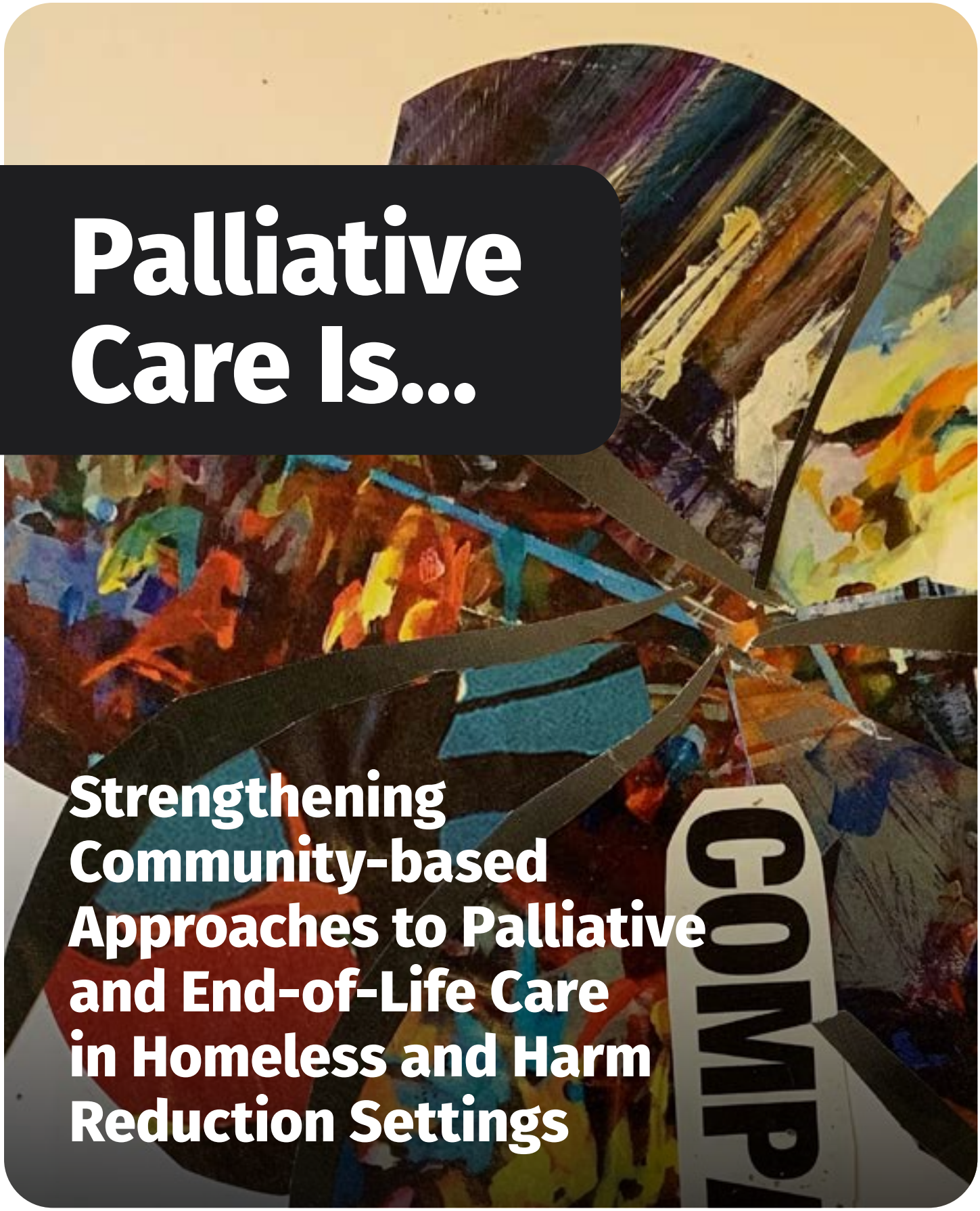
Palliative Care Is...



Strengthening Community-based Approaches to Palliative and End-of-Life Care in Homeless and Harm Reduction Settings

A discussion-based curriculum for all who care

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For more information about this curriculum, please visit palliativeapproaches.uvic.ca/palliative-care-is-curriculum/ or contact us by email at: palliative_approaches@uvic.ca.

