Toronto Shelter Network Grief & Loss Program Report

May 2023

TORONTO

TORONTO SHELTER NETWORK

ACKNOWLEDGMENTS

Our deepest thanks to all who engaged with this project and made this quality improvement report possible, with invaluable contributions from shelter service providers, staff from partner organizations, artists, the City of Toronto, our consulting partners and of course our TSN staff team and Board of Directors.

SPECIAL THANKS TO:

- Sonja Nerad for making this project possible through her leadership at TSN and advocacy for change across the sector.
- TSN Grief & Loss Advisory Committee, TSN sector tables, key informants and staff focus group participants.
- Our funders at The Ministry of Employment and Social Development Canada, Reaching Home Program; The Ministry of Housing, Community Homelessness Prevention Initiative, and the City of Toronto, Shelter, Support and Housing Administration, Homeless Initiatives Fund.
- Special thanks to Fred Victor, Dixon Hall, Salvation Army and Toronto Hostels Training Centre for key informant outreach and support.

This *Grief & Loss Program Report* was written by William Patrick Porter, reviewed by the TSN Grief & Loss Advisory Committee and Leslie Gash, Executive Director, and designed by Green Living Enterprises.

LAND ACKNOWLEDGMENT

The Toronto Shelter Network and our members convene on the traditional territories of the Indigenous nations who have lived here and cared for these lands since time immemorial. The land we call Toronto is covered by Treaty 13 signed with the Mississaugas of the Credit, and the Williams Treaties signed with multiple Mississaugas and Chippewa bands.

Toronto is the traditional territory of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples. The territory was the subject of the Dish With One Spoon Wampum Belt Covenant, an agreement between the Iroquois Confederacy and the Ojibwe and allied nations to peaceably share and care for the resources around the Great Lakes.

Today, Toronto is still the home to many Indigenous people from across Turtle Island and is now home to many diverse First Nations, Inuit and Métis peoples. Living on this territory makes all people in Toronto treaty peoples, including those who come as settlers, or immigrants of this generation or earlier generations, including those brought involuntarily as a result of the TransAtlantic Slave Trade.

We are grateful to live and work on this land and honour what our existence here means for the many Indigenous nations for whom this is home.

Recognizing this in a meaningful way means making commitments to sharing and upholding responsibilities to all who now live on these lands, the land itself, the water, the animals, and all of the resources that make our lives possible. In our work, let us be mindful of these commitments. Let us all be vigilant of our words and actions, including the ones left unsaid and undone. Let us choose our words and actions wisely.

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GLOSSARY OF TERMS

DISENFRANCHISED GRIEF

"[K. J.] Doka (1989) coined the concept disenfranchised grief, defining it as occurring in relation to "a loss that is not or cannot be openly acknowledged publicly, mourned, or socially supported" **(1)**.

DRUG POISONING CRISIS

This terminology is used to emphasize that stigma around substance use builds barriers to improved health outcomes, and that Canada's criminalized drug supply has been inundated with fentanyl. This is also an umbrella term that includes overdoses that are the result of legalized substances such as alcohol or prescription opioids.

ESTABLISHED RESILIENCE

Participants in this program highlighted that "resilience" is too often framed as a "deficit": something to be instilled or an individual shortcoming. This report instead references "established resilience" to highlight that sector staff already hold this skill set, practice it in day-to-day service delivery and have infused it in their decades of tools and care model development. There is instead a need for resources that range from financial to improved accessibility of mental, physical, emotional and spiritual support.

INNER-CITY WORKERS (ICWS)

"Professionals employed to support homeless and vulnerably housed people who may be living with addictions and/or mental health issues, including housing and shelter, outreach, peer support, and mental health and harm reduction workers" **(2)**.

HARM REDUCTION

"Focuses on respecting the client and their wishes, while listening to them without coercion, judgement, or discrimination" **(2)**.

HEALTH CARE PROFESSIONAL (HCP)

As a broader term than ICWS, researches have used HCP to identify "front-line health care professionals" **(3)** experiencing grief and loss across diverse sectors and regions.

PALLIATIVE CARE

"Includes, but is not limited to, end of-life care. A palliative approach focuses on quality of life for clients and the people who matter to them. This approach affirms life and understands death as part of each person's journey" **(4)**.

PWUD

People who use drugs.

YWUD

Youth who use drugs.

1. Program Overview

The Toronto Shelter Network (TSN) began the Grief & Loss Program to expand accessibility, quality and continuity of support and recovery services for staff across the sector. Staff supporting underhoused and homeless individuals have built many formal and informal models that respond to the unique contexts of grief and loss in the sector. This report elevates these efforts in the hope of reducing the emotional labour, program design and partnership development barriers to establishing effective grief and loss support options that centre staff experience and choice.

Witnessing the painful intersections of the drug poisoning crisis and COVID-19 pandemic, TSN members saw a gap in support for staff and began a Grief & Loss Advisory Committee. This committee has grown from 4 executive directors, and now includes 6 managers and frontline staff to ensure greater accountability in the long-term design and deployment of this program.

