Peer Health Worker Evaluation:
A Pilot Project of Kitchener Downtown Community Health Centre

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Executive Summary

This report is the final product of the evaluation project conducted in 2008-2009, funded by the Waterloo Wellington Health Integrated Network. The purpose of this evaluation project was to understand and describe how the Peer Health Worker Pilot Project operates within Waterloo Region, Ontario. This evaluation sought to identify the factors that facilitated and impeded project success and to suggest recommendations for project improvement and sustainability.

This project is a community health initiative that operates as a support service for people experiencing homelessness. People with lived experiences of homelessness were employed to address health issues among people experiencing homelessness. This project sought to 1) improve the health and well-being of people experiencing homelessness, 2) increase access to health and related community resources by people experiencing homelessness, 3) reduce the isolation of people experiencing homelessness, 4) increase the skills and confidence of Peer Health Workers (PHWs) to share information, make referrals, and provide feedback regarding programs and services, 5) develop a better understanding of the needs and barriers faced by people experiencing homelessness in order to develop better practices and supports, and 6) increase the participation of peers in community action and service planning. The duties of the PHWs were to establish rapport with people experiencing homelessness, listen to their concerns, and provide information referral and system navigation support regarding health, emergency, and related services.

The Centre for Community Based Research (CCBR) conducted this research in close collaboration with the project Evaluation Steering Committee and program participants. Data collection for the evaluation project took place between July 2008 and February 2009 and utilized several different data collection sources and strategies. Focus groups were conducted with PHWs, partner site staff, people experiencing homelessness, and the Project Coordinator was interviewed. Data was gathered by PHWs using a ‘Contact Record’ (see Appendix G).

Generally, the evaluation findings clarified and verified that program outcomes are similar to those desired and expected by the Evaluation Committee. Evaluation findings recognized that Peer Health Worker Pilot Project programming had a positive impact on people experiencing homelessness, with the potential to impact the broader homeless community. The following program successes were outlined from the perspectives of differing stakeholders:

- PHWs have a unique knowledge base of social services and how to access them.
- PHWs are able to provide unique emotional support because they have ‘been there’.
- People experiencing homelessness trust PHWs and the information they receive.
- People experiencing homelessness are comfortable approaching PHWs with issues.
- People said they are being connected with and referred to services by PHWs.

Evaluation recommendations advised the need to continue the existing programming. There is a need for greater promotion of the project within the continuum of outreach, on-going training and networking opportunities for PHWs, establishing more project support for PHWs, and adapting the program structure so that it coincides with the needs of the homeless community. Finally, program activities and outcomes should continue to be tracked and reflected upon and the budget should be updated and funding secured.
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Peer Health Worker Pilot Project Evaluation

A. Introduction

KDCHC

Since November 2000, The Kitchener Downtown Community Health Centre (KDCHC) has been operating as a non-profit organization that serves the broader public. KDCHC focuses on serving various community members (e.g., new Canadians, Aboriginal people, families, and people experiencing homelessness) who encounter barriers accessing primary health care and health-related services.

KDCHC’s vision, mission, and values support work that address individual and community health (see Appendix A). This work addresses determinants of health, including: income and social status, housing, employment, education, social support networks and others. KDCHC staff and volunteers have considerable knowledge and experience in supporting a variety of community development initiatives including peer support. For example, KDCHC has effectively engaged members of the community with lived experience in the following groups: Growing Up Downtown (families), Community Health Helpers (new Canadians), Homeless Advisory Group (people experiencing homelessness), and the Seniors Advisory Group (seniors). The organization’s mission, experience, skills and commitment have proven extremely valuable within the community.

Overview of the Peer Health Worker Pilot Project

In response to the needs expressed by people experiencing homelessness and people at-risk of homelessness in various community-based reports (e.g., Cowan, Khandor, & Mason, 2007; Gnaedinger, 2006; Homelessness Advisory Committee, 2007; Region of Waterloo, 2007), the Homelessness Advisory Group of KDCHC promoted and supported the development of the Peer Health Worker Pilot Project. The project is coordinated by Community Development Worker, Doug Rankin, and staffed by peer health workers, under the guidance of the Peer Health Worker Pilot Project Steering Committee.

Notably, in line with research that has found various benefits for peer support projects (e.g., Davidson et al., 1999, Perrault, 2006, and Solomon, 2004), the assumption for employing ‘peer’ health workers was that people who have lived experience with homelessness will be knowledgeable, approachable, trustworthy, and have a strong rapport with people experiencing homelessness.

“They have the ability to say to someone, here’s my experience, I’ve been through this…and I think it gives people hope to see someone who (has) really struggled and is now housed and doing better. I think that is a hopeful thing to see and that is encouraging”. (Project Coordinator)
Partnering with local agencies, this community initiative employed people with lived experiences of homelessness in order to address issues of social isolation, difficulties accessing health and health-related services. More specifically, this project sought to:

1) Improve the health and well-being of person experiencing homelessness
2) Increase access to health and related community resources by people experiencing homelessness
3) Reduce the isolation of people experiencing homelessness
4) Increase the skills and confidence of Peer Health Workers (PHWs) to share information, make referrals, and provide feedback regarding programs and services
5) Develop a better understanding of the needs and barriers facing people who are experiencing homelessness in order to develop better practices and supports
6) Increase the participation of peers in community action and service planning.

The duties of the **Peer Health Workers**, accordingly, were to establish rapport with people experiencing homelessness, listen to the peoples’ concerns, and provide information referral and system navigation support regarding health, emergency, and related services.

In order to achieve the above goals, the **Peer Health Worker Pilot Project** began with the selection, employment, and training of PHWs. PHWs were selected based on their life experience, skills, and knowledge (e.g., lived experience of homelessness, ability to build relationships, ability to maintain confidentiality, ability to maintain appropriate boundaries; see Appendix B for a complete job description). To meet the objectives, PHWs received both initial and ongoing training on how to build rapport, provide information and referrals for health-related services, and relevant documentation procedures.

The five PHWs worked at five different locations: YWCA Mary’s Place, Ray of Hope- Oasis Drop-in, K-W Out of the Cold- Trinity United Church, The Working Centre- St. John’s Kitchen, and House of Friendship- Charles Street Men’s Hostel. While on location at a partner site, the PHWs were expected to be a resource of physical and mental health information and associated resources for people experiencing homelessness. That is, during their three hour shift each week, they were expected to offer support and encouragement by listening and sharing information about their own experiences, provide referral information regarding health and health-related concerns, maintain confidentiality in order to respect the rights of their peers, adhere to the policies of KDCHC, and maintain a log of peer support activities (see Appendix for the Contact Form). Overall, the experience was expected to benefit the PHWs as well as the people they interacted with, by providing them with new skills and meaningful paid work. Sites were expected to offer support and supervision to the PHW. Each site was introduced to the PHW and given an explanation of the role of the PHW, the goals of the project, and their role. The sites were expected to contact the Project Coordinator with any concerns or comments.
B. Methodology

Background to the Evaluation

Between June 2008 and March 2009, the Peer Health Worker Pilot Project was involved in the evaluation research project led by the Centre for Community Based Research (CCBR). CCBR is a recognized leader in community-based research in Canada (over 300 research projects during its 26 years of operation) and a pioneer in participatory action research and evaluation. CCBR is an independent, entrepreneurial, not-for-profit organization whose mission is to use research to inspire social change and the development of communities that are responsive and supportive of people with limited access to power and opportunity.