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This curriculum was developed through the Palliative Approaches to Care in Aging and Community Health Research Program at the University of Victoria led by Dr. Kelli Stajduhar. We acknowledge and respect the Lək̓ʷəŋən (Songhees and Xʷsepsəm/Esquimalt) Peoples on whose territory the university stands, and the Lək̓ʷəŋən and W̱SÁNEĆ Peoples whose historical relationships with the land continue to this day. Collectively, those involved in this curriculum commit to our own journeys of personal and professional decolonization and reconciliation with Indigenous Peoples through relationship building, mutual trust, and reciprocity in the many places where we reside, live, learn, and work.

This curriculum honours and builds on the knowledge embedded in the Resource Guide: *Palliative Care Is…. A collective response to death, dying, and grief in the inner city.* In addition to those who contributed to the Resource Guide, we would like to thank the following people:

Project Lead: Ashley Mollison

Curriculum Designer: Kassandra Fernandes

Advisory & Contributors (Alphabetical):

Aidan Jensen-Holubowich
Alexandra (Lexy) Stewart
Amy Pritzker
Becky VanTassel
Bernice Kamano
Caitlin Leahy
Cara Bablitz
Carley McConnachie
Charlotte (Char) Futcher
Elizabeth (Liz) Harvey
Eric Lopatinsky
Hayley Sallis
Holly Prince
Janet Vandale
Kara Whitlock
Kate Leahy
Katie Thorne
Kim Toombs
Lindsay Yarrow
Matthew Busby O'Connor
Megan Conboy
Melanie Powers
Nikki Page
Renooka Misir
Shelley Perkins
Spencer Robinson
Tara Cohen
Trish Flannagan
Valerie Fiset

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About this Curriculum

Homeless Service Work is Changing

Advances in technology and health care in Canada have resulted in people living longer with more complex health conditions. For many people, however, living longer comes with the added consequence of a longer life in poverty, with meagre income and disability supports, and public pensions that do not meet the need for housing, food, and social connection. Diminishing government investments in housing and social spending over the last several decades has meant that the likelihood of being faced with homelessness and unstable housing is a reality for many who are aging in Canada. People are increasingly becoming homeless for the first time at an older age and consequently requiring health and social supports to 'age-in-place', oftentimes within congregate living facilities like shelters and supportive housing.



For those who have never been served well by Canadian health and social systems, inequities may compound across their life-course where preventable and treatable conditions (e.g., infections, wounds) become life-limiting when they are exposed to harmful structural conditions like racism and coloniality, poverty, and health system discrimination. Canadian drug policy disproportionately harms those experiencing homelessness with an increased risk of death, and life with chronic disability, such as brain injury or chronic infections, through exposure to toxic street drugs. People facing health and social inequities additionally face barriers to diagnosis, treatment, care, and support for chronic and serious illnesses like advanced cancers, severe lung disease, and organ failure. The need for health and social care increases as people approach the end of their life, which can come at an earlier age for people exposed to the structural harm of homelessness and other inequities; yet, countless barriers persist.

It is for these many reasons that care in homeless and harm reduction settings is increasingly difficult and medically complex. More than ever, people in these settings require care for health conditions alongside social ones. We live in and navigate systems that expect care at the end of life to take place among family members legitimized by legislation and policy that privileges biologically and legally connected (bio-legal) relations. Yet, bio-legal family can be estranged, unable, or unavailable for care.

Where Frontline Workers Fit

Despite barriers to system and family care, people are always giving and receiving care in settings of homelessness and harm reduction. These trusted circles can include neighbours, friends, family (including chosen and street family), and workers. The 'caregivers' in these contexts – whether paid or unpaid – also face barriers to accessing supports, being actively included and considered in the circle of care, and recognized for the work they do. Experiences with grief are especially profound in such roles where care (or lack thereof) is unjust, and deaths are frequent and witnessed.

Workers in homeless and harm reduction settings often go 'above and beyond' their existing roles to fill the gaps in care that they see on a daily basis. In doing so, they are met with ethical dilemmas (e.g., am I a worker or a human in this moment?), workplace risks (e.g., liability), and disenfranchised grief (i.e., the grief that comes from caring for those who are treated as undeserving and discarded by society), within organizations that are often under equipped to understand and support the full scope of their work. This is particularly true for workers with lived experience of substance use and homelessness, and other shared experiences, or those who are living in the same communities where they are also paid to provide care. Burnout, compassion fatigue, and vicarious trauma are the words used to shift blame onto workers for their reasonable response to the disconnect between what they feel is right and what they can do when the inequities they navigate are only growing exponentially.