To better understand the landscape of grief and loss support for staff in the sector, the advisory committee set out 3 organizing principles for service model development (Prevention, Intervention, Postvention), but no specific definition of “grief and loss” was named prior to engaging the sector. Engagements included 10 key informant interviews, 5 sector table focus groups and 3 staff only focus groups.

Building on a foundation of SSHA’s shelter standards and harm reduction framework, this report shares:

1. Participants conceptualizations of grief and loss.
2. Research and resources designed in the face of the HIV/AIDS epidemic, the drug poisoning crisis, and the COVID-19 pandemic.
3. An adaptable grief and loss service model for staff support that blends existing services, sector trends and participants visioning.
4. Outlines a capacity building and policy framework for implementation.

1.1 DEFINING GRIEF & LOSS

> **"The problem with stigma is "trying to keep yourself together" ... workers are in a perpetual state of loss... "moving on" is wrong, and can be offensive."** *– Key Informant*

While formal definitions - such as "grief is the pain and suffering experienced before, during, or after loss... a universal human process which involves a variety of emotions, including anger, sadness, fear, and others" **(4)** – are helpful, there are many unique understandings and worldviews on grief and loss among sector staff. Program participants expanded on "grief and loss" as a complex process, with non-linear impacts that requires a great diversity of responses to support individual and collective healing journeys.

As one participant noted quite succinctly: "loss is inevitable... it will happen several times in life... losing jobs, friends, family... it's a normal part of life and grief is a natural part of the healing process." Across all engagement formats, participants pushed for a conceptualization of "loss" that extends beyond bereavement and instead centres the emotional, psychological, physical, and spiritual experience and impacts of trauma. Many who framed loss within the language of trauma highlighted the stark reality that sector workers are both personally experiencing and witnessing loss "day-to-day".

One key informant stated "we are not like other workers" as there are care expectations and trauma experiences that go unrecognized in job descriptions and public discussions of the sector. As recent research affirms, "although many [Inner City Workers] ICWs witness deaths of their clients regularly, providing care at the end of life is not formally recognized as part of their job description" **(2)** and there are harmful implications for staff as they "experienced stress when weighing their own personal moral imperative to provide needed care to their clients against their employers'/organizations' policies that paradoxically, are in place to protect ICWs from stress and burnout" **(2)**.

Participants engaged by TSN described the emotional, psychological, and spiritual context of grief as: "waves of sadness, discomfort, instability, anger, guilt, depression, confusion, overwhelm, emptiness, frustration, devastation, feeling broke, empty, deep emotions, hopelessness, shock, loneliness, isolation, anxiety, sorrow, pain and hurt". The physical implications of grief were less frequently named, but some worried there is a chasm in understanding and naming grief as the driving force of degraded physical health.

1.2 CORE PRINCIPLES

> **"People are not *just* a skill set"**
>
> *– Key Informant*

Grief and loss work exists in the continuum of social justice and mental health work. It is not a new buzz phrase or replacement of the pillars for best practice. Grief and loss work sits comfortably in the cannon of harm reduction, palliative care, social determinants of health, trauma informed working, reconciliation, and wellness.

Staff see trauma informed working as foundational in the sector, and those in a position to hire and build partnerships agree. Maintaining a trauma informed practice is considered essential for service provision, but also for understanding, preventing, and responding to burnout, compassion fatigue and vicarious trauma. These discussions were mirrored by researchers that "point to the strong connections that exist between... traumatic stress, vicarious trauma, burnout, and compassion fatigue... resulting in high turnover rates in employment, negative health impacts, and disruptions to workers' personal lives" **(2)**. One key informant stated: "trauma is everything", and another affirmed the need to recognize "this is a thing... we need to stop and center this thing". The compounding challenges of stigma and disenfranchised grief were also named, and they will be explored throughout this report.

Reconciliation is a term that has a unique context in Canada, and the Truth & Reconciliation Report **(5)** and MMIWG Report **(6)** must first be centered in use of the term to advance any discussion of grief and loss. Program participants repeatedly used this term to define the worldview, relationship and reciprocity the sector should utilize in grief and loss service model development. Participant statements such as "grief is forever", have guided this project away from discussions of "moving on" and toward stigma reduction and "permission to grieve" in the work environment.

Many of the above-mentioned sector foundations will be expanded on later in this report, but it is helpful to acknowledge now that grief and loss can also be located within the umbrella of wellness. This project is tailored toward quality improvement and highlighting the unique needs of grief and loss support, but designed in parallel with SSHA's work on wellness.

2. Established Resilience

> "I can only offer what I know"
>
> *– Key Informant*

Despite a limited body of research on frontline workers experiences of grief and loss while supporting underhoused and homeless service users **(7)**, by framing grief and loss in the knowledge continuum of emergency response and social justice movements, we can clearly see the sector's great wealth of collective and culturally safe conceptualizations for support.

2.1 HIV/AIDS EPIDEMIC

> "Go to the folks who have been doing this work" *– Key Informant*

Toronto holds a very rich history of activism, resources development and collaborative action around grief and loss in the face of the HIV/AIDS epidemic. Many of the TSN member agencies engaged in this program rely heavily on counsellors and specialists who are grounded in HIV/AIDS activism. These counsellors' diversity of resources and experience enables them to support in both group and individual settings.

