MARCO Brief Report

COVID-19 Isolation and Recovery Sites Evaluation

November 2021

MAP Centre for Urban Health Solutions
UNITY HEALTH TORONTO
UNIVERSITY OF TORONTO

About the MARCO Study

The MARCO project is evaluating how local efforts responding to the COVID-19 pandemic serve people experiencing marginalization, and how these interventions can be improved. Changes in society to control the pandemic have affected everyone, but they place a particularly heavy burden on people who are marginalized.

We evaluated programs that support many communities who may be experiencing marginalization during COVID-19, including people experiencing homelessness, people with developmental disabilities, people who use drugs, and women who are experiencing violence. The MARCO Community Committee and Steering Committee chose the programs. The programs include:

- COVID-19 Isolation and Recovery Sites (CIRS)
- Encampment Outreach
- Substance Use Service (SUS) at the COVID-19 Isolation and Recovery Site
- Toronto Developmental Service Alliance's Sector Pandemic Planning Initiative (SPPI)
- Violence Against Women (VAW) Services

About this Report

This report is a brief summary of one of the MARCO Evaluations. This report highlights the key findings of the CIRS evaluation. The final, full length report will be released in December 2021.

The views contained in this report do not necessarily express the views of any MARCO community partner, funding agencies, MAP, St. Michael's Hospital, Unity Health Toronto, the University of Toronto, or any other organization with which MARCO authors or project team members may be affiliated.

Suggested Citation

Firestone M, Bayoumi AM, Steer L, and Khoee K (Co-lead authors), Akaehomhen A, Lee Soh B, Holness L, Nisenbaum R, Schlosser L, Beder M, Boozary A, Hwang S, Kolla G, Mohamed A, O'Campo P, Pariseau T. MARCO COVID-19 Isolation and Recovery Sites Evaluation Brief Report. Toronto, Ontario: MAP Centre for Urban Health Solutions, St. Michael's Hospital. November, 2021. Available from https://maphealth.ca/wp-content/uploads/COVID-19-Isolation-and-Recovery-Sites_MARCO-Nov-2021.pdf

Acknowledgements

MARCO gratefully acknowledges funding from: the Temerty Foundation and the University of Toronto through the Toronto COVID-19 Action Initiative; the University of Toronto's Faculty of Medicine Equity, Diversity, and Inclusion fund; and the St. Michael's Hospital Foundation.

We also thank the all of people who generously shared their thoughts, experiences and time with the project team. This includes the substantial contribution of people who use drugs and who used the Substance Use Services, and staff members from the COVID-19 Isolation and Recovery Site. Their contribution is gratefully acknowledged.

We also thank all the study participants who shared their experiences with the project team.

Land Acknowledgement

We wish to acknowledge the sacred land on which MAP and Unity Health Toronto operate. It has been a site of human activity for 15,000 years. This land is the territory of the Huron-Wendat and Petun First Nations, the Seneca, and most recently, the Mississaugas of the Credit First Nation. The territory was the subject of the Dish With One Spoon Wampum Belt Covenant, an agreement between the Iroquois Confederacy and Confederacy of the Ojibwe and allied nations to peaceably share and care for the resources around the Great Lakes. Today, the meeting place of Toronto is still the home of many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work in the community, on this territory. We are also mindful of broken covenants and the need to strive to make right with all our relations.

Website: maphealth.ca/marco Email: marco@unityhealth.to

What we did and what we learned

What was evaluated?

On March 17, 2020, the government of Ontario declared a state of emergency in response to the COVID-19 pandemic. Soon after, the first COVID-19 Isolation and Recovery Site (CIRS) was established in Scarborough to support people experiencing homelessness. CIRS provided a space where people experiencing homelessness who were affected by COVID-19 could isolate. Clients who stayed at a site had tested positive for COVID-19, had been exposed to someone who tested positive for COVID -19, or had been tested and were awaiting their test results. Two additional sites were added, a site in Etobicoke in April 2020 and one in Downtown Toronto in May 2020. Clients stayed in private rooms for 10-14 days or until they received a negative COVID-19 test result. Clients received supports from several teams, including peer workers, harm reduction workers, nurses, physicians, and shelter staff.

Several different partners were involved in running the CIRS, including community organizations, physicians' and nurses' groups, a hospital, and city agencies. The executive leadership of the CIRS included members from each of these groups, although not all groups were at the executive table at all times.

We evaluated the models of care within the CIRS. We interviewed 43 people who were involved in some way with the CIRS, including peer workers, harm reduction workers, shelter staff, nurses, physicians, team leads, executive leads, funders, decision-makers, and political leaders. We coded the interviews and looked for key ideas around how the CIRS were developed, their day-to-day operations, and how they functioned within a larger system of health and social services in Toronto.

We focus on 5 main areas in this brief summary. We will share more findings in future reports, publications and presentations.

What were the key findings?