The Curriculum

It is in and through this challenging context that we present a curriculum to recognize and strengthen community-based approaches to palliative and end-of-life care in homeless and harm reduction settings. For the last decade, our team at the University of Victoria has been working alongside people living and working in settings of social and structural inequity. A product of participatory, community-based research (2017-2022), we compiled our collective knowledge on death, dying, grief, and care from researchers, frontline workers and palliative care practitioners into the Palliative Care Is... Resource Guide. We have now turned this Resource Guide into relational, justice-oriented education. The curriculum was co-designed and tested in partnership with workers across Canada in various positions (e.g., frontline workers, educators, managers) in palliative care, and homeless and harm reduction settings. Our hope is that it will continue to be refined and strengthened as it is used and delivered.



On the surface, recognizing and strengthening community-based approaches to palliative and end-of-life care is not the radical solution we need to end poverty, ensure affordable and accessible housing for all, and end racism and discrimination. But it can help. In our engagements with workers over the last decade, we have collectively seen the value that comes from workers being seen, included, and engaged as an essential part of the circle of support:

- Supporting the identification of people who could benefit from a palliative approach to care resulted in better diagnosis and treatment options, more support with serious illnesses, and the chance to live longer, with a better quality of life.
- Talking and planning openly about care, dying, death, and grief led to organizations and teams orienting care around the priorities of the person in relation to their circle of support and community rather than the system's priorities.
- Conversations about people's care needs being 'too high' for the facility became centred around what conditions are needed to promote aging-in-place, better living conditions for clients and residents, and better working conditions for workers.

We believe that the solutions come from community and want to hear about the innovative policies, practices, and care approaches that you come up with! Please email palliative_approaches@uvic.ca to share your stories with us.

The Assumptions and Guiding Principles:

As we carried out development and testing of the curriculum with frontline workers, healthcare providers, educators, and managers in palliative care, and homeless and harm reduction settings, the following assumptions and principles emerged:



Care is already always happening: While it might not be called palliative care or caregiving, care is always happening among friends, neighbours, family, and workers in homeless and harm reduction settings. This curriculum is not about replacing this natural, community-centred care with professional services. It is about valuing the care work that is already happening, finding ways to better include workers in the circle of care, and supporting workers as paid providers as well as humans engaged in caring relationships.

We are not teaching people to be palliative care experts: It is essential that we honour the knowledge and approaches to care that come from living and working in homeless and harm reduction settings. Cultural safety, harm reduction, and trauma-informed, person-centred care is often foundational to the work and palliative care has a lot to learn about approaches to care that work for people who face barriers to mainstream health and social systems.

This is not about putting more on workers: This curriculum is first and foremost about recognizing the care work of people in homeless and harm reduction settings, and most importantly, getting them more support. For health care, this could look like better communication with workers, inclusion in decision-making, and honouring of their perspectives. In social care settings, this could look like better recognition of the physical and emotional toll of the work, honouring of the relationships that exist between 'clients' and 'workers', ritual to remember people who have died, better health benefits plans, paid time off, and individual as well as collective grief responses that are not only allowed to occur but actively encouraged and supported.

There is a difference between the philosophy and practice of palliative care: This curriculum operates on the assumptions that a palliative approach to care can get people more and better care and resources, yet we continue to work within systems with eligibility criteria that are not often conducive to an 'upstream' approach to palliative care. For instance, many palliative programs require people to have a life-expectancy of less than 3-months. A tension exists in a curriculum that seeks to increase capacity for identifying those who may



benefit from a palliative approach to care in a context where people may be ineligible for palliative care services.

Supportive workplace policy must accompany this approach: While we recognize and value how workers are already providing care, workers can't always be open in the workplace about how this care happens. We advocate for better recognition and working conditions through job classifications, and workplace policy and supports (e.g., paid time off, health benefits, etc.), that better reflect the ways in which workers are filling gaps in system and family care.

Structural changes are still needed: We advocate for better structural conditions so that people are not falling into homelessness, facing healthcare discrimination and racism, and criminalized and paternalized for being poor and using substances. These structural inequities are killing people, causing mental, emotional, physical, and spiritual pain and suffering that ripples throughout our communities and affects everyone.

Education provides an opportunity to de-silo health and social services: Aligned with an equity-oriented palliative approach to care, our approach to education seeks to remove the silos between health and social service sectors, providing opportunities for health and palliative care practitioners to step into homeless and harm reduction settings in helpful ways to offer support.

Outside homeless and harm reduction exclusivity: While we use the language of homeless and harm reduction settings, we see this curriculum as applicable and adaptable to other settings where people face barriers to health and social care. We encourage adaptations to your settings in the greater service of improving access to and quality of palliative care for all.