To build on the existing foundation of interpersonal strategies and actionable items in grief and loss service model development, key informants repeatedly named the work of Yvette Perrault and the AIDS Bereavement and Resilience Program of Ontario's (ABRPO) "handbook for managers and supervisors" **(8)** and their "report of a pilot for effective debriefing and support in multiple loss situations" **(9)**. The four tasks below are pulled from these resources, as they mirror and advanced the insights shared by participants in TSN's engagements.

Four Tasks for Organizational Support Following a Loss in the Workplace

- **Task I:** Give workers frequent, accurate information when there has been a loss in the workplace
- **Task II:** Allow workers time to have their unique and varied grief and loss responses
- **Task III:** Provide supports, including rituals, group debriefing sessions, individual support/counselling referrals
- **Task IV:** Offer training and education sessions related to grief, loss and trauma to help workers effectively manage their own grief, and the grief of others, in the workplace. Also offer sessions to help reduce worker stress and build their resiliency. Group sessions provide a mechanism to integrate the language and practice of loss, stress, coping and resiliency into the organizational culture **(8)**.

In the TSN engagements, participants predominantly referred to “ritual” as “memorialization”, and this has been carried forward in our service model. It is helpful to ground memorialization in the understanding that “while there are clearly personal, intimate aspects to any significant loss, this does not alter the fact that death and loss are as much a sociological phenomenon as it is psychological – that is, we need to consider the social aspects as well as the personal or psychological ones. The community dimension is a crucial part of this consideration. Part of the notion of community is a shared symbolism that gives a sense of connectedness. Rituals can be seen as an important part of that symbolism” **(8)**.

As participants discussed concerns about the emotional labour and capacity challenges of inclusive memorialization, the below ABRPO conceptualizations of ritual and appendices have been included for agency specific adaptation. Participants have also emphasized the need for culturally safe practices, and the institutional capacity to support those practices (ex. smudging indoors).

Personal Rituals

- **Candle Rituals:** Lighting a candle to connect with the Light within — at a difficult moment, a time of distress or depression, at a time of joy, for a dinner celebration, to honour the memory of a loved one.
- **Cleansing Rituals** to cleanse negative energy or difficult memories — a ritual prayer; a ritual shower or bath; a cleansing diet or fast; use of water, salt, music, bells, or incense to clear dense energy.
- **Forgiveness Rituals** to forgive and let go of hurts from the past — a prayer, a ritual gesture related to another person.
- **Thanksgiving Rituals** to acknowledge the blessings of life — a prayer, candle, flowers, gesture.
- **Rituals of Remembrance** to connect with — persons who have died, events of the past, special moments.
- **Creation of a Sacred Space** — an altar or some simple designated place in the home or garden, or a corner of the office where images, flowers, photos of loved ones, mementos, elements of nature and written prayers may be placed with meaning” **(8)**.

Rituals In Community

- **A Ritual of Transition**. This is a way of making a transition from a position where somebody or something was a part of someone’s life in a direct and physical way, to a new phase of life where that has changed. A funeral is a clear example of a ritual of transition- a formal way of bringing people together to acknowledge the fact of a transition from one set of circumstances to another.
- **A Ritual of Continuity**. An example of this is- after someone who was connected to the organization dies, their name is engraved on a plaque that is located on the agency’s Board room wall as an acknowledgement of those who came before **(8)**.

The ABRPO resources listed here do not stand alone, but are rather a sample of the comprehensive tools, guides and resources already exist to support this work.

2.2 DRUG POISONING CRISIS

> **"Lived experience is seen as a top skill, but what does that mean in the accreditation [degree] focused world?"** *– Key Informant*

> **"Why are we afraid to talk about staff using drugs?"** *– Key Informant*

The drug poisoning crisis has demanded harm reduction providers and activists move mountains to advance safe injection sites and non-abstinence-based programs **(10)**. When building a service model, it is essential to identify those who are least served by the status quo and understand how the proposed changes impact those barriers to support. A 2020 study has "indicated that even a single exposure to a fatal or non-fatal overdose can lead to considerable stress, burnout, and overdose-related compassion fatigue" **(11)**.

While it is certainly the case for many full-time managers and front-line workers, peer roles are explicitly designed to support "clients who are friends and family members" **(11)**. This shifts the support landscape as peers are often excluded from the "counselling, training and support" accessible to their colleagues. In a research study from British Columbia, "the most prominent stressors [for peer workers] include financial insecurity, lack of respect and recognition at work, housing challenges, lack of support services for PWUD, and constant exposure to trauma at work as well as death of loved ones" **(11)**. While certain relief, project based and precarious roles are absent from this research, participants in TSN's engagements shared concerns that such roles are often excluded from existing grief and loss support services and training.

The intricacies of established resilience among all harm reduction workers is also reflected in the utilization of expressive arts in trauma recovery, showing how "the decision for participants to publicly share artworks was also an act of care. In making visible their own grief and suffering over the loss of loved ones to overdose, many recognized their ability to help others navigate similar losses" **(12)**.

