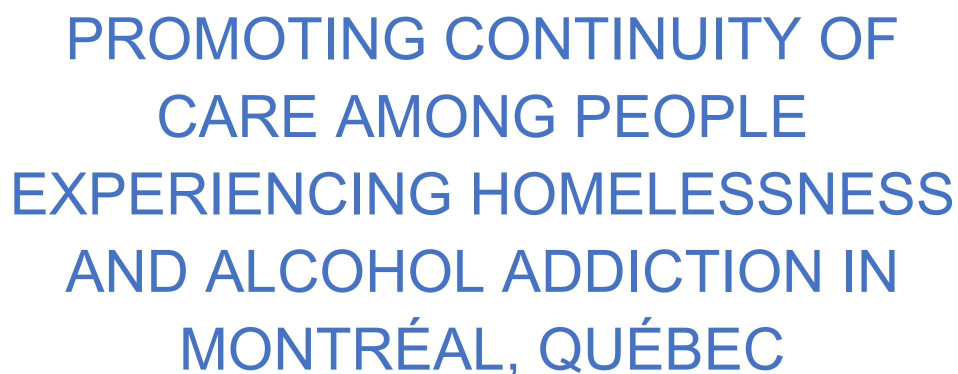

PROMOTING CONTINUITY OF CARE AMONG PEOPLE EXPERIENCING HOMELESSNESS AND ALCOHOL ADDICTION IN MONTRÉAL, QUÉBEC

Old Brewery Mission (OBM) Policy Lab 2022

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1.0 EXECUTIVE SUMMARY

People experiencing homelessness and alcohol addiction are likely to present with a complex health profile, including a range of physical, mental, social, and substance use needs. To respond to these complex needs, tailored and holistic health care is required. In June 2022, the Old Brewery Mission (OBM), a homeless-serving shelter in Montréal, launched a managed alcohol program which adopts a harm reduction approach to alcohol addiction. This program provides measured doses of alcohol to help participants manage their addiction, in place of the traditional abstinence-based approach. In addition, participants receive wrap-around services to help meet psycho-social needs, recognizing that treatment for alcohol addiction is just one aspect of their broader needs. Given the intensity of support provided by the managed alcohol program, this report aims to explore the challenges and barriers within the Montréal health care system that inhibit adequate and holistic health care provision *prior* to individuals seeking out intensive health care support through a managed alcohol program.

People experiencing homelessness and alcohol addiction face particular barriers with respect to accessing health care provided by the public health system, arising from the system being ill-adapted to their needs and realities. These barriers exist in primary care, specialized care, and interactions with health human resources, resulting in an overall health care experience characterized by a lack of continuity of care. People experiencing homelessness and alcohol addiction are provided little targeted support in navigating the health care system, nor are they typically prioritized for health care services.

This report presents key challenges and barriers experienced by the target population as they navigate the health care system. Key findings are summarized below.

<u>Primary care:</u> Although the overall population in Québec is often unable to access primary care, especially with respect to family physicians, people experiencing homelessness face a particular set of additional barriers that limit their access to primary care. Some of these barriers arise from the circumstances of experiencing homelessness, while others are systemic challenges. For one, basic needs such as obtaining shelter and food may take priority over health care needs. In addition, people experiencing homelessness may not have the necessary resources to seek out, access, and follow-up with primary care, including consistent access to phone lines, internet, or transportation options. Broader systemic barriers include the fee-for-service remuneration structure for family physicians, which incentivizes abbreviated visits and does not lend itself to patients with complex needs. Moreover, frequent loss and theft of health cards pose an ongoing challenge, despite policy accommodations to facilitate renewal of health cards. These challenges limit access to primary care, which means people experiencing homelessness often do not have established contact with the health care system. As a result, continuity of care is impeded for their overall health care needs, including the need for more specialized care.

<u>Specialized care:</u> The nature of the specialized care system, which is designed to address specific needs often in isolation from an individual's broader health profile, presents a barrier to receiving

care in a holistic manner for people experiencing homelessness. This challenge, inherent to the design of the system, is further compounded as people experiencing homelessness typically present with complex health profiles, but experience difficulties in attending multiple appointments for specialized services. Moreover, organizational policies and practices that do not account for the accessibility needs of people experiencing homelessness pose additional barriers. These challenges and barriers prevent people experiencing homelessness from having their specialized needs addressed, and contribute to the lack of continuity of care experienced within the health care system.

Interactions with health human resources: Throughout their interactions with health care providers and front-line staff, people experiencing homelessness often experience stigmatization and other harmful attitudes. This is often a consequence of staff being overburdened and undertrained to support people experiencing homelessness in a sensitive, trauma-informed manner. These interactions discourage people experiencing homelessness from seeking health care, and by extension, negatively impact the formation of stable, trusting relationships with health care providers.

These issues compound to create an over-reliance on emergency departments, which are unsuited to addressing the complex needs of the target population given the episodic nature of emergency care. These challenges reflect a health care system that is not well-equipped to provide holistic, coordinated health care services that are accessible and adapted to the complex health care needs of this population. This results in an overall health care experience where continuity of care is severely limited.

Recommendations

To improve continuity of care for people experiencing homelessness and alcohol addiction, five recommendations have been designed for OBM and the public health care system. The objective of the recommendations is to help OBM and the health system better respond to the needs of this population. With respect to the public health care system in particular, the recommendations are intended to go a step further in adapting service provision to the unique realities of homelessness. These recommendations acknowledge that people experiencing homelessness and alcohol addiction often present with a complex health profile overall, of which alcohol addiction is one component, and are designed from the perspective of improving access to, and better continuity of care.

The recommendations are:

1. **Incorporation of Health System Navigators at OBM and Within the Broader Public Health System:** OBM should create a health system navigator role to assist clients with understanding and navigating the health care system. OBM should likewise advocate for the same navigator function within public hospitals in the health care system, to ensure the target population is connected with health care services and experiences continuity of care among health care services. Similar to other shelters in Canada, OBM should also create a peer support network of current or former OBM clients to assist navigators with

specific tasks, such as the coordination of transport for clients to attend health-related appointments.

2. **Implementation of a Pilot Integrated Community Clinic Targeted for People Experiencing Homelessness:** OBM should advocate for, and work with the public health care system to, pilot a community clinic that offers primary health care, and potentially some specialized health care services, for people experiencing homelessness in downtown Montréal. This clinic would be an integrated and innovative solution that addresses major barriers to access, and lack of continuity of care, for people experiencing homelessness. A partnership would allow the public health care system, homeless-serving shelters, and other non-profit organizations to work together to meet the unique needs of this population.

3. **Training of Health Human Resources on Trauma-Informed Care**: OBM should offer appropriate training on trauma-informed, person-centred care for all staff, and advocate for this training to be offered in the public health care system. Trauma-informed care has been demonstrated to be effective in improving patient safety and trust, and person-centred care likewise improves interactions through greater openness and conflict resolution. These skills are essential for the health care workforce to adopt to improve trust and build positive relationships with people experiencing homelessness.

4. **Greater Availability of Low-Threshold Services:** OBM should advocate for amending policies and rules within addiction and specialized services that present particularly high thresholds to access for people experiencing homelessness. These include, for example, sobriety requirements, as well as more general policies, such as limited hours of access or restrictions on mobility, that prevent the target population from using specialized services. Adopting a low-threshold model would instead make minimal demands on patients, recognizing that services should be better adapted to increase acceptability and access for people experiencing homelessness.

5. **Review the Wider Policy Settings Affecting the Health System:** Within the health care system, there are various policies at the operational and institutional level that create undue barriers for the target population. OBM should advocate for, and participate in, a review of policies that present complex and significant challenges for people experiencing homelessness in their interface with the health care system:

    - **Institutions and points of access to the system**: examine location and physical accessibility of services;

    - **Regulatory options:** examine policies that impose conditions and requirements for accessing services, particularly with respect to RAMQ cards and information-sharing between public and private health providers (e.g. shelters); and

- **Funding and incentives:** explore options to improve capacity and incentives for family physicians to take on people experiencing homelessness within their roster of patients, and increase wages and benefits for health care staff to improve their ability to support people experiencing homelessness.

Taken together or individually, these recommendations serve as concrete opportunities to make health care system-level interventions to help adapt the system to better respond to the needs of people experiencing homelessness, and as a result, improve continuity of care for this population. An implementation plan, provided in Appendix B, suggests concrete activities to implement each recommendation, along with proposed timelines. However, OBM may wish to adapt this approach according to its own assessment of the priority and the capacity of partner organizations to engage. Further engagement, particularly with people with lived experience of homelessness and alcohol addiction, should inform the approach to, and implementation of, the recommendations.

2.0 BACKGROUND AND CONTEXT

2.1 Mandate

This report was prepared to provide the Old Brewery Mission (OBM) with policy and programmatic recommendations addressing the poorly coordinated health care services, and lack of continuity of care, of people experiencing homelessness and severe alcohol addiction (the 'target population') in Montréal.

2.2 Introduction

The harmful use of alcohol is a leading global risk factor for human health, and a well-known cause of premature death and disability.[1] Its harms are not uniformly distributed. Some populations, such as people experiencing homelessness, are more vulnerable to the detrimental effects of alcohol use.

In past decades, harm reduction interventions have been developed to address the specific health and social needs of people experiencing homelessness and alcohol addiction. Particularly, there is an emerging interest in introducing harm reduction programs within homeless-serving shelters in Montréal. Managed alcohol programs are examples of adopting a harm reduction approach to severe alcohol addiction. OBM is Québec's largest homeless-serving organization, offering a range of services for people experiencing homelessness, and engages in finding solutions to preventing and ending homelessness. OBM launched a managed alcohol program in June 2022, serving people experiencing homelessness and alcohol addiction who self-identify as men.

The broader policy lab challenge question was how OBM could fill the service gap in collaboration with its broader health care providers for people experiencing homelessness both from equity-seeking groups and with more complex health issues that require specialized support. Recognizing the prevalence of alcohol addiction across a wide range of people experiencing homelessness, and the emerging policy interest on addiction and homelessness, the question was refined in consultation with OBM to:

> *"How can OBM fill the service gap in collaboration with its broader health care providers for people experiencing homelessness and severe alcohol addiction that require specialized support?"*

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[1] Tiina Podymow et al., "Shelter-Based Managed Alcohol Administration to Chronically Homeless People Addicted to Alcohol." *Canadian Medical Association Journal* 174, no. 1 (January 2006): 45.

This report examines the barriers that inhibit OBM and its partners from supporting the target population in addressing their health care needs, including addiction needs, before becoming candidates for the managed alcohol program. The focus on alcohol addiction is consistent with the current Government of Québec's policy direction. The Action Plan on Homelessness (2021) and Mental Health (2022) lay the groundwork for the Government's direction relating to the policy lab challenge.[2] In April 2022, the Government also announced a wide-ranging set of reforms to the wider health system which aims to address a number of pressure points in the health system, including the need for more staff, improving access to health care services, and modernizing information technology.[3]

This report highlights gaps and barriers with regard to continuity of care along the continuum of emergency, primary and specialized health care services, as well as interactions between frontline staff and people experiencing homelessness. Based on this analysis, the report then outlines five proposed recommendations for OBM and the public health care system that aim to improve continuity of care for people experiencing homelessness with alcohol addiction.

2.3 Overview of Homelessness

Homelessness is a complex and multifaceted issue with detrimental consequences for individuals and societies. Homelessness has been defined by the Canadian Observatory on Homelessness as encompassing a range of living situations including people living unsheltered; people who are in emergency shelters; people who are in temporary accommodation; and those at risk of homelessness and whose housing situations are precarious.[4] In Canada, almost 235,000 people experience homelessness each year, with the numbers increasing.[5] The right to adequate housing, including the right to an adequate standard of living and the continuous improvement of living conditions, is a basic human right and has been recognized both internationally, in Article 11 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), and affirmed locally in the National Housing Strategy Act, 2019 (the Act).[6] Homelessness is therefore a severe deprivation of that right, and a lack of housing violates both the ICESCR and the Act.

The Canadian Alliance to End Homelessness envisions homelessness being "rare, brief and non-recurring", and suggests that action needs to be taken to ensure that problems do not increase

[2] Government of Québec, "Plan d'Action Interministériel en Itinérance 2021-2026." (2021). https://publications.msss.gouv.qc.ca/msss/document-003179/. "Plan d'Action Interministériel en Santé Mentale 2022-2026." (2022). Both accessed June 16, 2022. https://publications.msss.gouv.qc.ca/msss/document-003301/.