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Before You Begin

Understanding the Curriculum and Facilitation Process

This curriculum is designed to support conversations about serious illness, care, and loss in homeless, housing, harm reduction, and community service settings. The goal is not to turn workers into healthcare providers or palliative care specialists. Rather, these guides create space to talk about difficult situations, share experiences, and explore ways to support people who are seriously ill while also supporting one another.

These learning tools are designed to support conversation, reflection, and shared learning, not to deliver technical training. They are intended to help workers reflect on experiences they are already encountering in their work and build confidence in responding to situations involving serious illness, decline, and death.

Workers in homeless and harm reduction settings often recognize changes in someone's health and wellbeing long before healthcare systems respond. These tools are meant to acknowledge and strengthen that knowledge and experience and offer them support, confidence, and reassurance as they continue to work in these contexts and encounter these situations.

Facilitators do not need to be experts in palliative care to use these tools. What matters most is creating a space where participants feel comfortable reflecting on their experiences and learning from one another.

Participants may include workers offering supports and services on-the-ground, workers with lived experience, housing staff, social service providers, or healthcare professionals. Conversations may touch on personal as well as professional experiences with illness, death, and grief.

These tools may also be used with healthcare providers who are familiar with palliative care but may have limited experience working in homeless, harm reduction, or other settings where people experience structural vulnerability. In these contexts, care is often shaped by complex social, health, and systemic factors such as poverty, trauma, unstable housing, mental health challenges, and substance use.

Bringing participants together from different sectors can help build stronger and more responsive circles of care. By learning from one another's experiences, healthcare providers and community-based workers can better understand the realities of supporting people who are seriously ill in these settings and how a palliative approach to care can be adapted to meet people where they are.

Ultimately, these conversations aim to strengthen understanding across sectors and support more compassionate, coordinated care for people experiencing serious illness in contexts of homelessness and structural vulnerability.

Guiding Principles for Facilitators

Connection, Not Completion



These discussion guides work best when used flexibly.

You do not need to ask every question or complete every section of the guide. Follow the conversation where it is meaningful for the group.

The goal is connection, reflection, and shared learning, not finishing every activity.

Each module highlights key takeaways or core ideas. As long as participants are exploring those key concepts, the discussion is serving its purpose.

You Don't Need to Be the Expert

Facilitators do not need specialized expertise in palliative care.

Your role is to:

- guide the conversation
- invite reflection
- create a respectful and supportive space

Often the most helpful response is simply:

- listening carefully
- acknowledging what was shared
- inviting others to reflect or contribute

Facilitators should aim to be present, honest, and responsive, rather than perfect.

Preparing to Facilitate

While you do not need to be an expert, it is important to be prepared.

Before facilitating a module:

- Review the discussion guide ahead of time.
- Identify the key ideas and questions you want participants to explore.
- Consider whether there are local resources or policies you should be aware of.

For example, in the *Planning for the Future* module, it may be helpful to familiarize yourself with:

- local advance care planning tools
- substitute decision-maker laws
- community resources that support care planning

Facilitators should also be aware of the roles and scope of practice of the participants they are working with, as questions about responsibilities and boundaries may arise.

If you are unsure of an answer during a session:

- be honest.
- acknowledge the question.
- offer to follow up later or direct participants to someone who has expertise in that area.

Facilitators may also find it helpful to co-facilitate with someone who brings complementary knowledge or experience, especially when working with new groups.

Facilitating With Reflexivity and Care

Facilitating discussions about illness, death, and grief requires self-awareness and reflexivity.

Facilitators should reflect on their own:

- assumptions
- emotional responses
- potential judgments

Approaching discussions with humility and curiosity helps ensure the conversation remains trauma-informed, respectful, and inclusive.

Building Trust in the Room

These discussions work best when participants feel safe, respected, and connected.

If you are facilitating with a group that does not already know you, take time to build trust by:

- introducing yourself and your role
- inviting participants to introduce themselves
- acknowledging the experience and knowledge participants bring
- involving co-facilitators or trusted staff members when appropriate

Relationships and trust are essential for meaningful conversation.

Creating the Space for These Conversations

Conversations about serious illness, death, and grief can bring up emotional, relational, or spiritual responses.

Creating a supportive environment can help participants feel more comfortable engaging in these discussions.

Consider establishing a simple opening and closing structure for sessions – an example is provided later on in this document.