2.3 COVID-19 PANDEMIC

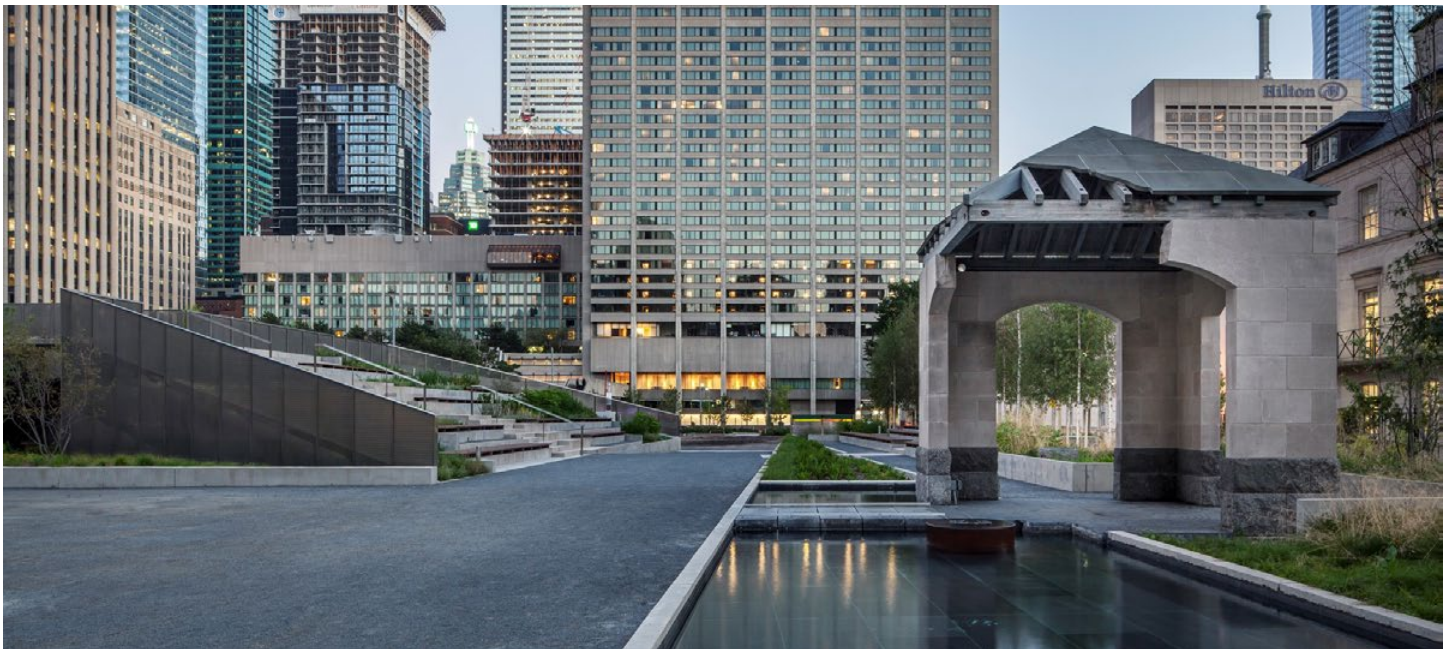
> **"We live in a society that tends to be death-phobic"** **(4)**

In a nation-wide study of 701 service providers, "most direct service providers (79.5%) working with people experiencing homelessness reported a decline in their mental health during the pandemic" **(7)**. Yet, on a truly global scale, the public discussion of service providers shifted to heroism. As researchers warned: "a significant problem with the dominant heroism narrative is that it stifles meaningful, and much needed, discussion about under what obligations healthcare workers have to work... We cannot ask all healthcare workers who go to work to accept personal risk beyond what is reasonably expected of them, as it is simply too demanding; we cannot, in short, expect heroism" **(13)**.

As participants shared that discussion of "increasing resilience" within the sector can be offensive or patronizing, this report has shifted toward ensuring a "constellation of supports" and sustainable financial resources. In early years of the pandemic, supports and resources expanded quickly to include self-guided and online mental health support platforms, as well as sector focused support (ex. GLoW Initiative **(14)**), and – in limited cases - temporary pay increases **(15)**.

To briefly highlight methodology, programs like The Pandemic Acceptance and Commitment to Empowerment Response (PACER) found success with delivery "based on the Acceptance and Commitment to Empowerment (ACE) model... [with] integration of the mindfulness-based Acceptance and Commitment Therapy (ACT) and the social justice-based Group Empowerment Psychoeducation (GEP)" **(16)**.

The above complexity speaks again to the sector's established resilience, as well as the unfortunate disenfranchised grief and loss in the sector. This brief review simply recognises that the sector already holds guidance on managerial support, public arts and creative healing strategies, and numerous collective solutions for healing.



The Peace Garden: Nathan Phillips Square (20) is a public space designated for ceremonial purposes.

3. Grief & Loss Service Model

> **"Grief and loss should be a regular agenda item at team meetings etc also at resident meetings not just when a tragic incident occurs"** *– Focus Group Participant*

Through this grief and loss program, TSN intends to share a baseline and service model for adaptability throughout the sector. There is no one-size-fits-all, but the hope is to offset the labour of research and identification of the wealth of available options.

