial workers, the sharing of an intervention philosophy appears to have been a factor in maintaining a sense of balance and in dealing with ambivalence.

A tension (or ambivalence) emerged between, on the one hand, the **living environment approach** and, on the other hand, the **significant number of available services** and **intervention options** on offer for a clientele that was "captive", due to the confinement measures.

> ***"[...] This was such a great opportunity for observations and interventions that could improve the dignity and living conditions of these people." [...] We are not highly interventionist physicians, but we can't let a man with dementia go back to the street."***
> (Administrator 4)
>
> ***"We have 14 days during which they can be with us, when we can establish a relationship, and tackle certain problems [...] Yes, this has perhaps led to a certain dichotomy between the views of some psychosocial workers and the more clinical or medical view."***
> (Administrator 7)

Perceived outcomes: Clinician and administrator perspectives

Some administrators and clinicians found that working in the isolation unit allowed professionals from different backgrounds to meet and develop new, trusting relationships.

> ***"It was really fun in terms of exchanges and practice sharing. [...] Now, when we call each other, we will know each other, and we will trust each other [...]"*** (Administrator 4)

Some administrators and clinicians found that the initiative served as a springboard for the adoption of innovative or updated practices that deserve to be more widely circulated in more conventional practice settings.

> ***"When there are crises, there are opportunities. [...] How do we ensure the sustainability of what we've developed and ensure that we use this knowledge going forward?"***
> (Physician-administrator 6)

Some administrators and clinicians described the satisfaction of the people experiencing homelessness who were admitted to the unit. In their opinion, residents were grateful that their needs had been acknowledged without judgment.

> ***"The vast majority of users were extremely satisfied with the services they received. [...] It was perhaps the intervention they needed most, within the current context, and without judgment."*** (Group interview, psychosocial workers)

LESSONS LEARNED:
ISOLATION UNIT IMPLEMENTATION OBSTACLES

Communication obstacles

- ⊖ Difficulty transferring information between shifts
- ⊖ Difficulty holding team meetings
- ⊖ Psychosocial workers found it difficult to deal with communication gaps

> ***"[...] I found that shift changeovers were really not conducive to communication, given that there were people arriving on the half-hour and others leaving on the half-hour. So, it wasn't a case of 'the entire day team meets with the evening team at the shift changeover', but rather 'one person arrives, another person leaves.' So communication was very difficult. It didn't help at all, this way of doing things between shift changeovers."***
> (Group interview, psychosocial workers)

Human resource obstacles

- ⊖ Lack of certain types of jobs, such as orderlies
- ⊖ Difficulty recruiting nurses and security guards

> ***"The security guards, the first ones we had, when they learned that we were going to have COVID positive patients, they stopped showing up."*** (Physician-administrator 6)

Obstacles related to Intervention approaches

- ⊖ Tension experienced by professionals with regard to the intervention options and respecting the individual's personal rhythm
- ⊖ Ambivalence between the living environment approach and the significant number of medical and psychosocial services available

> ***"I think that was wishful thinking on our part. We thought it was a good idea, but at the same time we knew ourselves, and we told each other—the physicians—that we would have to keep ourselves in check, and not be too interventionist, that we would see a lot of things that we would like to remedy because we're made that way, and that we would have to hold back. [...] So it was really hard not to be too interventionist, and, well, I don't know, maybe we got too hung up on ourselves, I don't know, in any case, we said that to ourselves at the beginning, and we knew it was going to be difficult, and it was, that's it."*** (Group interview, physicians)

LESSONS LEARNED:
ISOLATION UNIT IMPLEMENTATION FACILITATING FACTORS

Facilitating factors related to personnel characteristics

- ⊕ Previous relevant experience in the fields of addiction and homelessness
- ⊕ Volunteerism and motivation
- ⊕ Leadership
- ⊕ Flexibility and adaptability in the context of a crisis
- ⊕ Interdisciplinary collaboration

> ***"The fact that they were motivated and willing people is also a big part of Royal Vic's success. Everyone was doing their part, and most were happy that things were constantly changing, even if constant change can be difficult. I found the people were more positive than I would have initially expected."*** (Group interview, nurses)

Facilitating factors related to management

- ⊕ Program adaptability
- ⊕ Flexible management structures and senior management support
- ⊕ Seamless communication between physicians and administrators
- ⊕ Interprofessional co-construction

> ***"It's important to salute the efforts of everyone [...] of all the members of the teams that were ready. A series of services like this cannot just happen from one or two people putting their minds together, it takes a lot of collaboration, and the contribution of people working in the field. There was a lot of adaptation (suggestions) that came from the people who were onsite with our psychosocial workers, our nurses and our physicians [...] There is room for innovation on that front and, most of all, to adapt the services that we were in the process of setting up at Royal Vic, services centred on the needs of users. That's what made it work: 'Everyone got involved in making it happen'."*** (Administrator 7)

Facilitating factors related to **intervention approaches**

- ⊕ Living environment approach
- ⊕ Individualized support
- ⊕ Harm reduction and services provided according to a safe supply approach
- ⊕ Staff members shared an intervention approach

> ***"[...] Making the place as welcoming as possible with as few harsh rules as possible: There was no specific time for dinner, no specific time for dispensing or retrieving medication. We really tried to adapt to each person's rhythm."*** (Administrator 8)

STRENGTH AND LIMITATIONS OF THE STUDY

Strengths

- Working with a qualitative design based on a robust and proven theoretical framework allowed for in-depth interviews with professionals and administrators.
- The study differs from other similar studies in the scientific literature by combining a qualitative design with the use of objective data (operational data).
- The study benefited from the views of professionals, administrators and individuals who had contributed to the development and implementation of the isolation unit.