[3] Government of Québec. "Plan pour mettre en œuvre les changements nécessaires en santé." Accessed June 15, 2022. https://www.quebec.ca/gouvernement/politiques-orientations/plan-changements-sante.

[4] S. Gaetz, et. al., "Canadian Definition of Homelessness." Canadian Observatory on Homelessness Press, 2012, 1.

[5] Hannah Carver et. al., "What Constitutes Effective Problematic Substance Use Treatment from the Perspective of People who are Homeless? A Systematic Review and Meta-Ethnography." *Harm Reduction Journal* 17, no. 1 (2020): 2.

[6] United Nations, "International Covenant on Economic, Social and Cultural Rights (ICESCR)." Accessed July 1, 2022. https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights. Government of Canada, "National Housing Strategy Act," 2019. Accessed July 1, 2022. https://laws-lois.justice.gc.ca/eng/acts/N-11.2/.

in complexity and become harder to address.[7] Preventing this increase in complexity requires significant changes in a wide range of policy areas beyond housing, including justice, social welfare, and education.

While these various areas are important, health needs are also a major area where policy focus is needed. The rise in homelessness represents a growing public health concern. People experiencing homelessness have a much higher prevalence of physical and mental illnesses, including alcohol and substance use than the general population. In addition, people experiencing homelessness face life expectancies as low as 42 years for men and 52 years for women.[8] These disparities are partly a result of unjust social and economic policies, systems, and practices that create barriers to access to health care services.[9] Such health inequalities are socially and structurally produced, and are therefore preventable.

2.4 Homelessness and Addiction in Montréal

The health care and housing needs of the target population are complex because of the nature of substance use disorders and the high incidence of co-occurring health conditions. The perception that addiction is a personal or moral failing needs to be challenged, as addiction is in fact an illness. Although needs vary based on severity of health conditions and the number of years an individual has been addicted to drugs and/or alcohol and experiencing homelessness, the target population frequently uses emergency health services. Its members experience high rates of morbidity, hospital admission, and premature death, with mortality rates estimated to be almost four times higher than the general population.[10]

While each individual's path into homelessness is unique (as is each individual's experience of homelessness), there do tend to be common paths into homelessness. Often these experiences interact with one another (for instance, an individual's precarious housing and employment situations could affect health outcomes, or *vice versa*). After first experiencing homelessness, it is also common for individuals to cycle in and out, sometimes for months or years. Interactions with the health care system appear to be significant. In addition to contributing to the pathway into homelessness, the experience of living on the street, particularly for a sustained period of time, can exacerbate pre-existing health issues. According to the most recent Point in Time count of people experiencing homelessness in Montréal on a given night, 36.4% of respondents indicated they wanted assistance with physical health, and 33.1% with mental health services –

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[7] Canadian Alliance to End Homelessness, "Vision & Mission." Accessed June 16, 2022. https://caeh.ca/vision-mission/.

[8] Kevin Pottie et al. "Clinical Guideline for Homeless and Vulnerably Housed People, and People with Lived Homelessness Experience." *Canadian Medical Association Journal* 192, no. 10 (2020): E240.

[9] Margaret Whitehead. "A Typology of Actions to Tackle Social Inequalities in Health." *Journal of Epidemiology & Community Health* 61, no. 6 (2007): 473.

[10] Tiina Podymow et. al., "Shelter-Based Managed Alcohol Administration," 45.

the largest unmet need expressed by the population after either permanent or transitional housing.[11]

2.4.1 Health Care Needs of People Experiencing Homelessness and Alcohol Addiction

The prevalence of drug and alcohol dependence among people experiencing homelessness in high income countries is around 38% – almost ten times higher than that of the general population; although statistics vary widely between studies.[12] The prevalence of alcohol addiction within this population directly contributed to the scoping of this project. People experiencing homelessness and those vulnerably housed experience disproportionately high rates of alcohol addiction and other co-occurring health conditions, yet face many barriers to health care. These barriers are prevalent in both primary and specialized care for people experiencing homelessness and alcohol addiction, and in their interactions with health care staff. Such barriers break down continuity of care, further exacerbating the risks of more serious health problems.[13]

The target population has a variety of complex physical, mental, social, and alcohol management needs, as identified below.

Physical Health Needs
People experiencing homelessness and alcohol addiction present with multi-faceted physical health needs that are often left unaddressed for extended periods of time. They are more vulnerable to physical injuries that result from falls, traffic accidents and assaults. This population also often experiences physical conditions and illnesses directly related to alcohol addiction, including chronic inflammation of the digestive system, liver cirrhosis, pancreatitis, alcohol-related seizures, and damage to the central nervous system, which need medical attention.[14]

Mental Health Needs
The population experiences a significantly higher prevalence of mental health conditions and alcohol-related disorders than the general population.[15] Many mental health disorders remain undiagnosed or inconsistently treated because of the lack of continuity of care. While many homeless-serving shelters offer specialized services, such as the Projet de réaffiliation en itinérance et santé mentale (PRISM) program for psychiatric disorders and managed alcohol

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[11] Eric Latimer and François Bordeleau, "Enumeration of Persons Experiencing Homelessness on the Island of Montréal on April 24, 2018." (2019): 36.
[12] Seena Fazel et. al., "The Health of Homeless People in High-Income Countries: Descriptive Epidemiology, Health Consequences, and Clinical and Policy Recommendations." *The Lancet* 384, no. 9953 (2014): 1530.
[13] Catharine Chambers et. al., "High Utilizers of Emergency Health Services in a Population-Based Cohort of Homeless Adults." *American journal of Public Health* 103, no. S2 (2013): S302.
[14] Rossio Motta-Ochoa et. al., "'A Place to Be Safe, Feel at Home and Get Better': Including the Experiential Knowledge of Potential Users in the Design of the First Wet Service in Montréal, Canada." *Harm Reduction Journal* 19, no. 1 (December 2022): 2.
[15] Pottie et al., "Clinical Guideline," E240.

programs for alcohol addiction, they do not have, and are arguably not the place for, comprehensive programs to address complex health profiles.

Social Needs

External forces such as poverty, violence, stigmatization, alcohol dependence, and other wider social determinants of health affect the health and wellbeing of people experiencing homelessness, who are also exposed to the harsh living conditions of the street (e.g., extreme weather, robbery, harassment, police profiling and discrimination).[16] Individuals under the influence of alcohol and other substances are more likely to adopt risky behaviors, as well as behaviors perceived as “disturbing” by others; therefore they may need extra support and resources.[17]

Alcohol Management Needs

People experiencing homelessness may use alcohol and other substances as a way to cope with the trauma of homelessness, stress, and adversity, and they are less likely to access, and more likely to disengage from, alcohol addiction treatment.[18] Alcohol and substance use may also be influenced by previous trauma experienced both in childhood and adulthood, as well as post-traumatic stress disorder (PTSD).[19] If their alcohol addiction is severe, a basic priority for members of the target population may also be finding their next drink; without it, seizures may result, which in extreme circumstances may cause death. As a preventive measure, this may lead to the consumption of non-beverage alcohol among the target population, such as mouthwash, due to its lower cost, higher alcohol content, and ease of availability, leading to potential adverse health effects.[20]

Despite these challenges, existing public health care services for alcohol addiction are primarily abstinence-focused as opposed to harm reduction-focused. Services that are abstinence-focused, including dry shelters, often require people experiencing homelessness to be sober, which may lead to alcohol withdrawal. People experiencing homelessness specifically in Montréal have noted a need for more accessible alcohol management approaches along a continuum of abstinence to harm reduction.[21] Depending on an individual’s needs and preferences, any approach along this continuum could be valid.

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[16] Rossio Motta-Ochoa et al., “‘A Place to Be Safe’,” 2.

[17] Kristelle Alunni-Menichini et. al., “Current Emergency Response in Montréal: How Does it Fit in the Services Offered to Homeless People Who Use Substances?” *International Journal of Drug Policy* 82 (2020): 102758.

[18] Serena Luchenski et al., "What Works in Inclusion Health: Overview of Effective Interventions for Marginalised and Excluded Populations." *The Lancet* 391, no. 10117 (2018): 266.

[19] Lamya Khoury et. al., "Substance Use, Childhood Traumatic Experience, and Posttraumatic Stress Disorder in an Urban Civilian Population." *Depression and Anxiety* 27, no. 12 (2010): 1077.

[20] Sarah Kesselring, “Illicit Alcohol in British Columbia.” (2013). https://policycommons.net/artifacts/1200694/illicit-alcohol-in-british-columbia/1753811/.

[21] Motta-Ochoa et. al., “‘A Place to Be Safe’,” 10.

2.5 Objectives of the Project

The provision of patient-centred primary care, specialized care, and addiction services is essential to improving the health of people experiencing homelessness and alcohol addiction, yet significant barriers impede this population from accessing health services, and they often rely on emergency services.

This project focuses on the challenges related to continuity of care for people experiencing homelessness and alcohol addiction within the health care system, in recognition of their complex health profiles. The project therefore builds a case for policy and program recommendations that enable provision of holistic, trauma-informed, and coordinated primary and specialized health care services to meet the complex health care needs of this population within the health care system. While this report addresses some aspects of availability of health care, it does not directly engage with overall availability of services, as this was determined to be out of scope.

The project also does not directly address options to improve the target population's housing outcomes, even though housing stability is a key factor in an individual's health outcomes, as well as being an important goal on its own. The omission of housing largely reflects that the question put forward by OBM focuses on health care, as well as the additional complexity that would result from analyzing the role of various institutions involved in the housing market (e.g. key government and civil society actors). While the recommendations that result from this project have been designed to improve the target population's health outcomes, whatever their housing challenges have been, it is also likely that interventions which stabilize their housing outcomes will have positive health effects associated with them.

As noted above, the project takes place in the context of a large-scale reform of the health care system planned by the Québec government, following the significant challenges experienced throughout the COVID-19 pandemic. The reform aims to address a number of pressure points but does not contain targeted interventions to improve health care services specifically for this population – potentially a missed opportunity for the government in better supporting the health care needs of individuals experiencing homelessness.

2.6 Harm Reduction and Managed Alcohol Programs

Harm reduction is an alternative approach that is regarded as one of the most important yet controversial innovations in health policy that seeks to reduce the harmful effects of stigmatized behaviors such as drug use and alcohol addiction.[22] It goes beyond abstinence approaches, to focus on reduction of the harms associated with drug use. Canada is experiencing a new era of harm reduction policy making and investment, albeit with inconsistencies in implementation

[22] Shannon Dea, "Toward a Philosophy of Harm Reduction," *Health Care Analysis* 28, no. 4 (2020): 302.

across the country. This disparity reflects Canada's decentralized federal structure, as well as historically variable federal support for harm reduction.[23]

Harm reduction accepts alternatives that reduce harm, and promotes low threshold access to services as an alternative to the traditional high threshold approaches.[24] With regard to severe alcohol addiction, a harm reduction approach ensures that alcohol consumption takes place in a stable, safe environment. Managed alcohol programs are an example of adopting a harm reduction approach to severe alcohol addiction, designed to stabilize individuals' drinking.

These harm reduction approaches remain difficult to access in Québec, especially among people experiencing homelessness and alcohol addiction. Recently however, there is an emerging interest in introducing harm reduction programs in Québec, specifically within shelters serving people experiencing homelessness in Montréal.

2.6.1 Managed Alcohol Program at Old Brewery Mission

OBM launched its pilot managed alcohol program to serve self-identifying men who live on a dedicated, supervised site in which they are served regular doses of alcohol. Alcohol management is provided by OBM based on clinical advice from the CIUSSS du Centre-Sud-de-l'Île-de-Montréal (CCSMTL) team. The managed alcohol program was launched in June 2022 at OBM, with the intention to serve up to 30 participants.

2.7 Methodology

Research and analysis was conducted, drawing on the relevant literature. Existing literature was reviewed to identify common themes around gaps and barriers in health care access for people experiencing homelessness, with complex health profiles, including alcohol addiction. More than 100 documents from academic journals, think tanks, government agencies, homelessness sector, and newspapers were reviewed. Some French-language material, generally from the Québec government or non-profit sources, was translated to English using the "DeepL Translator" software for further analyses. Most sources were focused on the health care system and homelessness in Québec due to its unique context, although the search was not limited to Québec only.