The purpose of this evaluation project was to understand the Peer Health Worker Pilot Project. Further, this evaluation sought to identify the factors that facilitate and impeded project success and to suggest future recommendations for growth and sustainability.

Evaluation Methods

Data collection for the evaluation project took place between July 2008 and February 2009. The evaluation utilized several different data collection sources and strategies as a means of gathering multiple stakeholder perspectives. Utilizing multiple methods from multiple perspectives increases credibility of evaluation findings. Through examining information collected by different methods, by different groups and in different populations, findings can be corroborated across data sets, reducing the impact of potential biases that can exist in a single study (Global health sciences: Prevention and public health group triangulation, 2008). Accordingly, data was gathered in the context of focus groups, key informant interview, and Contact Record data.

Focus group participants were identified using a variety of methods. Two staff members from each partner site were invited and all PHWs were asked to attend focus groups. Additionally, snowball sampling was utilized in asking potential ‘people experiencing homelessness’ focus group participants if they were aware of additional people who should be contacted and included; whom they felt accurately reflected the research participant criteria. These sampling approaches yielded a total of three focus groups (PHWs, partner site staff, and people experiencing homelessness) and one key informant interview. In addition to the focus groups and key informant interview, survey data concerning the consumer population and PHW’s daily activities was gathered by the PHWs using a ‘Contact Record’ (see Appendix G).

This research and evaluation project involved many players and many ways of gathering information to determine the successes and challenges of the Peer Health Worker Pilot Project as well as to develop recommendations that would facilitate project growth and development. As a comprehensive community initiative, it was pre-determined that success for the Peer Health Worker Pilot Project could be operationalized on various levels: efficiency of project structure, project supports (e.g. partner site support, training), overall project successes and challenges, and project outcomes/impacts. Accordingly, data collection questions dealt with gaining an
understanding of the functionality of the project and its intended impacts, in relation to the broader community.

C. Evaluation Findings

The evaluation data has shown that the Peer Health Worker Pilot Project is a needed and effective initiative for people experiencing homelessness or people who are at-risk of homelessness. Many of the research participants were excited to talk about the details of the current project and the future of the initiative, drawing on the positive experiences they had in relation to this project. The evaluation findings demonstrated that there is a lot of validity to the belief that a peer support model can have meaningful impacts in the lives of people experiencing homelessness. Many of the evaluation findings, furthermore, were indicative of a strong sense that some of the key outcomes were being realized at both the individual level and, in theory, at the community level.

It was observed by all stakeholders that the Peer Health Worker Pilot Project was unique in that it employed people with lived homelessness experience to support people experiencing homelessness in order to increase social support and raise awareness of health and health-related services, by word-of-mouth. It also served a dual-role in that it not only impacted the people accessing services but also had a positive developmental effect on the PHWs.

The evaluation findings are organized in six sections that mirror the research questions, which are related to: 1) research participants, 2) project description, 3) project structure, 4) project supports, 5) project successes and impacts, and 6) project challenges. Furthermore, the findings were analyzed by stakeholder group (i.e., PHW, partner site staff, people experiencing homelessness, and Project Coordinator) and, afterwards, summarized in order to ensure clarity and transparency of the differing perspectives. Recommendations for future project improvement and sustainability are presented in the final section of this report.

1. Research Participants and Gathered Data

A total of 15 people participated in three focus groups that were co-facilitated by two CCBR Researchers. Four people participated in the PHW focus group, five in the site partner focus group, and 6 in the focus group for people experiencing homelessness. All focus groups were held at KDCHC. At the focus groups, participants were asked about the role of the PHW at their site, support and training of PHWs, the benefits and challenges of working or talking with a PHW, and emerging impacts of the PHW pilot project. The Project Coordinator interview questions focused on understanding the uniqueness of the project, the supports offered by the Project Coordinator and KDCHC, the successes and challenges to date, and impacts of the project (see Appendices C, D, E, and F respectively, for questions).

At the partner site focus group there were two representatives from one site, and one from each of three other sites. One of the sites was not represented. At the focus group for people who had experienced homelessness, two participants knew the PHW because they were staying at the
shelter. Two others had known one of the PHWs for quite some time from the community, and the others had interacted with at least one or two PHWs at various sites. One of the participants was also involved as a volunteer in the community.

At all focus groups, there was some consensus among participants on the major strengths and issues of the project, especially at the PHW and people experiencing homelessness focus groups. One drawback of the partner site staff focus group was that participants explained they had limited contact with the PHW or knowledge of the details of their activities. While the data gathered from this focus group offers less depth of insight into the project itself, participants offered a clear vision of how the project could be improved, roles better understood, and sites more involved.

Each PHW was asked to complete a Contact Record at the end of each weekly shift. A total of 73 Contact Records were completed. PHWs documented their daily activities with the people they met with during each weekly shift. The Contact Record provided the following information: how many people PHWs worked with, how many of them were new people, the gender of people worked with, if the person was an adult or youth, the types of issues they encountered, referrals given and received, and the type of assistance provided. These forms offered both quantitative and qualitative data and were used to supplement the information from the focus groups and interview.

Although steps were taken to ensure that PHWs completed the forms in a consistent manner, several aspects of the form were interpreted differently by each worker. Also, forms were only gathered from four of the five sites due to inability to obtain forms from one PHW.