Client-Centred Care

Clients at the sites had access to many services beyond basic health and shelter services. These additional services were important for making care centred on the needs of clients. They included:

- Wellness checks - checking in on clients regularly throughout their day
- Managed alcohol - providing alcohol to clients who use alcohol
- Safe supply of opioids and opioid agonist therapy – providing prescription opioids as an alternative to opioid drugs that people would buy themselves
- Cigarettes
- Snacks
- An outdoor space

Peer workers were very involved in providing these supports. Peer workers would regularly check on clients in their rooms and would go outside with them for clients' cigarette breaks. Peer and harm reduction workers had opportunities to build bonds with clients through these interactions. Many

Important ways that CIRS partners became more collaborative included building trust, creating space for open communication between partners, and vocalizing and recognizing power imbalances.

people we interviewed noted that clients were often more comfortable sharing information with these workers than with other staff. Peer and harm reduction workers had an important role in communicating clients' needs to staff on other teams, including doctors and nurses.

Relationships between partners

Relationships between the organizations that were the CIRS partners changed as the CIRS were set up and operated. Existing relationships were strengthened and new relationships were formed, all during an urgent and unstable environment because of the pandemic. At Scarborough, the partnership did not have a formal structure. In contrast, at Etobicoke and Downtown, a memorandum of understanding between the partners helped to create a formal executive table for decision making. This memorandum, along with an interim evaluation report, helped to move the relationship from one in which some partners had more power than others, to one that became more collaborative over time.[1] Important ways that partners became more collaborative included building trust, creating space for open communication between partners, and vocalizing and recognizing power imbalances.

Leadership within the CIRS

Leadership within the CIRS changed over time and was structured differently between sites. At first, study participants noted that there was a lot of top -down decision making, in which teams made of people who had more power in society, like doctors, also had more power at the CIRS. Over time, power was shared somewhat more equally. This change in structure happened because the CIRS leaders reflected on their power and about the kind of leadership they wanted to deliver. An interim evaluation report was very helpful in prompting people to think about the leadership structure.

Leadership styles also evolved to include more listening to people who were working directly with clients but some workers who interacted directly with clients felt like they still didn't know how decisions were made. While these workers appreciated being able to talk about their concerns with local leaders, they were often frustrated that their concerns did not seem to lead to concrete changes in decision making.

Underlying Values and Vision

The partners brought their own values and ways of working to the executive table. People we interviewed described the model of care at the CIRS in different ways. Some felt it represented a medical model, similar to a hospital setting. There was consensus that the CIRS shifted away from a medical model over time. Others named it a nursing model, a shelter support model, or a customer service model, speaking to the ways the model met clients' needs. Finally, some referred to the CIRS as a community model, one that centred around advocacy and approaches that recognize the impact of traumas that people have experienced in their lives. It was clear that care within the CIRS was evolving and adaptive, reflecting the perspectives of the many different

disciplines involved and their approaches to delivering health and social services.

Systems Issues

Many people we interviewed looked to the CIRS as a model for how services for people experiencing homelessness could be set up in the future. The CIRS offered many important lessons for shelters and supportive housing. It will be important for shelter and housing models to support clients with:

- Far-reaching case management
- A wide range of harm reduction services
- Many different types of workers, including harm reduction workers, peer workers, and nurses. Workers need a supportive and stable long-term work environment
- Coordinated and comprehensive discharge planning. Client should be included in their own discharge plans

When a client goes into a shelter now, it is usually for a short stay because they are homeless. In the future, this shelter stay could be an opportunity to work with the client to put them on a path out of homelessness. Getting to this model requires governments to invest in change, including more funding for housing that is safe, affordable, and stable. It also needs leaders in government who are willing to push for these changes. Finally, different professional groups and community groups will need to address historical barriers to working together effectively.

What are the recommendations moving forward?

1. Peer workers or people with lived experience should be involved in providing care in health and social care settings. Peer workers' expertise should be valued and included at the highest levels of decision making. Involving peer workers is likely to have significant benefits for clients. Peer workers need to feel their positions have stable funding and that they have workplace support to do their work effectively.

2. Partnerships need to be inclusive, with all parties having an equal voice and clearly defined roles. Partners should structure their decision making to be collaborative, innovative, and flexible.

3. Future projects in which different teams work together to care for people experiencing marginalization should pay close attention to who gets to be a leader and how to share leadership. Important aspects of leadership include collaboration, effective and open communication, and opportunities for workers to voice concerns. Leaders need to make sure that their decisions have real benefits for clients and for people working directly with clients.

4. The complex needs of people experiencing marginalization are best met by moving away from siloed, biomedical approaches towards integrated models that are client-centred.

References and Affiliations

References:

1. Kolla G, Ryckman K, Gaudry S, et al. *COVID19 Isolation and Recoverty Sites in Toronto - Synthesis of Learnings_May2020*.

Affiliations:

Unity Health Toronto: Ahmed Bayoumi, Michaela Beder, Michelle Firestone, Linn Holness, Stephen Hwang, Gillian Kolla, Rosane Nisenbaum, Patricia O'Campo, Lisa Schlosser, Kimia Khoee

University of Toronto: Ahmed Bayoumi, Michelle Firestone, Linn Holness

The Neighbourhood Group: Lorie Steer, Angela Akaehomhen, Bee Lee Soh

University Health Network: Andrew Boozary

Canadian Mental Health Association: Terry Pariseau

Canadian Institute for Substance Use Research, University of Victoria: Gillian Kolla

York University: Amal Mohamed