Alongside the literature review, 19 informants and stakeholders were interviewed (Appendix A) between January and June 2022. Stakeholders interviewed were homelessness researchers, advocates, practitioners, staff, and leaders in academia, the health care sector, homeless-serving sector, and government agencies. They had expertise, knowledge, and diverse views on current challenges and opportunities in the health care system for people experiencing homelessness and alcohol addiction. This report proposes five recommendations based on research, which were tested with some key informants through follow-up interviews.

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[23] Elaine Hyshka et. al., "Principles, Practice, and Policy Vacuums: Policy Actor Views on Provincial/Territorial Harm Reduction Policy in Canada." *International Journal of Drug Policy* 71 (2019): 143.
[24] Hyshka et. al., "Principles, Practice, and Policy Vacuums," 143.

2.8 Limitations

The interview and research process contained some notable gaps. The operations and policies of these health care institutions are very complex, and it was not realistic to identify and evaluate *all* pertinent policies. Although some Montréal-based stakeholders were interviewed, language barriers prevented discussions with some key stakeholders in the area. Interviewing people with lived experience of homelessness was also not possible, owing primarily to the difficulty involved in attaining the necessary ethical approvals.

The research was not narrowed down to, for example, a specific sub-population experiencing homelessness on the basis of gender identity, disability status, Indigenous heritage, or other factors. Despite Montréal's disproportionately large Indigenous population experiencing homelessness, solutions targeted for this population were not specifically considered, because they comprise a relatively small share of OBM's clients. The recommendations that result therefore do not provide particular guidance on how support might be provided on a sub-population basis.

2.9 Overview of Report

This report analyzes key barriers and challenges for people experiencing homelessness and alcohol addiction across the health care system, focusing on four substantive topics that were identified based on research and stakeholder interviews: emergency care, primary care, specialized care, and interactions with health human resources. People experiencing homelessness receive health care services from the public health care system and non-profit organizations (e.g. shelters). Discussion of the four substantive topics is framed around challenges in continuity of care for the target population. Recommendations are then discussed, including a list of implementation actions, and an overview of the expected costs and benefits for each, before a brief conclusion.

3.0 ANALYSIS OF THE HEALTH CARE SYSTEM

People experiencing homelessness and alcohol addiction face a number of major challenges and obstacles in the health care system, but one key challenge that appears to characterize their overall experience is a lack of continuity of care across the health care continuum. Despite their circumstances, individuals experiencing homelessness and alcohol addiction are often not provided targeted support in navigating the health care system to find services relevant to their needs, nor are they prioritized for access to care. As a result, individuals are faced with the challenge of navigating and circulating among various health care services, for different needs. Individuals experiencing homelessness already face persistent challenges in meeting their essential needs, such as shelter and adequate meals, which makes it even more challenging to seek out and access health care services. These factors contribute to a severely fragmented health care experience, in which continuity of care is nearly impossible to achieve.

The health care system itself appears ill-equipped to meet, let alone anticipate and adapt to, the unique needs of this population. Various challenges in accessing health care exist at each major contact point with the health care system – from primary care, to specialized care, to overall interactions with health human resources – resulting in a lack of *continuity of care* for this population overall.

To conceptualize the various types of continuity of care along the health care continuum, this report borrows and adapts the three major types of health care continuity identified in the literature:[25]

1. *Informational continuity*, which refers to documenting and transferring an individual's health information, including knowledge of their preferences and needs, across time and among providers
2. *Management continuity*, which refers to addressing health needs through a flexible, timely, and consistent continuum of services
3. *Relational continuity*, which refers to establishing ongoing and stable relationships between the individual and their health care providers

These types of continuity of care are closely connected, and come together to form a coherent health care experience.[26]

For the target population, these various types of continuity of care overlap and break down at multiple points within the health care system, resulting in overuse of emergency departments:

- *Primary care:* With limited access to primary care (e.g. family physicians), individuals experiencing homelessness often do not have a formal point of contact with the health care system, affecting all forms of continuity needed to address their complex needs. In particular, their health care information and needs are not grounded with a primary care practitioner (informational continuity) nor do they have opportunities to establish personal, trusting relationships with a primary care practitioner (relational continuity). These challenges subsequently impact how their overall health care needs are met from one provider to another (management continuity), including a limited ability to receive referrals to specialized care.

- *Specialized care:* The wide range of specialized services are challenging to access for people experiencing homelessness and alcohol addiction. The nature of the specialized care system itself, which is organized to address singular, specialized needs in isolation from an individual's broader health profile, presents a barrier to receiving care in a holistic manner (management continuity). In addition, the extent of overall health care information that is captured within the health care system is also inhibited by the design

[25] Robert Reid et. al., "Defusing the Confusion: Concepts and Measures of Continuity of Healthcare," *Canadian Health Services Research Foundation,* (2002): 4.
[26] Reid et. al., "Defusing the Confusion," 4.

of the specialized care system (informational continuity). Finally, limited relationships are established with health care providers (relational continuity).

- *Interactions with health human resources:* Stigmatization among staff and high staff turnover prevent individuals experiencing homelessness and alcohol addiction from building trusting, long-term relationships with health care providers (relational continuity), which subsequently impacts both informational and management continuity.

As a whole, breakdowns in continuity point to a systems-level problem – that is, the health care system is not well equipped to meet the complex, multi-faceted physical, mental, social, and alcohol management needs of this population. As a consequence, individuals instead rely on acute emergency services, often waiting until their health condition requires urgent attention. To improve health care access, there is a need to provide more targeted support and better adapt services to meet the needs of this population.

The subsequent sections of the report will outline why there is an over-reliance on emergency departments, followed by analysis of the major challenges and barriers that individuals are likely to experience in accessing care at each step within the health care system – primary care, specialized care, and interactions with health human resources – emphasizing in particular how continuity of care breaks down at each step, creating an overall health care experience that is severely fragmented.

3.1 EMERGENCY CARE

3.1.1 Introduction

The Canadian Association of Emergency Physicians (CAEP) defines emergency care as a field of medicine intended "for the timely evaluation, diagnosis, treatment and disposition of all patients with injury, illness and/or behavioural disorders requiring expeditious care."[27]

3.1.2 Examining Over-Reliance on Emergency Departments

Studies have shown that people experiencing homelessness have high rates of emergency department (ED) use, with rates sometimes reaching 3 to 4 times that of the general population.[28] This not only strains the health care system, but may point to broader systemic challenges, such as inadequate access to non-emergency health care services.[29] Among

[27] Canadian Association of Emergency Physicians, "Revised Position Statement on Emergency Medicine Definitions." Accessed July 6, 2022. https://caep.ca/wp-content/uploads/2017/07/revised_position_statement_on_emergency_medicine_definitions_10-may-2016.pdf.

[28] Margot B. Kushel et al., "Emergency Department Use among the Homeless and Marginally Housed: Results from a Community-Based Study," *American Journal of Public Health* 92, no. 5 (2002): 778. Gabet et. al., "Predictors of Emergency Department Use," 2.

[29] Kushel et. al., "Emergency Department Use Among the Homeless and Marginally Housed," 778.

populations experiencing homelessness, health care factors such as mental disorders and substance use disorders are associated with increased ED use.[30] In Québec specifically, one recent study found that substance use disorders and individuals' own perceptions of poor physical health (as a proxy of actual health conditions) are strong predictors of ED use.[31]

People experiencing homelessness tend to access EDs to address acute health needs, and in situations of crisis (e.g. overdose).[32] Because of their focus on such acute situations, EDs are not suited to the management of complex, ongoing health problems that people experiencing homelessness tend to exhibit. Primary and specialized care services are better placed to address these concerns. Studies have found that a range of factors may dissuade the target population from accessing health care services prior to their needs requiring urgent attention, including challenges in accessing primary care and stigmatization of people experiencing homelessness within the health care system, among others.[33]

As a result, individuals may instead resort to emergency services only when their needs become acute. High reliance on EDs, and the nature of short, episodic care provided in these settings, means that people experiencing homelessness are not able to establish sustained contact with the health care system, which means there is limited continuity with the broader health care system. The following three sections of this report will detail some of the issues in primary care, specialized care, and interactions with health human resources that contribute to this over-reliance.

3.2 PRIMARY CARE

3.2.1 Introduction

Primary care represents a patient's initial interaction with the health system for a given non-urgent health concern (with urgent concerns addressed in emergency departments). This interaction most often occurs with a physician, whether a family physician or physician at a walk-in clinic, or with a direct-access allied health professional such as a nurse practitioner. Primary care providers are well positioned to identify social contributors to poor health (for example, income and food insecurity) and connect patients to community-based services.[34] It is difficult even for people who are adequately housed to access primary care, and these difficulties are exacerbated when experiencing homelessness.

Primary health care serves a dual function in the health care system. The first function is the direct provision of frontline health care services. Several studies have shown that the provision and integration of primary care in the management of people experiencing homelessness

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[30] Gabet et. al., "Predictors of Emergency Department Use," 6.
[31] Gabet et. al., "Predictors of Emergency Department Use," 2.
[32] Alunni-Menichini, "Current Emergency Response," 7.
[33] Gabet et. al., "Predictors of Emergency Department Use," 6.
[34] Pottie et. al., "Clinical Guideline," 242.

improved the diagnosis and the treatment of chronic diseases, improved the care experience, and reduced both ED use and inpatient hospital admissions.[35]

The second function of primary care is coordination, which ensures continuity and movement across the health care system so that care remains integrated when specialized services are required.[36] All three forms of continuity of care: informational, management, and relational, begin at this "gateway" into the health care system. It therefore takes leadership among primary health care professionals to lay the groundwork for continuity, and as a result, ensure patients receive person-centred care along the health care continuum.

3.2.2 Barriers and Challenges in Accessing Primary Care

From the perspective of people experiencing homelessness, basic needs may take priority before overall health needs can be met. Their priority may also be finding their next drink; without it, seizures may result, which in extreme circumstances, may cause death. Severe alcohol addiction therefore requires services to help manage alcohol addiction, including the provision of detox services. Once basic needs are met, the central point of access in the health system for patients should be primary care. The target population most often does not have the knowledge or organizational skills, however, to independently seek, and attend, care along the health care continuum. Moreover, primary care services are not readily accessible for people experiencing homelessness without a number of resources, such as phone lines, internet, health cards, and transportation.

There are also particular challenges faced by the target population with respect to accessing family physicians. There is a shortage of family physicians in Québec, with long waitlists to be added to a family doctor's roster. People experiencing homelessness often do not have a family physician, and the odds of having a family physician decrease with the amount of time passed on the street, as documented by a study from Toronto.[37] As confirmed through a stakeholder interview, the application process to secure a family doctor requires that a person has a permanent address.[38] As a result of not being attached to a family physician's roster of patients, people experiencing homelessness do not have a touchpoint with the health care system and therefore lack management, informational, or relational continuity of care. In other words, as primary health care performs a critical gateway to specialized services, the lack of primary care access in and of itself limits access to specialized care.

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[35] David Joyce and Marjolaine Limbos, "Identification of Cognitive Impairment and Mental Illness in Elderly Homeless Men: Before and After Access to Primary Health Care," *Canadian Family Physician* 55, no. 11 (November 2009): 1110–1111. Thomas O'Toole et. al., "Applying the Chronic Care Model to Homeless Veterans: Effect of a Population Approach to Primary Care on Utilization and Clinical Outcomes," *American Journal of Public Health* 100, (Dec 2010): 2493.

[36] Health Canada. "About Primary Health Care." (August 2012). https://www.canada.ca/en/health-canada/services/primary-health-care/about-primary-health-care.html.

[37] Street Health. "The Street Health Report 2007," 4. https://www.streethealth.ca/downloads/the-street-health-report-2007.pdf. Erika Khandor et. al., "Access to Primary Health Care Among Homeless Adults in Toronto, Canada: Results from the Street Health Survey." *Open Med,* 5, *(*2011): 94.

[38] Interview, Social Worker, CHUM.