### 2. Project Description

Over the span of the evaluation (July 2008 to February 2009) PHWs met with a total of 480 people (average of 60 people each month). Half of them, 204, were new people. Most of the people were males (294) and there were 189 females. PHWs were asked to identify if someone they worked with appeared to be a teenager. By this definition, a total of 26 youth were encountered, of these, 19 were male and 7 were female. Youth made up only 5% (n = 36) of people worked with, a small proportion of total people worked with. PHWs cited that 39% (n = 186) of the total 480 interactions were “significant”. A significant interaction was defined with the PHWs as an interaction exceeding casual conversation where serious issues were discussed, or assistance, information, or referral was offered by the PHW.
Site Specific Information

<table>
<thead>
<tr>
<th>Site</th>
<th>Total people met</th>
<th>Total new people met</th>
<th>Number of females</th>
<th>Number of males</th>
<th>Significant interactions</th>
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</thead>
<tbody>
<tr>
<td>Working Centre- St. John’s</td>
<td>124</td>
<td>64</td>
<td>41</td>
<td>86</td>
<td>45</td>
</tr>
<tr>
<td>YWCA Mary’s Place</td>
<td>99</td>
<td>29</td>
<td>99</td>
<td>0</td>
<td>10</td>
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<td>92</td>
<td>16</td>
<td>48</td>
<td>44</td>
<td>58</td>
</tr>
<tr>
<td>Charles Street Men’s Hostel</td>
<td>165</td>
<td>95</td>
<td>1</td>
<td>164</td>
<td>73</td>
</tr>
<tr>
<td>Total</td>
<td>480</td>
<td>204</td>
<td>189</td>
<td>294</td>
<td>186</td>
</tr>
</tbody>
</table>

Type of interaction

In 53% (n = 270) of interactions PHWs provided information, 19% (n = 100) provided referrals, 20% (n = 101) followed up on past information or referral, 8% (n = 41) dealt with a crisis. Around half of all time spent with people was in brief conversation under 10 minutes. Details of time spent are outlined in the chart below:

![Length of PHW interactions](image)

Of all interactions that occurred, the person approached the PHW in 35% (n = 170) of cases. Most often, PHWs initiated contact with people. Nine people were referred to the PHW from the site and four people heard about the PHW from a flyer.

Issues Presented

Issues were documented by PHWs in two ways: qualitative and quantitative. First, they selected one of the general issue categories already provided on the checklist (quantitative). Second, they
elaborated on the issues by writing detailed comments (qualitative). The chart below illustrates the frequency of the issues, from the checklist:

Housing, emergency shelter and income were the top three issues, making up almost half, 43% (n= 466), of all issues presented, followed by relationships and mental health. Other issues encountered were clothing/ furniture 4% (n= 42), safety concerns 3% (n= 34), legal issues 2% (n= 23), abuse/ trauma 2% (n=22), immigration 1% (n= 9), and sexual health 1% (n= 7).

In addition to recording the numbers of instances of the above issues they came across in a checklist, PHWs recorded more detailed account of the issues that they encountered. These issues are as follows:

- Frustration, desperation, loneliness (n= 9)
- Issues associated with aging (n= 7)
- Shelter rules and limitations (n= 6)
- Transportation, need for bus tickets (n= 6)
- Discrimination/ racism (n= 5)
- Identification (n= 4)
- Issues related to disability (n= 4)
- Eviction, issues with landlords (n= 3)
- Furniture (n= 3)
- Issues with children (n= 2)
- Language/ communication barriers (n= 2)
- Telephone access (n= 2)

There is a range of issues that the PHWs were dealing with. It is good, accordingly, to have two different ways to recall them. However there was a discrepancy between the issues indicated in
the checklist and the issues indicated in a more open-ended way. This is one change that might be made to the data gathering form in the future.

### 3. Project Structure

In the Peer Health Worker Pilot Project there are a total of five PHWs, two women and three men. One PHW provided support at each of five sites, all located in downtown Kitchener. YWCA Mary’s Place is a formal emergency shelter for women and their families, House of Friendship Charles Street Men’s Hostel is a shelter for men, St. John’s Kitchen offers food and a wide variety of community services, Ray of Hope- Oasis Drop-in Centre is an interdenominational Christian service offering food and other support services, and K-W Out of the Cold Trinity United Church is seasonal and volunteer-driven emergency shelter and meal program.

**Getting Involved**

The Project Coordinator played a key role in developing and marketing this project. All partner site staff became involved in the project through their connection with the KDCHC and the coordinator. The Project Coordinator visited each site during PHW shifts and dealt with other issues as they arose. In addition, every PHW indicated that the coordinator had raised their awareness about the project and had played a key role in their understanding of how they might be a good fit for the project. PHWs were invited to apply for the PHW position by the Project Coordinator. PHWs were selected for the position based on their past experiences of homelessness, their skills and abilities, and their interest to give back to the community. KDCHC interviewed twelve people who applied to be a PHW, and hired five. The Project Coordinator played a supervisory and supportive role to the PHWs, in addition to acting as the key ambassador of the project.

All PHWs indicated that they had felt that the Peer Health Worker Pilot Project was a natural fit for them. Many of them had already been playing a similar role in their own spare time and were pleased to have the opportunity to do it in a paid capacity.

“We know the lifestyle and what people are dealing with,(which)attracted me to the position”. *(Peer Health Worker)*

The minimal time commitment also made it convenient to work in the project. Notably, they mentioned that it was a good learning opportunity and helped make difference in their own healing process. Overall the PHWs expressed that they are interested in ‘giving back’, they love helping people, and they believe it is a good fit for them in light of their past (homeless) experiences.

“I love helping people”. *(Peer Health Worker)*
Understanding the Role of Peer Health Workers

**Project Coordinator Perspective.** According to the Project Coordinator, the PHW role fits in very well at KDCHC in that they have administered peer worker projects in the past (e.g., community nutrition peer workers) and it fits KDCHC policies and values. An additional advantage is that PHWs are able to break the ‘us/them’ barrier that is often encountered by service providers and people experiencing homelessness.

“I also think that people have some insight into what people are going through if they’ve been there. I remember one peer worker saying to me they were working with someone who was really struggling and feeling very desperate. And they just said ‘just hang in there and keep doing what you’re doing, and it’s gonna get better, it might take a week, it might take two or three weeks but it’s gonna get better’. Just that kind of support at an emotional level is really important”. (Project Coordinator)

**PHW Perspective.** From the perspective of PHWs there were no typical shifts. Similar to how the people they talked to could change from one shift to the next, so did their work activities. First and foremost they spent time talking with, and listening to, people experiencing homelessness in order to see how they were doing and to see if they needed anything. They all indicated that providing referrals was a regular part of what they did.

PHWs linked people to different services (e.g., CMHA, K-W Out of the Cold, ROOF, ACCKWA, hospitals, The Working Centre, Mobile Crisis Team, etc.). Example referrals included referrals concerning HIV/STD testing, infections, suicidal thoughts, and bleeding, among all health-related things. Other referrals mentioned were a reproduction health project, Waterloo Regional Dream Centre, Grand River Transit, Whatever It Takes, Employment Insurance, Waterloo Regional Homes for Mental Health, Volunteer Action Centre, and referrals to apartments for rent. On five occasions PHWs referred a person to the site they were working out of.
**Contact Records.** The most common documented referrals provided by PHWs are as follows:

- St. John’s (ID clinic, nurse practitioner, psychiatric help, foot doctor) (n= 13)
- Working Centre (for employment, bus tickets, etc.) (n= 10)
- Out of the Cold (n= 9)
- Food Hamper Project (n= 7)
- House of Friendship (n= 7)
- KDCHC (n= 6)
- Thrift shops (n= 6)
- Doctor’s office (family doctor, audiologist, optometrist) (n= 5)
- Waterloo Region Self Help (n= 5)
- Catholic Family Counseling (n= 4)
- Lutherwood (n= 4)
- ROOF (n= 4)
- Addictions services (n= 3)
- Guardian Line (n= 3)
- Hospital or walk-in clinic (n= 3)
- Ray of Hope- Oasis Drop-in (n= 3)
- ACCKWA (n= 2)
- CMHA (n= 2)
- Kiwanis House (n= 2)
- YWCA Mary’s Place (n= 2)
- Pharmacy (n= 2)
- St. Mary’s Counseling (n= 2)

PHWs provided a range of types of assistance. Contact forms indicated that about half of all assistance provided is characterized as basic support (listening, validating, problem solving). The breakdown is as follows:

- 48% (n= 395) basic support
- 29% (n= 240) providing information
- 13% (n=104) providing referral
- 3% (n= 24) connecting people to site services
- 2% (n= 15) phone support
- 2% (n=15) advocacy
- Less than 3% accompaniment (n=6), meeting people (n= 10), and other (n= 9)

PHWs provided information, referral, supportive listening, and problem solving around a wide variety of issues. One PHW describes themself as a “non judgmental presence, someone to talk to”. Another worker describes that they “help people feel relevant”. In one shift, a PHW describes that they offered “encouragement, motivation, support, resources, information, someone to inquire on behalf of, a phone call, caring and compassion and empathy”. Another PHW said in one shift they “provided resource info, housing phone call, assisted with resume, (and made a) referral for housing”.

**Practical assistance** was a significant element of the PHW role. Some activities mentioned were help doing laundry, support with resumes and job search, assisting completion of various forms, giving out cigarettes, offering a free haircut, dealing with transportation issues and giving bus tickets, assisting with use of showers and supplies, and making arrangements to move belongings into storage. Helping people look for shelter and housing was a significant aspect of the assistance provided. This involved assistance finding shelter beds, calling potential landlords and housing service providers, and providing referrals for housing. Health information provided was
varied. One PHW provided information on attaining a hearing aid. Several workers responded to sexual health concerns and made referrals, and one provided someone with condoms. One answered concerns and referred a person for Hepatitis C nutrition concerns. One PHW helped a person protect their cast with a plastic bag. One PHW gave phone number of doctor accepting patients to two people, and another referred two people to an Optometrist.

*Supportive listening* was a major aspect of the assistance provided. Regarding one of her shifts, a PHW said “lending people my ear” was all that was required of her. Another worker listened to women who were sex workers and provided information on how to access the Guardian Line. *Support around relationships* was an important task for PHWs, especially those working with women experiencing violent or otherwise unhealthy relationships. *Calming people down* in a crisis situation was also a significant aspect of the role. Part of *offering emotional support* was celebrating good news and congratulating people on their achievements. Oftentimes PHWs offered words of encouragement, affirmation, and congratulations. As previously noted a major concern for people experiencing homelessness is social isolation (Cowan, Khandor, & Mason, 2007; Gnaedinger, 2006; Homelessness Advisory Committee, 2007; Region of Waterloo, 2007b).

*Following up with people* whom the PHW had previously interacted with was a key activity. One PHW helped the same person over the course of four consecutive shifts, providing emotional support, accompanying the person to the doctor and shopping due to the person’s inability to speak English. Another PHW followed up on ideas and suggestions with a person from a prior meeting and another PHW followed-up with someone who had secured housing. One worker followed up on someone they had referred and found she was attending psychiatrist appointments at St. John’s Kitchen. Following people through a crisis was also very important. One worker supported a youth who was leaving an abusive home to come up with a plan for finding housing and employment. Another worker “helped get a plan of emergency shelter for a man in crisis” and another supported a co-PHW who was supporting a person in crisis. One PHW supported a woman who had just been sexually assaulted and advised her to report the attack and seek medical care.

*Contacting other service providers* and accompaniment made up a small but significant aspect of the PHW role. There were two instances of a PHW accompanying a person in court and talking with a probation officer. One PHW talked with an OW worker on behalf of a person and another spoke to two staff members at Kiwanis House. On several occasions PHW accompanied a person to a service provider, such as to Canadian Mental Health Association, Waterloo Region Self Help, and Waterloo Regional Homes for Mental Health.

**Partner Site Staff Perspective.** Partner site staff had a good understanding of the model and intention of the PHW program. They showed support of the idea that people with lived experience of homelessness can offer unique support to people experiencing homelessness.

“I just think (the Peer Health Worker Project) is a good thing”. (Partner Site Staff)
The partner site staff did notice that PHWs were mingling and chatting with people and that they appeared very comfortable working with people experiencing homelessness. This was recognized as an important role by some of the partner site staff.

“I think the community that happens at (the site) is a really good fit for a peer health worker because a lot of people come in everyday just to socialize and have a positive place to be around people... the peer health worker really works in that context”.

(Partner Site Staff)

At one site having a PHW is helpful because the PHW is working on the day that the site staff are in meetings all day.

“I find there’s more a benefit for newer people that aren’t used to the system and what’s going on. People that maybe have more issues than as a staff member on a busy afternoon shift, you have time to deal with. They can vent and discuss their problems and hopefully get some guidance”.

(Partner Site Staff)

Due to minimal contact with the PHW, the role of the PHW in the perspective of partner site staff was a bit uncertain. They were unaware of what types of interactions PHWs were having or what type of information PHWs were imparting. At one site there seemed to be a lack of understanding that PHW had a different role from the rest of the staff. PHWs worked very much independently from their sites. Importantly, one site staff explained that this was the expectation from the start that the PHW would operate as a separate entity.

“Some days it was pretty quiet and not too many people were approaching the (PHW) and other days it was really hectic for him. We stayed back. That was his time”.

(Partner Site Staff)

**Perspective of People Experiencing Homelessness.** People experiencing homelessness found that PHWs were always talking with people and helping people out. For example, they noted that they would see PHWs having both short and long conversations with different people.

“Everyone had different issues, some guys are looking for a place to live and other guys are looking for a job”.

(Person Experiencing Homelessness)

People experiencing homelessness noted that PHWs did not really promote themselves; however, they would see them around quite often. It was sometimes a matter of being in the right place at the right time to get to know them and that they are available. Oftentimes they found that PHWs would be able to talk to the people that case workers, or other site staff, were unable to meet with.

“I was in need of a place to live...he gave me a couple of places to go look and the next day I saw him, he came and sat down with me and gave me a list of like five different places of rooming housing within the city that are fairly cheap but were within my budget. And then he told me about Gift for Sight just before Christmas and grabbed a
pair of glasses out of the deal so I was really happy about that”. (Person Experiencing Homelessness)

4. Project Supports

Support for PHWs is a significant component of the Peer Health Worker Pilot Project. Research participants were asked about the training and development of PHWs and what kinds of supports were in place. The results of these questions are outlined below.