Limits

- Interviews were conducted retrospectively, thus introducing a risk of recall bias.
- The research team was unable to document the views of the people who were admitted or those of the partners.
- Due to the public health situation, it was not possible to carry out *in situ* observations, which would have made it possible to cross-check information collected from interviewees.
- The unit's short existence limited the possibility of documenting its evolution through follow-up interviews with respondents at different stages of the project.

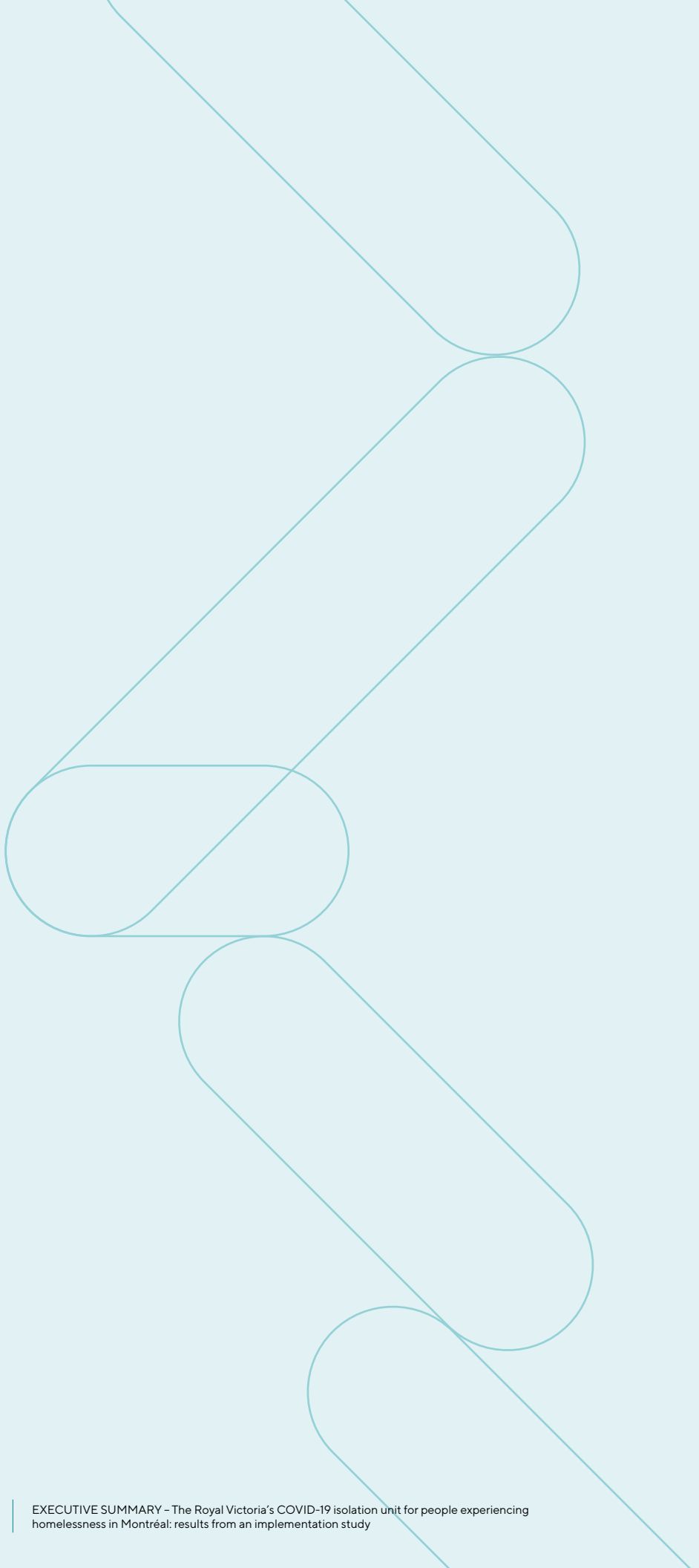
CONCLUSION — A FEW OBSERVATIONS

- The implementation of the isolation unit provided an opportunity to assess the **feasibility** and acceptability of **novel practices in the field of dependency** with interviewed stakeholders.

- The experience highlighted the importance of ensuring an **integrated response** (addiction and homelessness) to the needs of people experiencing homelessness during a pandemic, as well as the importance of **housing** and **living environment components** in the overall services offered to this segment of the population.

- The experience has revealed the need to develop novel **collaborative** and **multidisciplinary** approaches when working with people experiencing homelessness.

- Ultimately, the evaluation results of the isolation unit implementation **inform the development of similar initiatives elsewhere** in Québec and identify areas of improvement in preparation for subsequent waves of the COVID-19 pandemic.



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