Another pressure point is that the fee-for-service health care model in Québec does not lend itself well to medically complex patients in primary care. Under this model, physicians are reimbursed according to the number of patients they see in a given period of time. Physicians are incentivized to see patients quickly, which is acceptable for simple patient interactions, such as a prescription renewal, but does not encourage the additional time to adequately assess a person's addiction and complex health profile. Part of the proposed Québec health care reform announced in the spring of 2022 involves a per-patient fee structure, rather than fee-for-service, which appears to be a solution for this problem. Under the proposal, a physician would receive a fixed payment for each patient registered with their practice regardless of what services, or quantity of services, the patient receives during a specified time period. Whether the proposal improves on the status quo will depend on the extent to which it actually improves the incentives on family doctors to see vulnerable patients. As an example of the proposal's potential unintended consequences, some physicians worry that it will discourage family doctors from taking on vulnerable patients with complex illnesses on their roster by "cherry-picking" healthier patients.[39]

3.2.3 Health Card-Related Challenges

A major structural challenge faced by the target population is a lack of personal identification, including health cards. Evidence shows that the main reason reported by people accessing services for personal identification replacement was that it had been either lost or stolen. This is particularly true for many people who are precariously housed or homeless.[40] In keeping with studies conducted elsewhere, research conducted in Montréal indicates that RAMQ cards (Québec's health card) may often be lost or stolen as the target population copes with homelessness.[41] Once lost, RAMQ cards generally require proof of identity and a fee in order to be renewed, creating a substantial barrier to accessing non-emergency care for members of the target population.[42]

Both the Government of Québec and organizations like OBM have put in place policies and practices designed to account for the realities of homelessness. OBM makes storage space available for its clients to reduce the risk of theft, and also scans a copy of their RAMQ card into their client database when a person experiencing homelessness presents for the first time. The Government of Québec has put in place a facilitative two-step process to simplify the process for

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[39] CBC News, "New Quebec Health Plan Promises Better Access to Care, Improved Working Conditions for Nurses." (March 2022) https://www.cbc.ca/news/canada/Montréal/health care-reforms-quebec-1.6400317.

[40] David J. T. Campbell et. al., "Primary Healthcare Needs and Barriers to Care among Calgary's Homeless Populations." *BMC Family Practice* 16, no. 1 (December 2015): 139. Stephen Hwang et. al. "Universal Health Insurance and Health Care Access for Homeless Persons." *American Journal of Public Health* 100, no. 8 (August 2010): 1455. Amy Blank Wilson. "It Takes ID to get ID: The New Identity Politics in Services." *Social Service Review* 83, no. 1 (March 2009): 119.

[41] Motta-Ochoa et. al., "A Place to be Safe," 6.

[42] Government of Québec, "Replace or correct a health insurance card," (2020) https://www.ramq.gouv.qc.ca/en/citizens/health-insurance/replace-correct-card.

replacing RAMQ cards for people experiencing homelessness.[43] Since 2017, this process allows people experiencing homelessness to have their identity and residence in Québec verified by a designated organization (such as a shelter) without charge, which reduces the burden for renewing a health card.[44] Under the relevant regulations, such a RAMQ card is valid for only one year for people experiencing homelessness (compared with the usual four to eight years), but stakeholder interviews suggested their validity could be as brief as six months or as long as two years.[45]

Though the provincial government's accommodations for people experiencing homelessness to more easily replace RAMQ cards help mitigate frequent theft or loss of cards, front-line health care workers interviewed nonetheless noted that RAMQ cards remain a significant barrier to receiving care. Even with the simplified two-step process, the risk of replacement cards being stolen remains a significant challenge. The only solution that appears not to have been attempted is to identify health care services that the target population could access without a RAMQ card, although the implementation challenges of this would be significant.

3.2.4 Primary Health Care Services in Montréal

Although people experiencing homelessness encounter a number of barriers in accessing primary care, there are various public, private, and not-for-profit primary health care services available in Montréal, some of which are tailored to the target population. The discussion that follows, though not exhaustive, outlines the primary health care services that the target population can access in Montréal.

In Québec as a whole, integrated health and social services centres (CISSS) and integrated university health and social services centres (CIUSSS) are intended to ensure accessibility, continuity and quality of services for people in their territory. At these centres, people experiencing homelessness can receive appropriate services, or be directed to another resource within the "territorial services network".[46] These centres are reference points where people can go if they are experiencing health concerns. At the CIUSSS, there are also "Homelessness Pivot Officer" roles (French: Agents Pivot en Iténerance du CIUSSS), who promote accessibility, quality and continuity of health care and services for people experiencing or at risk of homelessness. However, these roles are intended to engage with homeless-serving organizations and similar organizations rather than directly supporting members of the target population. A program called

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[43] Santé Montréal, "Travaux Régionaux en Itinérance: Information sur les Travaux Régionaux en Itinérance et sur des Sujets Connexes," (2022) https://santemontreal.qc.ca/professionnels/services-et-outils/travaux-regionaux-en-itinerance/.

[44] Santé Montréal, "Travaux Régionaux en Itinérance."

[45] Government of Québec, "Regulation A-29, r. 1.", *Legis Québec* (2022) https://www.legisquebec.gouv.qc.ca/en/document/cr/a-29,%20r.%201. Interview, Nurse clinician, CRDM; Interview, Social worker, CHUM

[46] Government of Québec, "Integrated Health and Social Services Centres (CISSS) and Integrated University Health and Social Services Centres (CIUSSS)," (2018) https://www.quebec.ca/en/health/health-system-and-services/service-organization/cisss-and-ciusss.

"Connexion" is also part of the CIUSSS' Mental Health and Addiction Program, and includes outreach services to connect people experiencing homelessness to care (e.g. a referral to Montréal's Jewish General Hospital for mental health care).[47]

Local community services centres (French acronym: CLSCs) offer an intake, assessment, counselling and referral service for requests of a social or psychological nature. CLSC des Faubourg, specifically, has a Homeless Assistance Team that helps provide services for the target population. Upon arrival at a CLSC, the target population may consult a psychosocial worker with or without an appointment.[48]

Medicins du Monde (MdM) in Montréal has a multidisciplinary team of nurses, social workers, and volunteer doctors who offer health care to marginalized populations, including migrants and people experiencing homelessness, who have no access to health care coverage. These health professionals provide care such as health assessments, the identification of high-risk pregnancies, and ensures prenatal and postnatal follow-ups.

OBM, specifically, offers their clients more specialized care, including the PRISM program for psychiatric disorders, and the newly implemented managed alcohol program. However, primary health care services are not formally offered in-shelter.

3.2.5 Conclusion

The challenges identified in accessing primary care contribute to the overall lack of continuity of care experienced by the target population within the health care system. To improve continuity of health care for people experiencing homelessness, particularly as they often present with complex needs, there is a need to improve access to primary health care. In particular, primary health care professionals can improve continuity of care in a multitude of ways: establishing relational continuity, through trusting and stable relationships with patients; serving as a contact point with the health care system to ensure informational continuity; and coordinating access to specialized services in the context of an overall health care plan with respect to management continuity. If primary care becomes more accommodative for the target population, the ED would no longer be the key resource for individuals that have unmet health care needs that progressively worsen due to the delay in accessing treatment.

[47] CIUSSS du Centre-Ouest-de-l'ile-de-Montréal, "No Home? No Problem for the Helping Hands of the Connexion Team,"(2022). https://ciusss360.ca/en/no-home-no-problem-for-the-helping-hands-of-the-connexion-team/
[48] Government of Québec, "Primary Care Health and Social Services" (2022). https://www.quebec.ca/en/health/health-system-and-services/service-organization/primary-care-health-and-social-services

3.3 SPECIALIZED CARE

3.3.1 Introduction

Specialized care is a step further along the health care continuum beyond primary care, and addresses more complex health problems, such as addictions. The system in Montréal is fragmented, presenting barriers to continuity of care. Particular difficulties arise in managing referrals, physically accessing services, and organizational policies that set a high threshold for the target population to meet. These difficulties make the system particularly ill-suited to the flexible, timely and consistent provision of care that is needed for management continuity, with respect to meeting overall health care needs.

3.3.2 Overview of Existing Specialized Care Programs and Services

Providing a comprehensive overview of Montréal's specialized care system is not possible in this report, given the complexity inherent in the nature of specialization. Stakeholder interviews and Montréal-focused research identified several themes and issues that appear to pervade the system, as it is experienced by the target population across multiple forms of specialized care.

The specialized care needs of the target population are diverse. Depending on individual needs and preferences, addiction services are among the most important services needed. According to Montréal's most recent Point in Time Count of people experiencing homelessness, addiction (whether alcohol or otherwise) was the most common individual-level reason reported for loss of stable housing.[49] While this suggests a clear need for addiction support and services, members of the target population often require other specialized services as well to treat co-occurring physical and mental health conditions. Mental health disorders and other types of addiction are particularly common. Physical health issues, like chronic inflammation of the digestive system, liver cirrhosis, pancreatitis, or head trauma arising from accidents, also require treatment.[50]

Montréal does have several addiction services for the target population. The CLSC Faubourg appears to be the only clinic offering integrated addiction and general health services for members of the target population. The Centre de Réadaptation en Dépendence de Montréal (CRDM) provides addiction support (including for alcohol), for the general population, as well as dedicated addiction programming for people experiencing homelessness which encompasses short-term housing support with the goal of controlling relapse, and providing a safe space to transition to longer-term support. While the CRDM provides its services in French, the Centre de

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[49] Latimer and Bordeleau, "Enumeration," 27.
[50] Fazel et. al., "The Health of Homeless People," 1534.

réadaptation en dépendance (CRD) provides English-language support for alcohol addiction in a similar manner adapted for the target population. Beyond dedicated addiction services, more intensive interventions for particularly high-needs patients are offered at hospitals, such as the CHUM. There is no centralized institution that provides a comprehensive range of addiction services.

Other specialized services that the target population often requires are counselling and psychiatric services. The CHUM in particular offers psychiatric services for patients with severe psychiatric conditions. However, there do not appear to be any hospital-based services dedicated for meeting the needs of people experiencing, or at risk of homelessness. These services are often not designed to account for accessibility needs of people experiencing homelessness, resulting in significant barriers to access that are often overlooked as they do not tend to present as barriers to the same extent for the rest of the general population.

Partly as a consequence, organizations like OBM are also increasingly providing health care services for people experiencing homelessness as a stopgap. In addition to managed alcohol programs, the most recent example of other specialized programs are PRISM programs, which are designed to treat severe mental illness in-shelter in a relatively lightly-regulated way that contrasts with other modes of in-patient treatment or shelter accommodation. It contrasts with the public service offering by being built around the existing routine of people experiencing homelessness. OBM offers a PRISM program, which is likewise offered in Montréal at other shelters, such as Accueil Bonneau and Welcome Hall Mission. PRISM is a relatively new program, having been established in Montréal in 2013, however, one qualitative study of 20 male participants indicated its low-threshold approach and fit within the shelter environment supported participants with their recovery.[51]

3.3.3 Weaknesses in the Current System

Although, as noted above, services addressing the key health care needs of the target population are present in Montréal, they are often provided in a manner that is not adapted to the needs of people experiencing homelessness. Particular aspects of service provision that appear to contribute to the lack of continuity of care are referral processes, thresholds that patients need to meet in order to receive care, and lack of physical accessibility.

Referrals and other processes by which patients pass from one institution to another in the system, such as appointments, constitute a barrier to access for many members of the target population. The primary mechanism to access specialized care is often through family physicians, which presents a barrier for people experiencing homelessness, who typically do not have this form of established contact with the health care system. In the absence of family physicians, people may resort to emergency departments instead, where they are often referred to specialized services. Regardless of the location from which referrals are made, the target

[51] Brigitte Voisard et. al., "Insights from Homeless Men about PRISM, an Innovative Shelter-Based Mental Health Service," *PLOS ONE* 16, no. 4 (April 22, 2021): 12-13.

population often presents with complex needs, which often require multiple referrals. Given the realities of experiencing homelessness, it is challenging to organize and attend referral appointments among multiple specialists. This decentralization of specialized services impedes continuity of care, as individuals circulate among various services, but are not likely to have their holistic needs addressed.

Referral issues in addiction services in Montréal appear to be particularly pronounced. A number of interviews highlighted challenges with respect to coordinating referrals.[52] An example is the potential for risk of confusion among health care staff regarding the most appropriate addiction centre to which to refer a particular patient.[53] Even in cases where an appropriate organization has been identified, patients experiencing homelessness appear vulnerable to stigma, as other providers view those patients as 'difficult.'[54] The lack of awareness of where to refer patients, alongside a limited number of addictions-focused organizations willing to accept patients, highlights the extent of difficulties in connecting patients to the appropriate addiction services.