Training

Despite being considered experts in relation to the homeless community, PHWs found that some of their training was helpful whereas some of it was not. For example, regarding HIV and STIs, some of them knew a lot about the subject already and some of them did not. In particular PHWs found the suicide and overdose prevention training very helpful and went on to note that they would have appreciated more training in regards to addictions and mental health, as well as a better understanding of all the referral sites available to people experiencing homelessness. They all agreed that they are always open to hear and learn new things.

Support for Peer Health Workers

PHWs found that the Project Coordinator has done a good job in terms of providing them with support. He was seen by them as “extremely supportive”, always asking if they needed anything, and always taking the time to help if there were any problems. Consequently, the Project Coordinator appeared to be the PHWs’ most significant source of support.

“(Project Coordinator) has been extremely supportive. (He is) always asking if you need anything, and if there are any problems he’ll take time away to help – he places extra interest”. (PHW)

PHWs did not consider partner site staff to be a considerable source of support. There were some examples of the site supporting PHWs. One partner site staff said that the PHW was unsure how to operate at the site so he gave the PHW ideas for what to do and how to market their role. After a meeting with the project manager, the PHW, and the site, this PHW started to do better. All partner site staff said there was always an open-door policy and that PHWs were always welcome to talk to them should they ever need anything.

“I’m sure that if there was any serious issue that he felt he might need support himself, he would have come to us. We left that as an open door. (The PHW) was working independent of us. I thought it worked fine”. (Partner Site Staff)

Some of sites operate on a highly collaborative and communicative structure and having a worker who operated independently caused some confusion around support role of site. A couple of the partner site staff noted that the PHW did not want any connection to the staff at their site. According to one partner site staff, it would have been helpful for PHWs to understand what
kind of supports they can access from the site. This might have made them comfortable approaching the site for support. For example, one site partner staff was approached by the PHW in a crisis and said it would have been good if to have been approached before the crisis.

A clear understanding of what kind of training PHWs received and how they can be used as a site resource could have helped sites better support PHWs. Partner site staff explained it might be helpful for PHWs to have some training about their own issues and how they affect their work because this is something that all people doing this type of work need to do. All sites expressed their support for the concept of peer work but some felt as if they needed some additional clarity with respect to their involvement and their relationship with the PHW. Sites recommended clarifying the structure and what is expected of sites in terms of support from the beginning.

5. Project Successes and Impacts

When asking research participants about project successes they mostly talked about the value of the Peer Health Worker Model, no matter which stakeholder group they represented. That is, in the perspective of most research participants the Peer Health Worker Pilot Project was both successful and unique in that it used people with lived experience on the street to reduce social isolation and to increase the awareness and use of services. The following program successes are outlined in further detail below from the perspective of differing stakeholders.

- PHWs have a unique knowledge base of social services and how to access them.
- PHWs are able to provide unique emotional support because they have ‘been there’. Site staff may also have past experience with homelessness, but it might be more easily recognized in PHWs because of their title.
- People experiencing homelessness trust PHWs and feel they can be honest with them.
- People experiencing homelessness are comfortable approaching PHWs with issues.
- People experiencing homelessness said they trust the information they receive from PHWs.
- People experiencing homelessness said they are being connected with and referred to services by PHWs. PHWs also said they are connecting people. There is no measurement tool in place at this point to determine the numbers of people who are following through on the referrals they are being given by PHWs.

The Perspective of Peer Health Workers

PHWs felt that their lived experience on the streets placed them at an advantage when interacting with people experiencing homelessness. According to PHWs, their homelessness experience helped demonstrate to people that their position was not there to give them a hassle if they were doing something illegal. Rather, by being someone who knows where they were coming from they were more likely to be approached and trusted. All PHWs agreed that people felt comfortable to talk with them, although it took longer for some people to open up than others. One PHW recorded that the “guys called me ‘one of them’”. A PHW said that initially people would approach them because they knew them or had seen them on the streets before. According
to a PHW, PHWs give “people another person to connect with on another level… that is, on an even playing field”.

Judging from their own experience, PHWs agreed that people experiencing homelessness can be slow to trust service providers. This perspective was validated by people experiencing homelessness. PHWs said that it takes time talking, listening, laughing, and hanging out with people before they would open up. This may also true for other outreach workers. However, based on the opinions of PHWs and the people who accessed them, it takes less time for PHWs to gain the trust of people experiencing homelessness.

“My success is helpful to spread understanding and knowledge because of where I am coming from”. (PHW)

PHWs believe this is due to the skills and attributes they gained from their personal experience with homelessness. People who accessed PHWs cited that they were confident that PHWs were not judging them negatively or discriminating against them.

The Perspective of Partner Site Staff

Accordingly, all partner site staff agreed that people experiencing homelessness might be more comfortable speaking with a peer and that they had faith that PHWs were doing what they were hired to do (e.g., referrals, support).

“He was very comfortable dealing with them too. Like, when somebody else feels comfortable that draws them in”. (Partner Site Staff)

The partner site staff agreed that there is a great deal of value in PHWs ‘just being’ with people and that there is generally more trust because they are peers.

“It works really well for some people to have a peer talk about their similar experiences. This unique need isn’t being met through most agencies. Professionals have boundaries. In this way, it offers a unique dimension”. (Partner Site Staff)

Partner site staff believed that there was great value in being outside the organization and they were hopeful that they were doing great work but they did not have any information to suggest that the project was successful, other than simply seeing PHW interacting with people.

The Perspective of People Experiencing Homelessness

From the perspective of the people experiencing homelessness, the Peer Health Worker Pilot Project was a success. They felt that the best thing that could have been done was to hire people who had lived experience on the streets because they know where they have been and where other people are coming from. For example, PHWs were able to differentiate between housing and health-related services (e.g., STI testing).
“The smartest thing they did was hire people that had been on the streets before and know what we’re going through. If you’ve never been there you can only imagine”.
(Person Experiencing Homelessness)

All in all, people experiencing homelessness found that PHWs were very resourceful, nice, uplifting, and that they would never discriminate amongst who they would help and talk to.

“He helped myself and helped a lot of people”. (Person Experiencing Homelessness)

“If [the PHW] wasn’t there, there’s quite a few guys at [the partner site], for instance, that wouldn’t have anybody there to point them in the right direction”. (Person Experiencing Homelessness)

PHWs were always there to talk/listen to people and help out in any way that they could, so that needs could be met.

“Anything you ask her, if she doesn’t know she’ll find out. She’ll even phone and leave a message. She goes out of her way”. (Person Experiencing Homelessness)

“They [the peer health worker] have extra heart. They go that extra mile”. (Person Experiencing Homelessness)

People who accessed a PHW all agreed that the knowledge from PHWs is unique. They have a wide variety of knowledge of the inner workings of the way local social services operate. PHWs believe that their training represented a success because it supplemented what they had already learnt through their own personal experiences, which coincides with the project objective of providing peers with training and support.