The Advisory Committee used the organizing principles of prevention, intervention and postvention to aid the exploration of what's available and what could be available. Below are some of the direct quotes and unique responses from staff in the sector.

These quotes paint a picture of what existing support services are seen as ineffective, what solutions some agencies are already implementing and what opportunities lay ahead in collaboration.

3.1 ORGANIZING PRINCIPLES

Prevention

Promote protective factors and help seeking behaviors.

"Normalize and model help seeking behaviors among all levels of staff. Talk about help seeking not as an 'if' but a 'when' activity."

"The supportive culture of a workplace or lack thereof lends itself to prevention."

"Being informed and educated about grief and loss so one is aware of what it is how it affects us when one needs help and understanding the process."

"Validating listening and sharing experiences that you are not alone."

"Casual check-ins with staff without ulterior motives for the sole purpose of seeing how they are genuinely and honestly."

"I follow my teachings: what has been passed on by the elders and the healers in my community"

"For folks in palliative care, having care-full discussions about planned end of life, consent to have staff know their plans. Understanding that this will be hard for some people to hold."

Intervention

Reduce the impact of critical incidents; accelerate recovery; reduce physical and emotional symptoms associated with critical incident stress; suggest further interventions and resources.

"[We have] a spiritual advisor (non-denominational) support"

"[I do not recommend, but] we have EAP and are given a list of resources we can access when there's a traumatic event."

"[Would like to see] specialists such as the ones mentioned for employees to talk with instead of having to be someone from HR."

"3 days bereavement is not enough ... minimum 5 days ... it took me 2 years".

"[We need] established procedures for informing the staff of what occurred."

"[Our process for a critical incident includes] incoming staff are called, then an e-mail is sent out. All partners onsite are informed via e-mail."

"There is an inconsistency around the response to death: Why? How? Who found them? People want to know... Radio silence is harmful."

"There are programs for first responders (firefighters) that could be adapted?"

Postvention

Provide follow up support and resources to staff and clients following a critical incident.

"Follow up and check-ins from management ... the check-ins really make a difference"

"We have a ceremony once a year of lighting candles. It's quite moving and brings all staff together"

"[We have] monthly memorials prescheduled to remember cumulative losses in the community"

"Need to develop community relationships with other agencies"

"When working in a place where death happens often the culture becomes the 'norm'. The expectation is to move on keep working there needs to be more empathy"

"Noticing burnout compassion fatigue exhaustion in your teams which exacerbated the grieving process"

"[We could have] sector wide moments of silence or days of remembrance"
... ex. Aug 31, International Overdose Awareness Day

"[We could have] permanent memorial space (example a garden) for reflection."

"A lot of services require people to seek out... perhaps services that reach out to people?"

3.2 SERVICE MODEL

> **"We need a constellation of supports"** – *Key Informant*

To mirror what we heard from staff, grief and loss is not an "if" but a "when" scenario. This demands an adaptable continuum for support of staff experiences at work, in their personal lives, communities, cultural or global contexts.

The service model conveys a constellation of supports that are non-linear and in constant motion. It confirms what unique actions, support services and collaborations are best suited to meet staff where they are. This design is aspirational and aims to be a tool for benchmarking and development.

FIGURE 1: GRIEF & LOSS SERVICE MODEL

Onboarding

Participants in managerial and frontline roles are eager to have onboarding that is inclusive of grief and loss, but no participants claimed such training was established at their agency. Broader discussion and contracting exist around wellness and self-care, but they do not explicitly address grief and loss in the sector during onboarding. One key informant event pondered "maybe this [grief and loss] should even be something we talk about in the interview process?".

Employee Assistance Programs

EAP is roundly seen as falling short due to limited sessions, provider knowledge gaps, referral and support delays. There are reports of staff having to explain concepts like "harm reduction" in the face of judgment from providers. While some guides exist to help agencies assess the quality of EAP services **(8)**, key informants in upper management highlighted the lack of capacity for the sector to give feedback and enact change with these large EAP corporations. Managers also shared a perception that staff experience stress and stigma in accessing EAP due to staff perception that there is a lack of confidentiality.

External Collaborators

There's an urgent need for the sector to share information and resources on external collaborators. The individual nature of these contractual and informal relationships means that these many external collaborators are also operating at capacity. Further engagement is needed to conceptualize the possibility of centralizing, collectively contracting and "benchmarking" success.

Palliative Education and Care for the Homeless (PEACH): Dr. Naheed Dosani has done amazing work for the sector and is well known in the media for advancing palliative care for individuals experiencing homelessness **(17)**. The PEACH team has frequently provided intervention and postvention response for teams, but there is limited capacity for this work while meeting service user demands **(18)**. No other external collaborator was named as frequently as the PEACH team.

Grief Counselling: Collaboration with counselors who specialize in grief and loss enables familiarity in individual and group support. Currently, each agency builds these relationships from the ground up through the networks brought to the agency by employees. Interpersonal relationships and years if not decades of collaboration proceed the successful establishment of grief and loss counsellors in the constellation of support.