In the case of patients who receive care from emergency shelters or other community providers, crossing the boundary from public to non-profit (i.e., private) providers also presents challenges as private providers do not receive the same extent of information about a patient's medical record that is available in the public system, through the Québec Health Record. Without complete access to medical records, shelters are limited in their capacity to provide health services. Discussions with OBM also highlighted that Québec's system of managing health information restricts private providers' access to a greater degree than that of other provinces.[55]

Physical accessibility can also exacerbate barriers associated with the referral process. People experiencing homelessness tend to experience greater challenges with mobility, and also tend to require multiple appointments in different parts of Montréal. Feedback from stakeholder interviews suggested that the referrals process is ill-adapted to the difficulties that arise from the combination of a large number of appointments to attend and limited mobility.[56] Where individuals have physical disabilities, service access can become harder still where the physical environment is insufficiently accommodating. CRD, for instance, is not built to enable wheelchair access.[57]

Moreover, organizational policies that establish high thresholds for accessing specialized care have been shown to discourage or prevent the target population from seeking care. In particular, one study of Montréal's health care response for substance users experiencing homelessness highlighted sobriety requirements and intrusive questionnaires, as barriers to access.[58] Sobriety

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[52] Interview, Nurse, Centre Anglophone de Réadaptation en Dépendance.
[53] Interview, Nurse, Centre Anglophone de Réadaptation en Dépendance.
[54] Interview, Nurse Clinician, CRDM.
[55] Interview, Executive Director, Medicins du Monde.
[56] Interview, Executive Director, Medicins du Monde; Interview, Nurse, Centre Anglophone de Réadaptation en Dépendance.
[57] Interview, Nurse, Centre Anglophone de Réadaptation en Dépendance.
[58] Alunni-Menichini, "Current Emergency Response," 7.

requirements in particular are typically reinforced in publicly-offered addiction services that are focused on abstinence from alcohol as the treatment method. These rules reflect policy choices about the parameters under which care is provided, and for the target population, they can sometimes render a service inaccessible. Interviews highlighted concrete examples consistent with the research, including prohibitions on bringing cellphones or pets, or limited service hours and constraints on entering and exiting the facility freely, as examples of rules of conduct that can pose barriers.[59] Some non-addiction services in Montréal, such as psychiatric services, were also noted to make sobriety a condition of access.[60]

Outpatient care presents another challenge, with a lack of follow-ups being experienced in terms of both care and medications. A recurring theme in stakeholder interviews were challenges associated with follow-up consultations, meaning patients do not get the ongoing care they need. For instance, after a seven-day inpatient detox at the CRDM there may be limited follow-up after discharge, increasing risk of relapsing into addiction as there is limited outpatient support after the inpatient stay.

3.3.4 Conclusion

In considering what a good system of specialized health care might look like, three key objectives stood out in research and stakeholder interviews:

- Care should be **holistic**, in that treatment for one condition should be informed by, and responsive to, other aspects of the patient's health profile. The patient should also not experience conflicting treatment or being 'passed around' the system. Referral processes currently present a barrier to achieving these aims.
- Care should be **easy to access**. While referral processes present a barrier to access, other eligibility thresholds in the system can effectively impede accessibility.
- Care should **not finish at the end of a specific appointment** or interaction with the system. The system should, but currently tends not to, work to follow-up and support the patient in meeting their goals.

The current system in Montréal appears to fall short of these goals, restricting continuity of care with respect to accessing a given service, with broader implications on accessing multiple specialized services, as these challenges multiply. This prevents people experiencing homelessness from seeking out specialized services, and increases reliance on emergency departments.

[59] Interview, Nurse, Centre Anglophone de Réadaptation en Dépendance.
[60] Interview, Social Worker, CHUM.

3.4 INTERACTIONS WITH HEALTH HUMAN RESOURCES

3.4.1 Introduction

Many physical and mental health disorders among people experiencing homelessness and alcohol addiction remain undiagnosed or inconsistently treated because of limited access to health services and missed opportunities for care. These challenges are multi-faceted, and can be exacerbated through stigmatizing, negative interactions and relationships with health care providers. This propagates mistrust of the health care system among people experiencing homelessness, and reduces relational continuity.[61] In addition to discriminatory staff attitudes towards this population, gaps in staff recruitment and retention also create barriers to accessing and utilizing health and social services within the health care system and in homeless-serving organizations (e.g. shelters), largely because long-term, trusting relationships are not established.[62] This hinders management continuity, as individuals are discouraged from seeking out health care services. Disparities in relational continuity for the target population compared to the general population disproportionately impacts their access to, and utilization of, health care, suggesting that the target population is at risk of serious inequalities in health outcomes.

Health human resources (HHR), including health care professionals, social workers, and case managers, engage directly with people experiencing homelessness and alcohol addiction in homeless-serving shelters and within the health care system to provide an array of social and health services. Specific challenges related to HHR that impact relational continuity of services include staff attitudinal concerns and staff recruitment and retention. As confirmed by stakeholder interviews, attitudinal concerns are comprised of, but not limited to, stigmatization and discriminatory attitudes among staff toward people experiencing homelessness, while staff recruitment and retention include staffing gaps and high staff turnover rates, both within the public health care system and the homeless-serving shelters.

3.4.2 HHR Interactions with People Experiencing Homelessness

The organization and delivery of care at the clinical level and within homeless-serving shelters is an important lever that can be used across primary and specialized care settings to enable more socially accountable care and more equitable health outcomes. Socially accountable care is inclusive care that reduces barriers for marginalized and underserved populations to access the support and care they need. Health care workers and homeless shelter case managers are integral HHR within the health care system, which needs to be organized in such a way that improves relational continuity and contributes to better health outcomes. With health care

[61] Pottie et. al., "Clinical Guideline," E240.
[62] Interview, Nurse Clinician, CRDM.

providers increasingly under pressure, and a growing number of patients living in precarious situations, there needs to be a shift in the organization and delivery of health care systems. This shift requires a nuanced understanding of problematic issues that result from, or are created by, discriminatory staff attitudes and gaps in staff recruitment and retention, as summarized below.

3.4.3 Staff Recruitment and Retention

Québec's health and social services system is a complex network made up of more than 1,600 facilities of different sizes and missions, nearly 4,000 community organizations, and hundreds of clinics. More than 300,000 workers deliver a variety of services to the general population, including people experiencing homelessness.[63] HHR recruitment and retention is therefore a critical component in ensuring continuity of care, particularly for vulnerable groups, such as people experiencing homelessness.

Challenges Facing Staff in Homeless-Serving and Health Care Sectors
The homeless-serving sector supports people experiencing homelessness, complementing, and often working collaboratively with, the public health care system. Staff in both the health care sector and homeless-serving sector encounter numerous challenges as a result of complex and intersecting issues spanning the systems-, organizational, and individual-level, which weakens relational continuity. The lack of trusting, stable relationships with health care providers presents a barrier to accessing health care for the target population which subsequently impedes continuity of care within the health care system more broadly.

System-Level

Factors at the systems level play a major role in creating challenges for frontline staff in both sectors. Funding is a significant factor that hinders the employment of staff in the health and homeless-serving sector. As a result of funding issues for instance, homeless-serving shelters are understaffed, and most health human resources in the sector are not paid a living wage. Organizations are therefore restricted in their ability to provide extensive support services for people experiencing homelessness and alcohol addiction.

Organization Level

Precarious employment in the health care and homeless-serving sector is a significant source of stress experienced by frontline workers, which may impede relational continuity. Precarious employment is defined as work that is unstable with uncertain remuneration, low wages, limited or no benefits and statutory entitlements, and non-standard employment.[64] A survey conducted by the Canadian Center for Policy Alternatives found 22% of skilled professionals with full-time

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[63] Government of Québec. "Changements nécessaires en santé."
[64] Trish Hennessy and Ricardo Tranjan. *No Safe Harbour: Precarious Work and Economic Insecurity among Skilled Professionals in Canada*. Canadian Centre for Policy Alternatives. 2018: 9.

positions across dozens of industries felt that their employment was precarious. This survey included workers in health, social and community services.[65]

High rates of staff turnover and understaffing are major causes of stress in the health care and homeless-serving sectors. Employees in these sectors may be committed to their work, but still tend to leave their jobs after only two years.[66] High rates of staff turnover are attributed to low wages, a lack of communication, trust, and opportunities for career development – issues that may impact employees' abilities to continue to work in the sectors.[67] Stakeholder interviews identified high staff turnover rate as impeding development of trusting relationships between people experiencing homelessness and staff, thus negatively impacting relational continuity.[68]

Increased workload and working long hours are prevalent in the health care system. Prior to the COVID-19 pandemic, the health care system was already experiencing an acute shortage of staff. The situation has been exacerbated by the pandemic, as a high number of frontline staff have taken leaves of absence. Québec's Ministry of Health and Social Services estimated that as of January 2022, more than 50,000 health care workers were absent.[69] Increased absenteeism requires extensive work reorganization, with the majority of staff experiencing a shift in their duties and increased workloads. Absences or unfilled positions are systematically covered by staff through overtime, which is mandatory in the Québec health care system. As a result, the proportion of time worked in overtime has increased by 5.4% from 2019-2020 to 2020-2021. However, the 2022 Québec government reforms propose to overhaul the overtime policy.[70]

Individual Level

Mental health challenges**,** including compassion fatigue, emotional exhaustion, depression, and disillusionment, are common among HHR in hospitals and in homeless shelters.[71] Compassion fatigue is characterized by both burnout and secondary traumatic stress (STS). Staff experiencing burnout on its own or as part of compassion fatigue may feel frustration, anger, depression, exhaustion, depersonalization with patients, and low self-efficacy.[72] STS is similar to post-traumatic stress disorder (PTSD) and can make workers feel anxious, fearful, experience intrusive

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[65] Hennessy and Tranjan, *No Safe Harbour*, 10.
[66] Vanessa Rios, "Frontline Workers: Urban Solutions for Developing a Sustainable Workforce in the Homeless Services Sector of Los Angeles County." PhD dissertation, Antioch University, Los Angeles, CA, 2016: 2
[67] Rios, "Frontline Workers,", 2.
[68] Interview, Nurse Clinician, CRDM.
[69] Government of Québec. "Changements nécessaires en santé."
[70] Government of Québec, "Changements nécessaires en santé."
[71] Justine Levesque et. al., "Understanding the Needs of Workers in the Homelessness Support Sector." (2021). https://www.homelesshub.ca/sites/default/files/attachments/HubSolutions-Understanding-Needs-Oct2021.pdf.
[72] Andy Reeve et. al., "A Brief Acceptance and Commitment Intervention for Work-Related Stress and Burnout Amongst Frontline Homelessness Staff: A Single Case Experimental Design Series." *Clinical Psychology & Psychotherapy* 28, no. 5 (2021): 1002.

reminders of traumatic events, have difficulty sleeping, and feelings of avoidance.[73] Similarly, workers experiencing disillusionment might feel disappointed with their jobs because the expectations of their job do not match the reality of their work. Also, disillusionment is a common challenge experienced by staff given that patient progress often occurs more slowly than anticipated.

Moreover, burnout and stress may result from supporting patients with past histories of trauma, who have a wide range of support needs. The various mental health challenges experienced by workers in this sector are often explained as vicarious trauma due to the constant exposure to traumatic events and client distress. People experiencing homelessness may be dealing with complex issues, such as untreated mental illnesses, substance use issues, or may find staff untrustworthy. Lack of trust makes it hard for workers to meet the expectations of their roles because patients are unwilling to accept help from them.

3.4.4 Staff Attitudes

Stakeholder interviews confirmed that there are discriminatory attitudes among staff toward the target population in the Montréal context. The target population regularly experiences barriers related to stigma and discrimination, and a lack of long-term relationships and trust towards the health care system.[74] As an example, psychiatrists may require people with alcohol addiction to return for psychiatric care once their addiction is under control, demonstrating limited understanding of, and empathy towards, addiction. Furthermore, people experiencing homelessness who present to EDs repeatedly may also be met with mixed reactions from ED staff, who may have made attempts to help them in the past.[75] Such discriminatory attitudes, stigma, and lack of trust negatively impact relational continuity.