“You can hire somebody who has all kinds of college degrees and all this and that but they haven’t been [on the streets,] we can’t relate to them, they can’t relate to us. The people that have been there are the right people for the job. They know exactly what we’re talking about - the stuff that you learn by being there...in the trenches”. (Person Experiencing Homelessness)

Project Coordinator Perspective

The Project Coordinator’s perspective echoed that of people experiencing homelessness. He had the benefit of seeing PHWs in action and hearing firsthand the things that PHWs did to make a difference. It was apparent to him that people are, indeed, accessing health and health-related services more often due to the work of PHWs.

“I’ve heard stories of people accessing crisis services because of information they got from a peer. Whenever that happens it’s a great thing. People in crisis need all the support we as a community can provide”. (Project Coordinator)
6. Project Challenges and Suggested Changes

When asked about project challenges, depending on their relationship to the project, research participants identified seven major themes: 1) length of time, 2) timing, 3) salary, 4) training, 5) clarification, 6) promotion, and 7) support. In addition, the Contact Records provided information concerning the challenges, barriers, and gaps in the service context.

**Length of time**

With the exception of the partner site staff, all research participants identified time as a project challenge. PHWs all felt that three hours a week was not enough time, especially when PHWs include time to write up weekly Contact Forms. A lot can happen in a week and it is difficult to have many in-depth discussions in one three hour shift.

“It is not enough time to work for three hours at one site. Time runs out really quick when you’re discussing something that is ‘heavy’ with somebody”. (PHW)

This finding was corroborated by both the people experiencing homelessness and the Project Coordinator. People experiencing homelessness felt that it was hard for PHW to tackle the issues of everybody that enters a site. Accordingly they felt that more time and/or more PHWs would be beneficial. The Project Coordinator was not convinced that three hours a week was the best model. Even two three hour shifts a week could be a significant improvement.

“It’s not enough time in the week. Even to have two three hour shifts could be a huge improvement”. (Project Coordinator)

**Timing**

Timing of shifts was identified as a challenge by both PHWs and people experiencing homelessness. Specifically, both groups felt that it was important that somebody could ‘be there’ and available when nobody else was. For example, many support services shut down at the end of the work-day. Consequently, there is a need for somebody to be available after certain hours. It is not certain if this person should be a PHW, but such a person could help direct people to services that are still available and address health and health-related needs during this time. PHWs agreed and felt that their shifts need revolve around the schedule of the homeless population.

“It’d be useful to have a Peer Health Worker after business hours…at the churches…equipped with phones”. (Person Experiencing Homelessness)

**Salary**

PHWs recognized their salary as a potential challenge. Some of them felt bothered that they did not get paid much for what they do and the risk they put themselves in. There were a number of
situations that arose that a PHW felt unsafe at their site. They also felt that paid training and/or free access to community workshops could prove beneficial.

Training

With the exception of people experiencing homelessness, all research participants specifically mentioned the potential benefits of additional training. PHWs identified the potential utility of addictions and mental health workshops and the partner site staff identified the need for self-marketing skills and more training about resources available for referral. A lack of knowledge could easily prove challenging when working with the homeless population.

Role Clarity

Clarity with respect to PHWs’ roles and their relationship to the different sites was identified as a challenge to the project by partner site staff, PHWs, and the Project Coordinator. Although partner site staff understood and supported the Peer Health Worker model, they lacked clarity in the following areas: their relationship to the PHW, how they could provide support, what kinds of services the PHW were providing and are capable of providing, whether or not the PHW should be treated as another site staff member, etc. Increased role clarity could augment the number of reciprocal referrals occur between PHWs and site partners.

One site partner suggested it might help for sites to have a sense of how much support the PHW at their particular site requires. For some of PHWs and the partner site staff, there was an expressed lack of understanding regarding their role in relation to health. Some research participants suggested that the word ‘health’ be removed from their title as it could imply that they were trained as a form of health professional. The Project Coordinator, in addition, noted that because some PHWs have other supportive roles in the community it is sometimes difficult for them to discern where the boundaries are between their roles and relationships with people.

Promotion

The majority of research participants expressed the need to increase community awareness about PHWs and what their role is. Although almost all homeless research participants indicated that they knew of PHWs they all expressed the need for a sign or something that could indicate when a PHW would be on-site and what they could provide. According to a partner site staff, PHWs need to sell themselves to people accessing the site, and some marketing skills would be very helpful.

“A lot of people don’t know [about the project]. Don’t know about the focus”. (Person Experiencing Homelessness)

“Should be, maybe, a posting that he is there every week...or maybe have a sign-up list”. “There’s no advertising that is there”. (Person Experiencing Homelessness)
Support

Support from the partner site staff and from the Project Coordinator was identified as a relevant challenge. The Project Coordinator expressed that it was difficult to balance a supervisory role and allowing them the opportunity to “find their own way”. For example, although almost all PHWs found a relatively easy transition into their role, one found that it took about five months to “break the ice”. More time for the Project Coordinator to supervise and facilitate the project could prove beneficial. The partner site staff expressed ambiguity surrounding their role in relation to monitoring PHWs ability to do their job and address any issues they may have. It is important to reiterate the need for a clear understanding of each stakeholder’s role in order for the project to unfold successfully. Furthermore, an understanding of what kind of support is needed and desired could prove beneficial.

Challenges, Barriers, and Gaps in the Service Context

Based on information received from PHWs and in the contact forms they completed, there were a variety of challenges within the service context of this program. Four themes emerged: issues with emergency shelter, barriers to health, barriers to housing, and other service barriers. Issues with emergency shelters included: difficulty reaching site staff, safety, lack of supervision, limited hours of registration, stress (e.g., police presence), options for those rejected, duration of stay, differing rules, availability of supplies, and lack of projects similar to Out of the Cold in warmer months.

Issues related to health barriers included: lack of a walk-in clinic within the area, lack of support services following release from withdrawal management, eligibility requirements of substance abuse programs, lack of follow-up support systems, and being turned away from the hospital. Issues related to housing barriers included: wait lists, affordability, availability of youth shelters and housing, discrimination, referrals, and lack of follow-up.

Finally, issues concerning other service barriers included: difficulty accessing phone service for people experiencing homelessness, not enough site supervision and intervention (e.g., fights happening at sites), communication barriers, sense of judgment from site staff toward people experiencing homelessness, transportation, lack of support following release from jail, and difficulty regarding justice diversion.

D. Recommendations

A set of seven recommendations based on the evaluation findings have been developed to enhance the Peer Health Worker Pilot Project growth and sustainability.

1. Continue Peer Health Worker Project

The findings of this evaluation indicate that the Peer Health Worker Project has great value and potential for providing support and information to people experiencing homelessness in
Waterloo Region. The potential of the project will be increased when action is taken on the remaining recommendations.