Psychotherapy: Only one agency (Fred Victor) specifically discussed their collaboration with an educational institution to provide psychotherapy as a parallel stream of support to grief counselling and EAP. This program utilizes psychotherapists finalizing their accreditation to support staff with structured therapy at a discounted rate that enables broader availability.

Urgent Internal Support

For most agencies, there is no urgent on-site worker who is delegated to grief and loss support. Executive directors, managers, team leads and other staff may provide urgent support, but the only established role named for on-site urgent support was the "Chaplain". These roles often provide ongoing onsite support for both service users and staff. While the role often centers "spiritual wellness", it is not restrictive to a particular religious practice. They often provide psychotherapy, counselling, and referrals to culturally safe or specialist support.

Memorialization

While agencies that serve youth proved more likely to have biweekly, monthly or annual memorialization services to reflect and respond to grief and loss, other agencies saw memorialization was inequitably based on relationships with the individual client or staff. Memorialization ranges from fresh cut flowers to structured committees of staff and service users who – for example – create a display with images and information about individuals who have passed. Reducing the emotional and physical labour of envisioning and delivering on memorialization activities would greatly improve a more sustainable and inclusive practice.

StreetARToronto: Front Line Heroes
Left: Artist: Jarus, Photo: William P. Porter / **Right:** Artist: Que Rock, Manitou Nemeen (Spirit Dancing) Nipissing First Nation Anishnawbe/Odawa, Photo: William P. Porter

Debriefing

Key informants and focus group participants shared difficulty experienced during pandemic lockdowns as their informal debriefs with staff or community were greatly restricted. In research, "some ICWs expressed that talking to their coworkers and peers (the people that "know what it's like") was the most helpful source of support" **(2)**. Stories of unsuccessfully debriefing with family, friends or other community during the pandemic emphasize the need for resourcing informal debriefing.

Critical incident, staff disclosure, clinical/formal and informal debriefing vary widely based on the resources of individual teams, the mandate of sector agencies and the skill sets of their leaders. Participants shared that not all managers have the capacity or "emotional literacy" to support a debriefing session and emphasised that this does not inherently make them a "bad" manager. Developing a team of facilitators and flexible debriefing protocols is needed to support staff safety and engagement.

As previously referenced, the Good Grief Care Pilot report is currently utilized by the sector, and a strong resource for debrief modelling. The report is a deep dive into "Impact Debriefing Circles, questionnaires – one for circle participants and one for organizations, and training – for both managers and frontline workers and peers" used in the pilot **(9)**.

Ongoing Training

In contrast to onboarding, there is greater sector capacity for ongoing training: with Palliative Education and Care for the Homeless (PEACH), Breakaway (GLoW Initiative) and Toronto Hostels Training Centre of particular note. Focus group participants and key informants pushed for greater consistency, greater accessibility (ex. early education staff, overnight workers, peer workers) and preventative – rather than reactionary – booking of these trainings.

4. Implementation Framework

> **Someone asked: If I have a triggered response, what will you do for me?"** *– Key Informant*

There is no single pathway to achieving a "constellation of support" for staff, but looking at the baseline of service provision we can see what challenges exist for accessibility, quality and continuity of support and recovery services for staff across the sector.

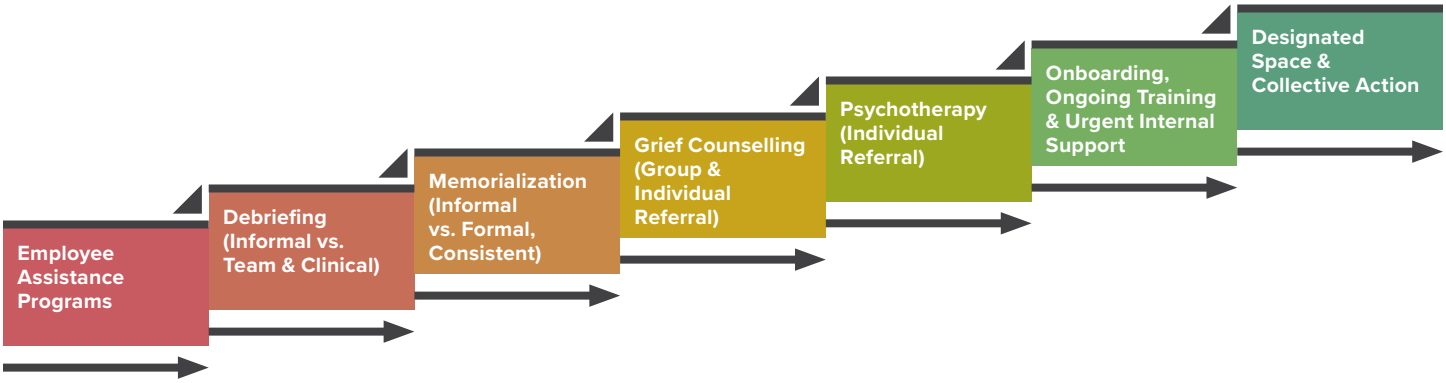
4.1 SCALING CAPACITY

This report finds there is no standard of practice for staff grief and loss support in the sector. This means the demands of scaling capacity are unique to each agency, but themes of moving from time-limited to enduring support and from referral to urgent support are critical.