Many studies reveal that people experiencing homelessness hold negative perceptions towards service providers due to past interactions from various settings in Montréal. These perceptions include:

- The perception that service providers do not understand them as they feel disrespected and judged because of their alcohol addiction, and for their past "mistakes" such as prior eviction, poor credit history, and criminal records.[76] Rude behaviours and disrespect from service providers may discourage people experiencing homelessness from wanting to seek out services.

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[73] Petrovich, James, Mary K. Twis, and Spencer Evans, "Practice with People Experiencing Homelessness: An Analysis of Secondary Traumatic Stress in the Workplace." *Journal of Social Distress and Homelessness* 30, no. 2 (2021): 117.

[74] Sabrina T. Wong et. al., "Enhancing Measurement of Primary Health Care Indicators Using an Equity Lens: An Ethnographic Study." *International Journal for Equity in Health* 10, no. 1 (2011): 10.

[75] Interview, Emergency Room Physician, St. Mary's Hospital.

[76] Brittany Sznajder-Murray and Natasha Slesnick. "'Don't Leave Me Hanging': Homeless Mothers' Perceptions of Service Providers." *Journal of Social Service Research* 37, no. 5 (2011): 462.

- The perception that service providers are not supportive of them in terms of navigating resources available, and that they do not care about them.[77]
- Fear of service providers among people experiencing homelessness is a barrier to communication, as they may withhold information about their health, particularly substance use.
- Negative service environments may not be welcoming to the target population as they may result in (re)traumatization and creation of feelings of powerlessness. Distrust of service providers may be a persistent barrier among the target population because of their histories of victimization.

3.4.5 Conclusion

How an intervention is delivered is critically important. For those experiencing homelessness and alcohol addiction, engagement with all forms of treatment or service can be particularly problematic due to HHR's judgmental attitudes and stigma.[78] The relationship between the target population and service providers may be crucial to their engagement and maintenance in health care intervention efforts. People experiencing homelessness perceive an environment to be positive if they have access to staff with lived experience of homelessness, alcohol addiction/substance use, or other relevant life events – who may then relate to them more effectively. Compassionate and non-judgmental attitudes within a positive and facilitative service environment may support the development of trusting and stable relationships between staff and people experiencing homelessness, thereby bolstering both relational and management continuity of care for this population.

3.5 SUMMARY

As a whole, people experiencing homelessness and alcohol addiction encounter various challenges in accessing health care, which leads to a lack of continuity of care across the health care system – in primary care, specialized care, and interactions with health human resources. This appears to stem from a systems-wide failure to properly adapt, and facilitate access to, health care services for the target population. This contributes to an over-reliance on emergency departments among the target population.

3.5.1 Primary Care

People experiencing homelessness often face numerous, persistent barriers in accessing primary care. This lack of access is a major breaking point in the health care system, as individuals often do not have a primary point of contact, particularly a family physician. This is often a consequence of multiple challenges and barriers, including frequent loss and theft of RAMQ cards, and the fee-for-service structure for physician remuneration. Lack of access to family physicians reduces

[77] James Petrovich et. al. "Practice with People," 117.
[78] Caitlin Wise and Kenneth Phillips, "Hearing the Silent Voices: Narratives of Health Care and Homelessness," *Issues in Mental Health Nursing* 34, no. 5 (2013): 360.

continuity of care by restricting broader access into the health care system, particularly with respect to specialized services.

3.5.2 Specialized Care

The design of specialized services, which address singular needs, present a barrier to addressing holistic healthcare needs for people experiencing homelessness. Moreover, the target population faces challenges in accessing specialized health care services in a manner that is adapted to their needs. This is particularly prevalent in the referrals process, physical inaccessibility of services, and organizational policies that impose high thresholds for access. As a result, individuals typically receive fragmented access to specialized care.

3.5.3 Interactions with Health Human Resources

People experiencing homelessness experience victimization, bias, and stigma along their health care trajectory, which produces poor outcomes and discourages further interaction with the health care system. Consequently, staffing gaps and large staff turnover rates within the health care system and in the homeless-serving sector, particularly among HHR serving the target population, is a major barrier to building long-term, trusting relationships. Discontinuity in forming relationships with HHR runs across the health care system and the homeless-serving sector, reducing access to health care services overall.

4.0 RECOMMENDATIONS

4.1 Continuity of Care within the Health Care System

The overarching theme of this project is continuity of care within the Québec health care system. There is a lack of an integrated, coordinated health care response for the target population, which leads to a high reliance on emergency rooms. A lack of health care services that are adapted to the unique needs of the population, including low-threshold services, contributes to the lack of continuity of care.

It is worth revisiting the significance of some of the research constraints outlined in the introduction. While a range of professionals with experience in homelessness and addiction services were interviewed, the number of people interviewed with experience working in those areas in Montréal was relatively small considering the number of institutions involved in this policy area. It was also not possible to interview people with lived experience of homelessness or addiction. As a result of constraints on the team's capacity to identify and evaluate relevant policies, and to hear from those who have experienced homelessness, this report's informational basis is incomplete. There will therefore be limitations with regard to how the proposed recommendations will align with the needs and preferences of people experiencing homelessness.

That said, the interviews and research conducted did raise a number of recurring themes that informed the focus on continuity of care, and the resulting recommendations. There is considerable flexibility available to OBM in the way in which it proceeds with the recommendations. Recognizing this report's informational basis, OBM should engage widely, and particularly with people experiencing homelessness, to gauge the impact of the proposed recommendations in improving access to health care and continuity of care overall, and make adjustments wherever necessary, to best align the proposed recommendations with the needs of people experiencing homelessness.

4.2 Recommendation Evaluation Criteria

The goal of the recommendations is to enhance continuity of care by increasing coordination within the health care system and improving access to health care services by increasing low-threshold, accessible services for people experiencing homelessness and alcohol addiction. The multifaceted nature of continuity of care for this population requires complex reform across a number of policy areas. Based on stakeholder interviews and research conducted, a list of potential programmatic and policy recommendations was drafted. Two criteria were used to evaluate recommendations:

- the impact on the target population if implemented successfully; and
- the likelihood of successful implementation.

The first criterion assessed to what extent the intervention, if implemented, would meaningfully reduce key continuity gaps and barriers identified in the target population's experience of the health care system. The second criterion assessed whether a proposed recommendation was feasible. It included the necessity and expected difficulty of the respective institution being able to implement it, the expected difficulty of OBM gaining support from partner organizations, the scale of technical challenges (e.g., medical or legal hurdles), or funding barriers. Guiding principles to prioritize recommendations included the strength of evidence, as well as the key principle in this field of meeting people experiencing homelessness "where they're at," meaning that instead of the vulnerable person having to adapt to the health care system, the system should, at least in part, adapt to their needs.

The expected costs and benefits of each recommendation are described. Because of the criteria's focus on the target population, the analysis does not consider financial benefits that may arise in the form of savings to the public health care system, arising from reduced reliance on emergency services. Partly, this omission reflects a lack of required expertise in a cost-benefit analysis of this kind. More fundamentally, it also reflects a belief that better health care for the target population is worth pursuing, whatever the financial cost. Up-front funding barriers were considered under the second criterion, where they might affect a recommendation's likelihood of successful implementation.

4.3 Policy and Program Recommendations

A foundational issue regarding what to recommend was the extent to which the public health system should be made responsible for fulfilling its mandate of truly universal health care as it relates to the target population (and other vulnerable populations), versus giving capacity to the voluntary sector to meet those needs in the absence of clear leadership from the public sector. Stakeholder interviews raised a range of views regarding the strengths and weaknesses of either option. Advantages of the former approach include the greater resources and the moral responsibility of government in making publicly funded resources accessible, and ensuring uptake among all segments of the population. Weaknesses include the inherent challenge of making a system as broad and complex as the health system work for everyone, and the fact that the system is far removed from the target population's needs.

A more practical challenge was the scope of the project, and the complexity involved with identifying the precise policy drivers behind gaps and barriers experienced by the target population. Particularly in the specialized but also in primary care services, some services may involve access barriers like sobriety requirements or barriers such as physical accessibility, which effectively prevent members of the target population from receiving care. Locating the precise policy levers to address each barrier is complex, and would involve looking across federal, provincial, and municipal jurisdictions. In addition, it would involve examining other substantive policy areas, given that barriers faced by the target population do not end with health policy.

Five recommendations were developed for OBM and its partners to address some of the service gaps with respect to the target population. Although the recommendations were developed with the target population in mind, they would generally be likely to support the health and wellbeing of other people experiencing homelessness with complex health profiles. This partly reflects the focus on policy and program solutions to the problem, but it also reflects the fact that a diversity of service offerings is needed given that each person's health profile is unique.

The recommendations are listed in order of prioritization, and would require action and buy-in from OBM and its partners, as well as from the health care sector. The recommendations include discussion of next steps OBM could take to implement them, which are presented separately in Appendix B, along with suggested timeframes and partner organizations.

Recommendation 1: Advocate for the Incorporation of Health System Navigators in Shelters and within the broader Public Health System

Health system navigation has emerged in the last few decades as a method to support patients with complex health care needs in understanding, and navigating, the health care system, thereby improving continuity of care. In the long term (three years or more), health system navigators are warranted to provide navigational support for local homeless-serving shelters. Navigators are warranted within the public health care system to assist with the complex health care planning needs of the target population and others with complex health profiles.

According to the available evidence, health system navigators show a great deal of promise in their capacity to have a positive impact on people experiencing homelessness. A key guiding principle for health system navigators, for example, is person-centredness, meaning that they meet clients 'where they're at' and take into consideration their preferences.[79] A scoping review of health system navigation for people experiencing homelessness found positive effects, including increased rates of screening, usage of and retention in care, improved relationships with primary care providers, and improvements in self-reported physical and mental health.[80]

There are several dimensions of effective health system navigation that would benefit the target population in Montréal. Shelters and the public health care system can prioritize which of the following functions should guide specific navigational needs:[81]

- **Connection:** working in collaboration with Montréal's health network, including the five CIUSSS locations and associated Homelessness Pivot Officers, navigators can effectively link the target population with primary care, specialized care, and community services.
- **Education:** while staying up-to-date with evolving health care services, health system navigators also provide education for their clients and other community service providers about how the health service system works, mental health and addiction symptoms, potential treatment modalities, and different treatment approaches.
- **Linkage facilitation:** Navigators may also support the service plan and client connection through reminders, transportation planning, or accompanying patients to their appointments. The precise methods of facilitation are likely to vary depending on a client's needs.
- **Follow-up:** Navigators follow-up with patients post-referral to determine if the patient successfully connected to the service. If necessary, the navigator may re-engage with the client to develop a more appropriate long-term care plan.

Among health professionals within Montréal hospitals, there is some lack of clarity, as corroborated through stakeholder interviews, about local addictions services, bolstering the need for health system navigators.[82] Stakeholder interviews suggested health system navigation is such a critical function that it may need to be a role in and of itself.[83] Nurses and social workers provide a great deal of navigational support, including visiting with case managers at OBM and providing support to clients on the streets where social workers know clients typically reside; however, their comparative advantage as social workers is in providing direct patient care.[84] Dedicated navigation roles can not only help to ensure navigators have sufficient time to establish expertise in navigating the health care system, but can help ease the workload of

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[79] J. Ellen Anderson and Susan C. Larke, "The Sooke Navigator Project: Using Community Resources and Research to Improve Local Service for Mental Health and Addictions," *Mental Health in Family Medicine* 6, (March 2009): 26.
[80] Christina Carmichael et al., "Exploring the Application of the Navigation Model with People Experiencing Homelessness: A Scoping Review." *Journal of Social Distress and Homelessness*, January 9, 2022, 8.
[81] Anderson and Larke, "Sooke Navigator," 26.
[82] Interview, Nurse, Centre Anglophone de Réadaptation en Dépendance.
[83] Interview, Nurse, Centre Anglophone de Réadaptation en Dépendance; Interview, Social Worker, CHUM.
[84] Interview, Social Worker, CHUM.

nurses, social workers, and case managers, who will have greater capacity to perform their core patient care duties.

Recognizing that navigators would likely engage directly with people experiencing homelessness, consideration could be given to ‘peer navigators’, who have lived experience of homelesness and/or alcohol addiction, to increase trust and facilitate relationship building with patients.[85] Similarly, considering Montréal’s Indigenous homeless population, there is likewise merit in hiring Indigenous navigators, to ensure support is provided in a manner that is sensitive to the needs of Indigeneous peoples.