2. Clarification of Stakeholder Roles

It is recommended that the Peer Health Worker Pilot Project establish clear lines of communication between all stakeholders involved in the program, in order to clarify the roles, services, support systems, and expectations of the program. Clarity of PHW role in relation to the role of partner sites and the Project Coordinator is necessary. This may require discussion by the steering committee of what type of role each site should be having, keeping in mind that sites often cannot take on much more work. It important that the project management explore how to carry out site relationships before the project moves past the pilot phase. This would include developing a plan for consistency in reporting at sites, and clarifying confidentiality policies. It is necessary to revise the project model plan prior to visiting sites. This may involve sites interviewing potential PHWs to determine a good match.

3. Greater Promotion Within the Homeless Community

It is recommended that the Peer Health Worker Pilot Project increase public promotion within each of the partner sites and within the homeless community. This can include the use of marketing materials such as posters, sign-up sheets, community-related forums, and other forms of program promotion. Program promotion can increase the use of PHWs, create opportunities for project improvement, and increase attainment of desired project outcomes and goals. Furthermore, it could serve to enhance and expand partnerships within the continuum of outreach. This would be site dependent. A further recommendation for promotion is the consideration of changing the title of the project to Peer Outreach Worker Project.

4. On-Going Training and External Networking Opportunities

It is recommended that the Peer Health Worker Pilot Project provide on-going training to its PHWs. Although they are experienced and knowledgeable about homelessness they can continue to benefit from learning more about issues related to homelessness (e.g., addictions, mental health, resources, and boundaries). Continued training and networking with existing service providers can serve to increase their value and increase their ability to work within the homeless community. A variety of training opportunities can also serve to keep PHWs engaged and continuing to grow within their role. It would be beneficial for PHWs to attend existing training at sites on a variety of topics.

5. Stronger Project Support for PHWs

It is recommended that the Peer Health Worker Pilot Project pursue the establishment of strong support networks for PHWs. As PHWs are providing emotional support for their homeless peers, so too do PHWs need their own source for support. The supportive role of partner sites should be established so that there is a clear understanding of what kind of support is available to PHWs and how the use of such supports. Sites should be instructed on the types of supports they should
provide to PHWs. Sites should be made aware of the types of training PHWs have had, to clarify potential areas for support. In addition, some form of emotional support/counseling should be made available for PHWs in either an individual or group capacity. Notably, the Project Coordinator should not be relied upon to provide the majority of support. Self-help workshops in addition to the availability of a counselor at KDCHC could prove beneficial in this regard.

6. Adapted Project Structure

It is recommended that the Peer Health Worker Pilot Project adapt a project structure that coincides with the needs of the homeless community. The addition of even one shift per week per site could have a major impact on the homeless population. If this is not possible within the current budget, it is recommended that the project scale down on the number of sites and PHWs, but double the time at each site. Even one more weekly shift at a site would increase PHWs ability to follow up on referrals, crises, and other support. This would entail a process of going to each site and reconfiguring the project specifically to each site. It could, furthermore, be beneficial to consider having a PHW available after business hours in order to provide support when other support providers close. In addition to shifting the project structure with regards to timing, the salaries of PHWs should be assessed and increased if possible. These are issues need to be discussed by the steering committee.

7. Ongoing Monitoring and Reflections

It is recommended that the Peer Health Worker Pilot Project continue to track and document all project activities and outcomes. It should do that by using tools that can be designed to assess the objectives, outcomes, and greater goals of the project. Some tools could be designed in close collaboration with partner sites and the homelessness service provider network. For example, the Contact Form should be redesigned. For ease of future evaluation and on-going monitoring, an up-to-date logic model could prove extremely beneficial. A logic model would clearly map the relationship between project activities and expected project outcomes. Finally, in addition to tracking project activities and outcomes, constant reflection on lessons learned by PHWs, site partners, and related staff and consumers could benefit the project further. The tools developed for this round of data gathering need to be adjusted. This tracking could take place through the steering committee. They will consider future ways to gather further information from PHWs.

8. Stabilize and Secure Funding

It is recommended that the Peer Health Worker Pilot Project work towards stabilizing funding. This can be done through solidifying current sources of funding. It is necessary to identify the budget required to support any increased needs of the project, and update the project budget accordingly.
E. References


Homelessness Advisory Committee, 2007


F. Appendices
Appendix A – Vision, Mission, Values

Our Vision

Our Vision is to build on people's own capacity to achieve health and well being for themselves, their families and their communities. We are committed to a continuum of care model that is accessible, equitable, appropriate, holistic and transformative.

Our Mission

Our Mission is to provide, or facilitate access to, a continuum of care including: comprehensive primary health care; illness prevention; health promotion; and community capacity development for people in the downtown Kitchener community, and those from different ethno cultural groups, with a particular emphasis on those who experience barriers to accessing appropriate health resources.

Our Values

We value the community through:

- Respect
- Excellence
- Partnerships
- Accessibility
- Integration
- Diversity
**Appendix B – Peer Health Worker Job Description**

**Position:** Peer Health Worker

**Organization:** Kitchener Downtown Community Health Centre

**Goal of Position:**

To create access to community resources and connection to the community through support, encouragement, and referrals at specified sites to those who are at risk of homelessness or who are experiencing homelessness in downtown Kitchener.

**Reports to:** Doug Rankin

**Location:** Peer workers receive training and attend meetings at the Kitchener Downtown Community Health Centre

Workers will provide peer support at one of the following locations:
- Ray of Hope- Oasis Drop-in Drop-In
- House of Friendship, Charles Street Men’s Hostel
- YWCA Mary’s Place
- St. John’s Kitchen

**Activities:**

- Offer support and encouragement by listening and sharing personal insights and experiences
- Provide referral information regarding health and health related concerns
- Maintain confidentiality, respecting the rights of the peer
- Adhere to the policies of the Kitchener Downtown Community Health Centre.
- Keep a log of peer support activities
- Participate in training and peer health worker meetings

**Qualifications:**

- Lived experience of homelessness
- Proven experience developing relationships and providing support
- Ability to value an individual’s right to privacy
- Ability to maintain appropriate boundaries in helping relationships
- Ability to commitment to two hours outreach per week, and one two hour meeting per month, for 9 months

**Expectations:**

- Complete volunteer orientation and screening at KDCHC
- Participate in initial 10 hour training
- Commit to Peer Health Worker Pilot Project for 9 months
- Attend monthly meetings
- Maintain log of volunteer activities including contact, referrals and issues
• Maintain confidentiality and respect personal boundaries between peer workers and recipients of support

Benefits:

• Satisfaction of assisting others as a mentor and role-model
• Personal growth through training, meetings, and peer support activities
• Job skills training and reference
• Links to a range of services and organizations in the community
• Honorarium
• Bus ticket for transportation
Appendix C – Focus Group Questions for People Experiencing Homelessness
Focus Group with People who Access Peer Health Workers

1. Did you talk with a Peer Health Worker?
   • How did that go?
   • What did you do together?
   • Did they help you?
   • How did they help you?
   • Did you ask them any questions?
   • Did they answer any questions?
   • If no, why not?
   • Was there anything that they did not help you with?