Reflecting the participants perception of capacity in the sector, EAP has been placed on the lowest end of capacity while securing designated space and collective action has been placed at the highest. While onboarding and ongoing training may be perceived as more easily achievable than urgent internal support, participants shared that such capacity building work demands intensive emotional labour and similarly requires additional resources.

Space for Grief: This Method Collective installation at the Toronto Reference Library (May 2023) is another expiable of public space and expressive arts utilization for collective action in grief and loss support.

FIGURE 2: CAPACITY BENCHMARKS



4.2 ORGANIZATIONAL POLICY

In developing organizational policy for staff grief and loss support, human relations have been placed at the foundation. While some participants have stated that they do not want to engage directly with HR when they need support, the realities of insurance and EAP requires that HR have the capacity to assess, advance and challenge such provision. From staff to upper management, many expressed a lack of clarity on EAP utilization and growing convictions that investments in grief counselling, psychotherapy and urgent internal support staff could produce better outcomes.

With greater resource clarity, management is well positioned for design and delivery. For example, some managers shared that non-hierarchical committees (building off the governance success of harm reduction committees) could be well suited to improve the support continuum. It is important to recognize that management may not have the knowledge, professional or emotional capacity to design all protocols or lead support for staff throughout prevention, intervention and postvention.

This is where formal and informal extremal partnerships can be strengthened. Although some external partners identified through this program shared capacity challenges, interagency contracting could produce better funding sustainability, allow for urgent support teams or advance stronger ties with existing/parallel emergency service supports.

Staff are positioned at the top of this figure as a representation of their vital position, but these layers are porous and reciprocal. Staff experience is the focus of this project, but both leadership and frontline expressed a desire to extend such benefits to service users. If agencies can provide this level of support to staff, there is potentially less labour in developing improved grief and loss provision for service users.

FIGURE 3: DESIGNING SUSTAINABLY

5. Discussion

Through TSN's sector tables and committees, it's possible to disseminate these resources and facilitate feedback mechanisms to move beyond this baseline of service provision.

There is a clear need for additional resources in the sector, and those range from establishing entirely new roles for urgent internal support to expanding funding for external collaboration. TSN member agencies have repeatedly shared concern about high turnover rates and loss of staff to parallel governmental roles with higher salary capacity, and shared that both of these issues create barriers to developing long-term sustainable service models. While there are committees that have been developed for harm reduction, some key informants have stated that parallel grief and loss committees have struggled with the weight of the task.

Recognising the need for greater investment, the potential for improved interagency collaboration and the sectors true impact on public health and all emergency services, we can advance the work of "acknowledging and honouring" grief and loss.

6. Appendix

External Collaborators

This is only a small list of external collaborators shared throughout the project. There are individual providers (ex. counsellors) and agencies not included in this list out of respect for collaborator capacity issues and the nature of some collaborator agreements. TSN aims to work with our members to support formalization of provider agreements and expand access pathways across the sector.

- AIDS Bereavement and Resiliency Program of Ontario (ABRPO): https://abrpo.org/
- Anishnawbe Health Toronto: https://aht.ca/
- Bereaved Families of Ontario: https://bereavedfamilies.net/
- Breakaway (GLoW Initiative): https://breakawaycs.ca/programs/grief-loss/
- Hazel Burns Hospice: https://www.hbhospice.com/
- Inner City Heath Associates (ICHA): https://www.icha-toronto.ca/
- Method Collective: https://www.methodcollective.ca/
- Ontario Association of Children's Aid Societies: https://www.oacas.org/
- Palliative Education and Care for the Homeless (PEACH): https://www.icha-toronto.ca/programs/peach-palliative-education-and-care-for-the-homeless

ICHA – PEACH (4)

ICHA | Inner City Health Associates

PEACH Resource for Frontline Workers
Caring for Clients Experiencing Homelessness in COVID-19

Appendix A – Advanced Care Planning Worksheet for Frontline Workers with Clients

This is not a legal document. It is meant to be a worksheet to help guide conversations with your clients.
*Adapted from Homeless Palliative Care Toolkit "Questions to Consider"

Client:	**Date completed:**
Illness Understanding What do you understand about your current health situation and how you may be impacted by COVID-19? Are you having any particular worries or concerns about COVID-19?	**Comments:**
Relationships Who are the people that you trust the most? Is there a person you would trust to help the medical team make decisions for you if your health condition got worse? Do you have a spouse, children or parents? What living family members have you remained in touch with? Do you have an emergency contact number for a person you would want to update if you got ill?	**Comments:**
Who would you like to be there if you were to get ill? Who would you NOT want to be there if you were to get ill? Would you like support to reconnect with your family?	**Comments:**
Are there any cultural or spiritual preferences that are important for us to know about in caring for you?	**Comments:**
Quality of Life What brings you joy? What do you enjoy being able to do throughout the day? Are there things you have always wanted to do but have not done yet?	**Comments:**
Setting/Treatment Would you like to talk to a doctor or nurse about this? Where would you want to be cared for if you were to get ill with COVID-19? If doctors thought that they could not provide any more treatment to prolong your life is there a place where you would like to receive your end of life care? (eg. Shelter, Hospital, Hospice)	**Comments:**
Some patients with COVID-19 get very sick and require machines, such as ventilators or life support to keep their bodies alive. Are there any treatments that you know you would want/not want if you became ill? Would you like to talk to a doctor about this?	**Comments:**
Legacy Have you thought about what would happen to your things if you were to die? Who might you want to give your belongings to? Have you written a will or letter of wishes? If not, would you like to? What would be important for you at your funeral? How do you want to be remembered?	**Comments:**