It is recommended that OBM:

- *Create a health system navigator role at OBM*. In order to support the target population navigate their complex health care needs, OBM, in the short term, could create the position for, and hire, a health system navigator within the shelter. This role would involve close collaboration with OBM case managers, who currently support clients in managing both health care and housing needs. A navigator would serve as a resource for case managers with respect to the health care system. As Homelessness Pivot Officers at the CIUSSS locations do not directly interact with the target population but with shelters themselves, the navigator could liaise with these officers on behalf of the target population and develop strong working relationships with health care institutions, including local hospitals, for example.

- *Create a health system referral strategy.* Also, in the short term, it is recommended that OBM collaborate with the CIUSSS network, including the Homelessness Pivot Officers at CIUSSS, the CLSCs, as well as relevant specialized service providers (e.g. addiction services) to create a health care referral strategy. This would entail working with the public health services to map out existing health care services, and explore ways to more efficiently connect individuals with health care services (e.g. expedited referrals). The strategy could be created and implemented by the health system navigator.

- *Create a peer support network.* In the short term, OBM could create a peer support network of current or former OBM clients who have struggled with alcohol addiction. OBM could also consider hiring a formal and paid coordinator position for this peer support network. Similar to other shelters in Canada, these peer supporters could collaborate with the health system navigators and perform certain tasks, such as helping to transport, or coordinate transport, for clients to attend health-related appointments.[86] Members of this peer support network may also serve as a resource for OBM’s health system navigator, providing additional lived experience perspectives as needed to help the navigator best fulfill their role.

[85] Carmichael et. al., “Exploring the Application,” 8.
[86] Interview, Social Work Student, Shepherds of Good Hope.

It is recommended that OBM <u>advocate</u> for:

- *The implementation of health system navigators within the publicly funded health system,* in the long term. These navigators, based in Montréal hospitals, would support the target population, as well as other populations with complex health care planning needs. Due to their complex health profile and difficulties with attending appointments, the target population will likely require a greater intensity of navigational support in comparison to the stably housed population. Social workers and health professionals could delegate to navigators on their team to ensure patients have the tools and resources they need to understand, attend, and participate in care. The public health system navigators could develop strong relationships with OBM's health system navigator to help provide linkage of services. Recommendation two involves the design and implementation of a pilot integrated community clinic that offers largely primary health care for people experiencing homelessness; at this proposed clinic, a health system navigator will aim to ensure continuity of care for the target population.

Cost-benefit considerations:

The main cost of this recommendation is the salaries of health system navigators. The median health navigator salary is $44,246 in Montréal.[87] A potential risk involved is if navigators are not well connected within the overall health care system, they may not help address the fragmentation within the health system. Members of the target population would re-tell their story during health meetings, which may bring up past traumas and risk them being disconnected from the care they need. Ensuring that navigators are well-trained and have knowledge of Montréal's unique context can help avoid this risk. Regarding benefits, health system navigation can help address health problems in a timely manner, thus preventing health concerns from becoming chronic in nature. It also promotes a positive patient experience and frees up valuable time of nurses and social workers within the health system itself, who often spend hours on the phone trying to link their patients to local health services, such as detox programs.

<u>Recommendation 2: Pilot an Integrated Community Clinic Targeted for People Experiencing Homelessness in Partnership with the Public System</u>

People experiencing homelessness often cycle among various health care institutions and the services and support they receive are often not enough to meet their needs. The wide-ranging set of reforms announced by the Government of Québec in April 2022 to address challenges facing the health system, however, paid minimal attention to the plight of people experiencing homelessness regarding access and continuity of health care.

OBM has broad experience working with people experiencing homelessness and alcohol addiction, but currently lacks sufficient capacity to provide more in-shelter primary and specialized care services. It also does not have enough resources to serve this population through health outreach services. The capacity gaps that exist not only at OBM, but also in the wider

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[87] Monster.ca. "Patient Advocate / Navigator Salary Estimate in Montreal, Quebec," 2022, Accessed July 6, 2022. https://www.monster.ca/salary/q-patient-advocate-navigator-l-Montréal-quebec.

homeless-serving sector, coupled with a lack of prioritization of the specific health needs of people experiencing homelessness through policy or service provision at the public health system level, have created gaps that hinder access to, and continuity of care for this population. These gaps can be filled by targeted intersectoral collaborative efforts involving a partnership model between OBM and other shelters, not-for-profit organizations, and the public health care system, to advance the common goal of improving access to, and continuity of, care for this population.

It is recommended that OBM should advocate for the public health care system to:

- Pilot the design and implementation of a bilingual, low-cost and integrated community clinic that offers primary health care, and potentially some degree of specialized health care services, for people experiencing homelessness in downtown Montréal in partnership with the public system.

This dedicated clinic should be operated by the public medical institutions, such as McGill University Health Care or Centre hospitalier de l'Université de Montréal (CHUM) in partnership with OBM and other homeless-serving shelters. Health care services should be designed to meet the primary, and potentially some specialized health care needs of people experiencing homelessness. Coordination to external services could be provided by health system navigators, who would likewise be located at the clinic, in addition to public health care system and homeless-serving shelters. The clinic's service offering would not have to stop at primary care, but physical space and other logistical factors may constrain the number of some specialized services that could be offered. Experience in British Columbia, in particular, shows that non-primary care services such as pharmacy and dental care can in some cases be offered in a community setting (albeit with different policies around the provision of voluntary sector care).

The proposed location of this clinic is downtown Montréal, which is near to OBM and other shelters and would significantly reduce geographical barriers related to access and continuity of care for the target population. The public health care system should ensure the clinic is staffed appropriately with physicians, clinical nurses, a public health system navigator, and other health care and non-medical staff, as well as fund physical infrastructure and medical equipment. OBM and other shelters are the established point of contact with people experiencing homelessness, and therefore have insight into their health care needs, and can provide meaningful input, and advocate for, the services offered at the facility.

Cost-benefit considerations:

Building and equipping the new clinic would be costly for the government. Furthermore, dedicating some health human resources to serve people experiencing homelessness at the clinic would mean taking resources away from the public health care system that serves the general population. However, a collaborative partnership is beneficial in many ways. It would enable increased interaction between homeless-serving shelters and the public health care system, with the goal of designing services to meet the needs of people experiencing homelessness. Establishing this clinic would ensure that people experiencing homelessness have a reliable source of health care to meet their overall needs, rather than navigating across various services,

often facing barriers to access and continuity, as is the case in the current system. This would further ensure the public system better adapts to the needs of this population.

<u>Recommendation 3: Offer Training on Trauma-Informed, Person-Centred Care for all Staff interacting with People Experiencing Homelessness</u>

To ensure that HHR, including health system navigators, and frontline workers have the skills to meet the needs of the target population, education and training resources should be provided on trauma-informed care, person-centred care, and other pertinent topics. Trauma-informed care has been shown to be helpful in encounters with patients who are experiencing homelessness. It is an important approach to help patients gain a sense of safety and trust in the clinical encounter, to limit stigma and other barriers the target population experiences in accessing health care services, and to ensure continuity of care. In addition, person-centred care includes essential skills for HHR, including interpersonal skills (teamwork, and leadership); conflict resolution skills; and creativity and openness when working with people experiencing homelessness and other vulnerable people.

Trauma-informed care provides a safe space within which to offer a wide range of support services in a coordinated and ongoing way, and can be used as a universal approach to better caring for people experiencing homelessness with alcohol addiction, providing them with greater choice and control over their own continuity of care. It acknowledges the need to understand a patient's life experiences in order to deliver effective care and has the potential to improve patient engagement, treatment adherence, health outcomes, and provider wellness.

Furthermore, as recommendation one is the implementation of health system navigation for Montréal homeless-serving shelters and the health care system, it is critical that HHR gain access to educational resources and/or training on health system navigation. Some HHR professionals may not be aware of what health system navigator roles fulfill within an organization, and may even be resistant to collaborating with navigators within health care teams. In addition to trauma-informed and person-centred care-related training, it is therefore important that training be provided about health system navigation and the critical importance of the navigator role to address vulnerable populations and their complex health needs.

It is recommended that both OBM and the Public Health Care System:

- *Explore opportunities to offer effective training on trauma-informed, person-centred care* for all staff in public health care organizations and homeless-serving organizations annually, and during staff onboarding. Outcome measures to evaluate attitudinal changes may also be warranted.

Cost-benefit considerations:

Trauma-informed services within both primary and specialized are provided in a welcoming and appropriate manner to address the special needs of those affected by trauma. However, training on trauma-informed care may not automatically lead to positive staff attitudes and trusting relationships between staff and their clientele. Due to continuity of care challenges within the

public health care system, people experiencing homelessness may still have to retell their life story and medical history repeatedly, even if HHR are well trained. The training itself might also be expensive regardless of the level at which it is implemented. Despite these uncertainties, training on trauma-informed care has been favoured by stakeholder interviews as a relatively impactful recommendation in addressing staff discriminatory attitudes toward people experiencing homelessness. OBM and its partners may therefore advocate for provision of training resources by the public health care system for its HHR.

Recommendation 4: Advocate for Greater Availability of Low-Threshold Services

Across the health care system, and particularly in the context of specialized care services, there are a number of conditions for entry into the service itself that present barriers to access for the target population. With respect to alcohol addiction and other specialized services, the requirement to abstain can present a nearly insurmountable barrier to access for the target population. In addition, other barriers, such as hours of access, prohibitions on bringing cellphones or pets, or being allowed to enter and exit the facility freely, can further prevent substance users experiencing homelessness from using addiction and other specialized services.[88]

While each of these restrictions could be justified on the grounds that they improve acceptability of the service for patients, they can also restrict access for the target population. Low-threshold services, which make minimal demands on the patient, provide an alternative approach aimed at increasing the acceptability of a service.[89]

It is recommended that OBM advocate for:

- *Improved availability of low-threshold services,* in the long term. While requirements around sobriety are one candidate, OBM should challenge the system to identify as many rules as possible that could be changed or amended for the target population, recognizing the importance of adapting services to their needs.

Cost-benefit considerations

The primary benefit from increasing availability of low-threshold services comes from increased flexibility for the target population about the conditions under which they receive care and/or where they receive care. Adapting services to ensure people experiencing homelessness could be confident that they would not be turned away, increases accessibility of services for members of the target population. The main direct costs of this recommendation – both in funding and in time – would depend significantly on the nature and extent of services to be amended or provided, and the staff and facilities required.

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[88] Alunni-Menichini "Current Emergency Response," 5-6.

[89] Alberta Health Services, "Harm Reduction: Low-Threshold Services."(2019). Accessed July 6, 2022. https://www.albertahealthservices.ca/assets/info/hrs/if-hrs-low-threshold-services.pdf.

Recommendation 5: Review the Wider Policy Settings Affecting the Health System

In addition to the programmatic recommendations identified above, the research and interviews undertaken highlighted several policy areas that appear to warrant reform over and above what is currently on the Government of Québec's agenda.

A review of policies is therefore recommended**,** focusing on operational policies and institutional barriers that impede the health system's ability to serve this population. This review should be jointly led by OBM and other homeless-serving organizations, the provincial government, health providers, and people with lived experience of homelessness. Consultation with relevant stakeholder groups would also be needed.

It is recommended that OBM advocate for, and participate in, a review of policies, focusing on the following topics of priority:

- ***Institutions and points of access to the system.*** There is an opportunity to improve both the number and accessibility of services that the target population can access. Potential policies here include:
    - Location and physical accessibility of services, in view of the target population's limited mobility. The integrated community clinic would help lessen the severity of this issue, but it would remain a significant barrier within existing health care services for the target population.
    - Whether to offer a centralized health care institution for addictions (alcohol and potentially other addictions) by one organization, for all levels of severity, as proposed during a stakeholder interview. This would eliminate confusion about where to refer patients seeking treatment for addiction, but would require careful design to ensure the range of services necessary to meet the needs of the target population are available.[90]

- ***Regulatory options****.* This involves looking at rules that inhibit who can access care, and under what conditions, over and above the improvements expected from the recommendations around an integrated community clinic and other low-threshold services. Examples are:
    - Whether potential exemptions to RAMQ card requirements are warranted for people experiencing homelessness. If such exemptions are expected to be infeasible, alternative options could include extending the validity of RAMQ cards reissued to people experiencing homelessness beyond the current 6 to 24 months, or investigating other solutions to reduce the risk of theft.
    - Options to improve information-sharing between public and private health providers, which appears to be a constraint to receiving care for patients who go to shelters.