2. Did you trust the PHW?
   • Did you believe what they told you?
   • Were you particularly happy about anything they helped you with?
   • Did you tell anyone to talk to the PHW?

3. Did you know that the PHW has experienced homelessness?
   • (If yes) How did you feel knowing this?
   • (If no) would it have made a difference to you to know that?
   • Is this worker different than other staff you have interacted with?

4. Would you approach the Peer Health Worker about an issue in the future?
   • If yes, what type of issue?
   • Would you ask them about a health issue?
   • If no, why not?
   • Do you want a PHW to be at the site?
Appendix D – Peer Health Worker Focus Group Questions

PHW Focus Group Questions

1. How and why did you become involved as a Peer Health Worker?
   • What made you want this job?
   • Is this job a good fit for you?
   • Are you more suitable for this job than others and why?
   • What is making the lives of people who are homeless most difficult?

2. What do you do as a Peer Health Worker?
   • What happens at a typical shift?
   • Do you link people to services? What kind (mental health, sexual health, etc.)?
   • Do you feel like 3 hours a week is adequate?
   • What would you do with your time if you had more hours on the job?
   • What are the most interesting things about your job?

3. What is it like to work at your site?
   • What is it like to work with other staff there?
   • How have you been supported at your site (examples)?
   • What have the challenges been?
   • How comfortable do you feel doing something different from the staff there?
   • Would there be benefits to having closer ties with site outreach workers?

4. What kinds of support and training have you received from KDCHC?
   • Do you feel the training prepared you adequately for the job?
   • What more do you need to know about health for your job?
   • What needs to be built into the project for you to feel more supported?
   • How does working within KDCHC policies affect your work? Is it helpful?

5. If you think generally about your job, what is going well and what is not?
   • What kinds of skills have you learned?
   • What has changed for you as a person?
   • Will it help you to build a better future?
   • Were there hard moments for you personally?
   • Did you have any setbacks (e.g. recurring trauma)?

6. What could be changed about and how?
   • What is your vision for this project in the future?
Appendix E – Site Partners Focus Group

Site Partners Focus Group

1. How did you get involved with the Peer Health Worker Pilot Project?
   • What do you do when the PHW is there?

2. What is it like to have a PHW at your site?
   • What was it like having someone working under a different framework within the structure of your organization?
   • Did the day, time, etc. they were there work for your organization?
   • How do they interact with the other workers at the site?
   • How is their role different from outreach/shelter workers’ role?

3. How did the Peer Health Worker interact with the people accessing your site?
   • What do they do?
   • Did you observe the PHW interacting with people who use services offered by your site?
   • Did people seem comfortable approaching the worker?
   • Did you receive referrals from PHWs? What kind of referrals? Were they appropriate?
   • Are adequately equipped to do their job?

4. How was the PHW supported at your site?
   • How did you support them?
   • Do you have an example of a time when they required support?

5. What impact has the PHW had at your site?
   • What is the impact on people who access the services?
   • Are they accessing services (e.g. health) more due to PHWs being there?
   • Did you receive comments from people (clients) on their contact with PHW? What did they say?
   • What is the impact on the greater community (KW homelessness support network)?

6. What’s been going well?

7. What’s not been going well? Challenges?
   • What needs to change?

8. Would you like to have a Peer Health Worker at your site in the future?
   • If no, why not?
   • What benefits would this have to your organization?
   • How could the project have a greater impact on the community?
Appendix F – Project Coordinator Interview Questions

Interview with Doug Rankin

1. How is the PHW project unique in the KW area?

2. What is your role in the project?
   • What do you do?

3. How does the project fit in at the health centre?
   • How did the workers work under the policies of KDCHC? Were they supportive of the process or hindering?
   • How has it impacted the culture of KDCHC? What have been reactions to the project (from KDCHC staff, and partner staff)?

4. What types of support did you offer PHWs?
   • How was the training? What more do the PHWs need to know?
   • How could the sites be more supportive?

5. Are they better equipped to do the job because they have been homeless?

6. What has been the impact of the project?
   • How has it impacted the PHWs personally?
   • Has it impacted people experiencing homelessness personally? How? Examples?
   • How has it impacted you and your perspectives?
   • To what degree are people who are homeless accessing healthcare?
   • What types of services are they accessing (mental health, sexual health, etc.)?
   • What overall barriers to services stand out to you the most?

7. What’s going well?

8. What’s not going well?

9. What needs to change?
   • How? What would that take to improve the project?

10. Final comments? What do you hope the report will achieve?
## Appendix G – Peer Health Worker Contact Record

Worker Name: __________________________

Location: __________________________________________

Date: ________________  Total number of people met: ____  Number of new people met: ____

Number of Significant Interactions: ____

<table>
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<tr>
<th>Person met with (Female/ Male, Youth/ Adult)</th>
<th>Approx. time spent meeting</th>
<th>New person</th>
<th>Provided info</th>
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<th>Person approached Peer Health Worker</th>
<th>Attended to crisis</th>
<th>Person provided information about barriers/gaps in services</th>
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Please fill in details on other side of page

Please put a checkmark in each box that applies
<table>
<thead>
<tr>
<th>Issues presented:</th>
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<tbody>
<tr>
<td>- Health-physical</td>
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<td>- Health-mental</td>
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<td>- Health-substance use</td>
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<td>- Health-sexual</td>
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<td>- Abuse/trauma</td>
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<td>- Other:</td>
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</table>

<table>
<thead>
<tr>
<th>Assistance provided:</th>
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<tbody>
<tr>
<td>- Basic support (listening, validating, problem solving)</td>
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<td>- Provided information</td>
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<td>- Provided referral</td>
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<td>- Site service connection</td>
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<td>- Phone support</td>
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<td>- Accompaniment</td>
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<td>- Advocacy</td>
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<td>- Other:</td>
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| Gaps/barriers in services and/or information: | |
|---------------------------------------------| |

| Referrals provided: | |
|--------------------| |

| Other comments (e.g. significant interactions outside of shift) | |

<table>
<thead>
<tr>
<th>Referral to Peer Worker came from:</th>
<th>#</th>
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</thead>
<tbody>
<tr>
<td>- Site staff/ volunteer</td>
<td></td>
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<tr>
<td>- Friends/ peers</td>
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<tr>
<td>- Peer Health Worker initiated</td>
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<tr>
<td>- Other:</td>
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</tbody>
</table>

| Referral to Peer Worker came from: | |
|------------------------------------| |

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