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BEREAVEMENT SUPPORT (19)

Activity worksheet:

Bereavement support

- Use this activity sheet (perhaps as a team) when **thinking** about how best to respond to the impact a death will have on everyone within your project or service
- Consider what more can be done to ensure everyone is well supported, and who out there can support you, e.g. your local palliative care or bereavement service
- Think about the practical and emotional things needed, and what **actions** to take, i.e. reviewing policies and procedures, meeting with local bereavement service
- How might the bereavement section of the toolkit support your project or service to have the most informed approach to supporting clients and staff?

What practical things can you consider? *How do current policies and procedures meet the needs of everyone, (e.g. could more be done in the initial hours and days following a death, notifying clients, family and external agencies, or in keeping clients informed (e.g. coroner/room clearing)*	**Thoughts and actions**
Can more be done to meet emotional impact? *e.g. Additional measures to meet a range of grief reactions among clients and staff; impact of a sudden/traumatic death, identifying potential risk factors (e.g. clients with multiples needs/losses), responding to difficult behaviours (e.g. increased substance use, angry outbursts). Who or what can help you put things in place? e.g. local bereavement service, GP, 1-1 and group support.*	**Thoughts and actions**
Are additional bereavement supports needed? *Are current levels of support for both clients and staff sufficient? If not, what more can be done (e.g. sharing ideas/concerns with your local bereavement service, displaying information on grief and loss). How well supported are those who struggle to engage with services? – what additional supports might be needed?*	**Thoughts and actions**
Planning funerals and other celebrations. *Is more needed to enable you and clients plan for and participate in public funerals, or celebrations of life, (e.g. a joint meal, remembrance service for all clients who have died)? How could your local bereavement service support you? Information around public funerals and celebrations in the bereavement section of the toolkit may also help.*	**Thoughts and actions**

WHEN GRIEF COMES TO WORK (8)

Employee Assistance Professionals' Checklist

Does your EAP training and experience encompass the following?

1. **Workplace Grief**
   - ☐ The workplace experiences many grief-precipitating events such as terminations, significant change in the workplace, issues of illness, death or crisis events among workers and their families.
   - ☐ An appreciation of communities of meaning, multiple loss, impact of disenfranchised grief.
   - ☐ The impact on productivity, morale, interpersonal relationships and turnover is significant, depending on workplace response.
   - ☐ Few employers, supervisors or workers are adequately prepared for an effective response to death and loss in the workplace.
2. **Basic Grief Concepts**
   - ☐ Normal grief encompasses stages commonly experienced by grieving people.
   - ☐ Complicated grief is differentiated from normal grief in its causes and its range of responses.
   - ☐ Different cultures grieve differently.
   - ☐ Special events, such as holidays and anniversaries are significant to survivors.
   - ☐ The tasks of grieving refer to how people manage their grief.
3. **Factors Affecting Grief Responses**
   - ☐ Type of loss.
   - ☐ Timing of loss.
   - ☐ Previous losses.
   - ☐ Relationship to the deceased and type of attachment.
   - ☐ Current support system and how they have been impacted.
   - ☐ Work-related pressures.
   - ☐ Workplace responses.
4. **Signs of Grief**
   - ☐ Physical signs manifested in the workplace.
   - ☐ Cognitive changes in normal work patterns.
   - ☐ Emotional-Behavioural symptoms related to depression and substance abuse.
   - ☐ Change in social relationships with co-workers.
5. **Aiding Grieving Workers**
   - ☐ Crisis intervention.
   - ☐ Needs assessments.
   - ☐ Interpretation of relevant organizational policies- i.e. can people donate sick time or leave time?
   - ☐ Short-term counselling.
   - ☐ Workplace support groups.
   - ☐ Referrals to community resources and mental health practitioners.
6. **Guiding Co-Workers of Grieving Workers**
   - ☐ Needs assessment.
   - ☐ Initial debriefing, ongoing bereavement support.
   - ☐ Review of appropriate responses and language.
   - ☐ Funeral/Memorial attendance, including visitation, follow up visits.
   - ☐ Written communications: cards, journals, memory book.
   - ☐ Organized support systems- help family with chores, children, etc.
   - ☐ Planned activities for ongoing emotional support.
7. **Training Supervisors of Grieving Workers**
   - ☐ Differentiating appropriate and inappropriate roles.
   - ☐ Talking with workers and co-workers.
   - ☐ Setting realistic expectations.
   - ☐ Implementing management strategies- job restructuring, time off.
   - ☐ Interpreting organizational policies **(8)**.

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