[90] Interview, Nurse Clinician, Centre Anglophone de Réadaptation en Dépendance.

- ***Funding and incentives.*** Options for improving the system's ability to serve the target population in this area include:
    - Finding an alternative to the fee-for-service model for family doctors that encourages them to take on (and provide adequate treatment to) members of the target population. This should include ensuring that the fee-per-patient model proposed as part of the 2022 Quebec health care reform, if adopted, does not create the unintended consequence of dissuading physicians from accepting members of the target population.
    - Improved wages and benefits for health care staff. Retention, turnover, and precarious employment appear to be reducing the extent to which trusting relationships can be built between staff and the target population, and are attributed in part to inadequate wages and benefits.

4.4 Options Considered but Not Recommended

The provision of health outreach services to the streets, and provision of more primary health services in-shelter were considered, but not recommended. In their place, the recommendation regarding an integrated community clinic was developed, which appears to be a more innovative and potentially meaningful way of OBM collaborating with its public-sector partners to deliver services. Outreach services are underpinned by the principle of 'meeting people where they're at' and reducing geographical access barriers for people experiencing homelessness. Although it guarantees access to some programs and services, such a model is unable to provide a wide array of health services to people experiencing homelessness due to lack of space and high costs of operations and medical equipment. Health outreach services are also already provided by organizations such as Médecins du Monde (MdM) and Connexion.

The provision of more primary health services in-shelter fronts a "fixed outreach site" approach which helps address geographical barriers to care, as people experiencing homelessness do not need to travel to appointments outside of the shelter environment.[91] In-shelter care has the potential to address the health care needs of people experiencing homelessness in a timely manner, and presents less disruption to their day-to-day activities. However, provision of more in-shelter care was not recommended because OBM already provides it through a collaboration with other clinics such as the CLSC des Faubourgs. The expansion of specialized care at OBM was also not recommended as it would not make a measurable difference over and above the current PRISM program's offering with respect to mental health. Finally, some stakeholder interviews also highlighted that specialized physical health services also tend to be impractical to offer in a shelter environment.[92]

[91] Danalyn Byng, "Homelessness and Access to Health Care: Policy Options and Considerations" *Healthy Dialogue* 1, no. 1 (September 4, 2012): 3.
[92] Interview, Executive Director, Medicins du Monde.

With respect to RAMQ cards, the option of implementing a mechanism to store RAMQ cards at OBM was considered, with the objective of preventing theft and loss. In particular, it was explored whether OBM could establish a personal identification (PID) bank for its clients, providing them a safe and secure location to store personal documents, which could be accessed by clients when needed.[93] However, this option was not pursued because OBM already provides individual lockers for clients where they can store their belongings, including RAMQ cards, and OBM keeps scanned copies of its clients' RAMQ cards on its client database.

5.0 CONCLUSION

Homelessness is a systemic policy failure. It intersects with many different areas of a person's life, and thereby requires concerted action over a number of policy areas to resolve at a system-wide level. This report highlights health care as one such area, with a particular focus on alcohol addiction. The interactions of people experiencing homelessness with the health care system are characterized by a lack of continuity of care, due in large part to the system's inability to adapt services to meet their needs.

One of the major challenges in providing advice with respect to health care for the target population was the immense underlying complexity. Health conditions, like many other issues, can worsen if left unattended and the best time, or type, of intervention is not always obvious until it is too late. Providing advice on the issue also poses a challenge with judging how much to accept and work within the current system to achieve more equitable outcomes, and how much to point out that that system is fundamentally inequitable. These are just some of the complexities that came up in the course of the project.

At its most basic level, however, the key thing that is missing is a simple one: desire to act, particularly on the part of governments. Whether it is public sector budgets, siloed thinking in the system, or a political judgement that homelessness (or addiction) are moral failings that are not 'worth' further investment, health system settings appear to reflect the widespread misunderstanding of homelessness and addiction. Community organizations like OBM have been active in this space pushing for more support alongside partners inside and outside all levels of government, but the range of different needs at the population and individual level is truly expansive. The recommendations in this brief will hopefully provide some options for doing better by people experiencing homelessness and alcohol addiction.

[93] Chris Sanders et. al., "'You Need ID to Get ID': A Scoping Review of Personal Identification as a Barrier to and Facilitator of the Social Determinants of Health in North America." *International Journal of Environmental Research and Public Health* 17, no. 12 (January 2020): 4227.

Appendix A: Stakeholder Interviews

The following stakeholder interviews were completed to help inform this report:

#	Role and Organization	Interview Date
1	Associate Professor, Department of Family Medicine, McGill University	Feb 22, 2022
2	Staff, Projets Autochtones du Québec	Feb 25, 2022
3	Scientist, Associate Director, University of Victoria	Feb 25, 2022
4	Associate Professor, Faculty of Arts, School of Social Work, McGill University	Mar 4, 2022
5	Staff, Old Brewery Mission	Mar 9, 2022
6	Staff, Old Brewery Mission	Mar 10, 2022
7	Physician, Notre Dame Hospital (Montréal)	Mar 11, 2022
8	Professor Emeritus, Department of Psychiatry, McGill University	Mar 16, 2022
9	Professor, Department of Psychiatry, McGill University	Mar 17, 2022
10	Social Work Student, Shepherds of Good Hope	Mar 17, 2022
11	Professor, Max Bell School of Public Policy	Mar 18, 2022
12	Professor, UQAM, University of Québec	Mar 21, 2022
13	Nurse Clinician, Centre de Réadaptation en Dépendence de Montréal (CRDM)	Mar 23, 2022
14	Emergency Physician, The Montréal General Hospital	Mar 30, 2022

15	Lawyer, CIUSSS	Mar 31, 2022
16	Addictions Medicine Physician, CISSS	June 8, 2022
17	Nurse, Centre Anglophone de Réadaptation en Dépendance (works out of St. Mary’s Hospital)	June 9, 2022
18	Executive Director, Medicins du Monde	June 13, 2022
19	Social Worker, CHUM	June 13, 2022

Appendix B: Implementation Plan

The objective of this appendix is to provide a concrete implementation plan for the recommendations outlined in the report. Each recommendation is broken down into specific actions, with indicative timelines and partners to engage for each. Timelines proposed have been categorized as short-term (defined as up to one year), medium term (one to three years), or long-term (three or more years).

<table>
<tr><td colspan="4">Recommendation 1: Advocate for the Incorporation of Health System Navigators in Shelters and within the Broader Public Health System
Impacts:
● Assists with the complex health care planning needs of the target population
● Provides advice on addressing health problems in a timely manner, preventing health concerns from becoming chronic
● Promotes a positive patient experience and frees up valuable time of staff within the health system</td></tr>
<tr><td>Intervention</td><td>Activities</td><td>Timelines</td><td>Partners</td></tr>
<tr><td rowspan="2">Create a health system navigator role at OBM</td><td>Create position & job description for the role, with consideration given to ‘peer navigators’ (people with lived experience of homelessness and/or former alcohol addiction)</td><td>Short-term</td><td rowspan="2">Public Health Care System (GPs, Physicians, Nurses etc.), Health Care Professional Associations, Homelessness Pivot Officers at CIUSSS locations, Other Shelters</td></tr>
<tr><td>Interview and hire a health system navigator in the shelter</td><td>Short-term</td></tr>
<tr><td rowspan="3">Create a health system referral strategy at OBM</td><td>Map out existing health care services</td><td rowspan="2">Short-term</td><td rowspan="3">Public Health Care System, Homelessness Pivot Officers at CIUSSS locations, Other Shelters</td></tr>
<tr><td>Research the general referral landscape in Montréal</td></tr>
<tr><td>OBM health system navigator to design and implement the referral strategy</td><td>Short-term</td></tr>
<tr><td>Create a peer support network at OBM</td><td>Coordinate a group of current/former OBM clients who have struggled with alcohol addiction into a network (this network can help coordinate transport for clients to and from health appointments)</td><td>Short-term</td><td>Local community, Specialized Addiction Centres</td></tr>
<tr><td rowspan="3">Advocate for the implementation of health system navigators within the publicly funded health system</td><td>Review existing gaps in referral processes of the public health care system</td><td rowspan="2">Short-term</td><td rowspan="3">External Policy Experts and Think Tanks, Local Universities based in Montréal (e.g., McGill University), Other Shelters, Health Care Professionals, Health Care Professional Associations</td></tr>
<tr><td>Design advocacy plan</td></tr>
<tr><td>Conduct advocacy and lobbying efforts to influence creation of health system navigation role</td><td>Ongoing, long-term</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">Recommendation 2: Pilot Integrated Community Clinic Targeted for People Experiencing Homelessness in Partnership with the Public System.
Impacts:
● Increase interaction between homeless-serving shelters and the public health care system</td></tr>
</table>

- Provision of a reliable source of health care to meet overall needs of target population, Centralized provision of health care services are better adapted to the needs of people experiencing homelessness

Intervention	Activities	Timelines	Partners
Advocate for the public health care system to pilot the design and implementation of a bilingual, low-cost and integrated community clinic that offers primary health care, and potentially some degree of specialized health care services, for people experiencing homelessness in downtown Montréal	Assess gaps in health service provision for people experiencing homelessness	Short-term	Public medical institutions such as McGill University Health Care or Centre hospitalier de l'Université de Montréal (CHUM), Homeless-Serving Shelters, Government of Québec, Canadian Medical Association, Think Tanks
	Establish and/or facilitate multisectoral collaborative model of care for people experiencing homelessness, involving government and homeless-serving shelters	Medium-term	
	Advocate for the design and implementation of the pilot integrated health care space within the public health care system, and lobby for its funding from government	Long-term	

Recommendation 3: Offer Training on Trauma-Informed, Person-Centred Care for all Staff Interacting with People Experiencing Homelessness

Impacts:

- Provide training to ensure health human resources can engage in a positive and open manner toward people experiencing homelessness
- Patients gain a sense of safety, and develop long-lasting and trusting relationships with health human resources
- Trauma-informed and person-centred care provide a safe space within which to offer a wide range of support services in a coordinated way

Intervention	Activities	Timelines	Partners
OBM (and other shelters) and the public health care system to offer effective training on trauma-informed, person-centred care for all staff	Develop trauma-informed care training manual in collaboration with instructors and train all staff at OBM annually	Medium-term	Public medical institutions such as McGill University Health Care, Other universities in Montréal, Other Homeless-Serving Shelters
	Partner with instructors in medical faculties in local universities to offer annual trauma-informed training in the public health care system - alongside other existing courses	Long-term	

Recommendation 4: Advocate for Greater Availability of Low-Threshold Services

Impacts:

- Reduce barriers to access within addiction and specialized care for the target population
- Complement existing services with flexible services that improve accessibility for the target population

Intervention	Activities	Timelines	Partners
Advocate for improved availability	Review existing policies regulating provision of addiction and specialized health care services, including sobriety requirements	Short-term	Government of Québec, City of Montréal, External Policy Experts and Think Tanks, Local

<table>
<tr><td>of low-threshold services</td><td>Develop and implement an advocacy plan, & engage in advocacy efforts for the public system to progressively provide low-threshold services for the target population</td><td>Medium-term</td><td>Universities based in Montréal, Other Shelters, Health Care Professionals, Health Care Professional Associations</td></tr>
<tr><td colspan="4">Recommendation 5: Review the Wider Policy Settings Affecting the Health System</td></tr>
<tr><td>Intervention</td><td>Activities</td><td>Timelines</td><td>Partners</td></tr>
<tr><td rowspan="2">Advocate for, and participate in, a review of policies, focusing on institutions of access to the system, regulatory options, and funding and incentives</td><td>Institute policy review processes, including conducting research, to understand existing policies in the prioritized areas and establish policy gaps</td><td>Medium-term</td><td rowspan="2">Government of Québec, City of Montréal, External Policy Experts and Think Tanks, Local Universities, Other Shelters, Health Care Professional Associations</td></tr>
<tr><td>Coordinate multisectoral collaboration to present findings and advocate for policy changes to better respond to the needs of people experiencing homelessness</td><td>Long-term</td></tr>
</table>

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