Opening

At the beginning of a discussion:

- introduce yourself and your role
- explain the purpose of the conversation
- acknowledge that some topics may be difficult
- remind participants that sharing is voluntary

This helps create clarity about the intention of the conversation and the expectations for participation.

Holding the Space

During the conversation:

- allow for silence and reflection
- acknowledge emotional responses if they arise
- remind participants they may step out or take a break if needed

Participants may share difficult experiences or losses. Listening and acknowledging those stories can be an important part of the process.

Closing

Ending discussions intentionally can help participants transition out of emotionally heavy topics.

Consider closing by:

- acknowledging the work participants do
- recognizing the care and commitment involved in supporting others
- reminding participants of available supports or resources if needed
- thanking participants for their openness and contributions

Recognizing System Realities

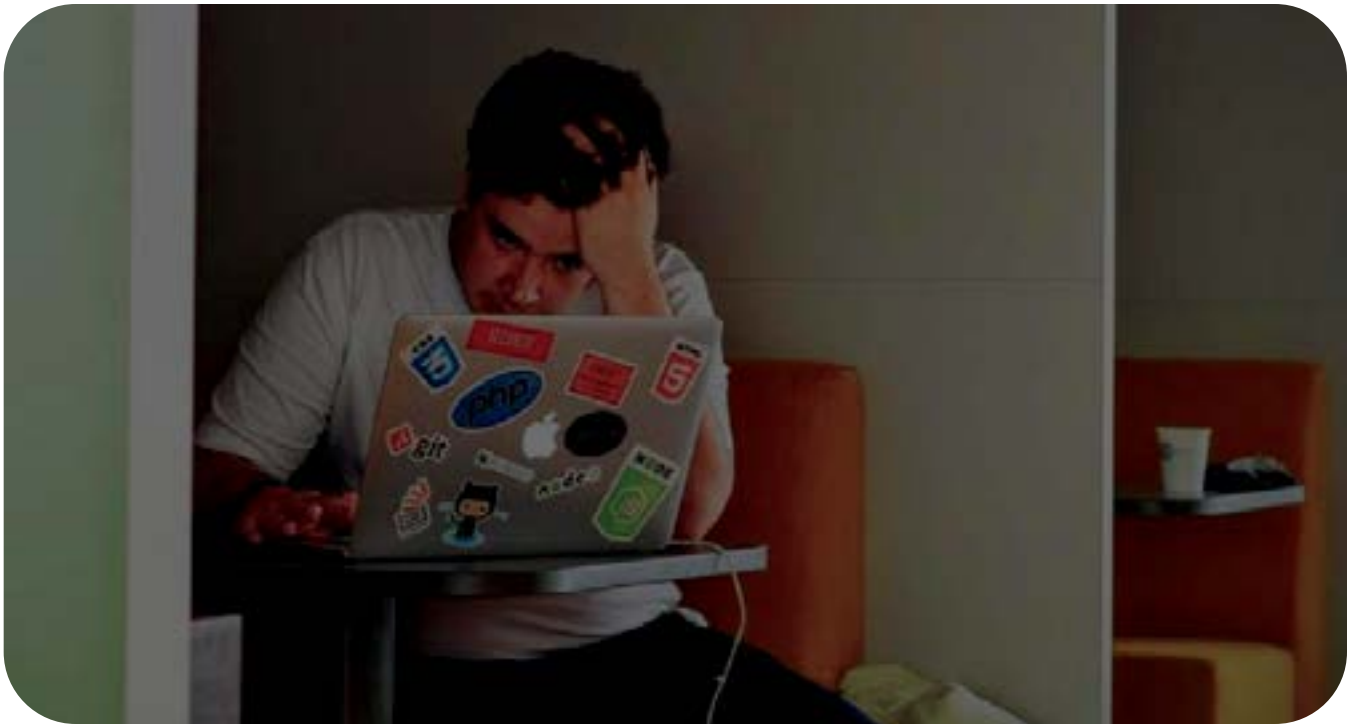
Discussions may surface frustration with healthcare systems, policies, or gaps in services. These feelings are valid and common in work involving structural vulnerability.

While the curriculum cannot fix those systems, the purpose is to help workers:

- better understand their role in a palliative approach to care
- support one another
- identify opportunities for collaboration and advocacy
- reduce system harm

Naming these realities and working toward reducing their harm can help participants feel less isolated in the challenges they face.





Supporting Participant Wellbeing

Topics such as serious illness, death, and grief can bring up strong emotions. Participants may recall experiences of loss or situations that were difficult to navigate.

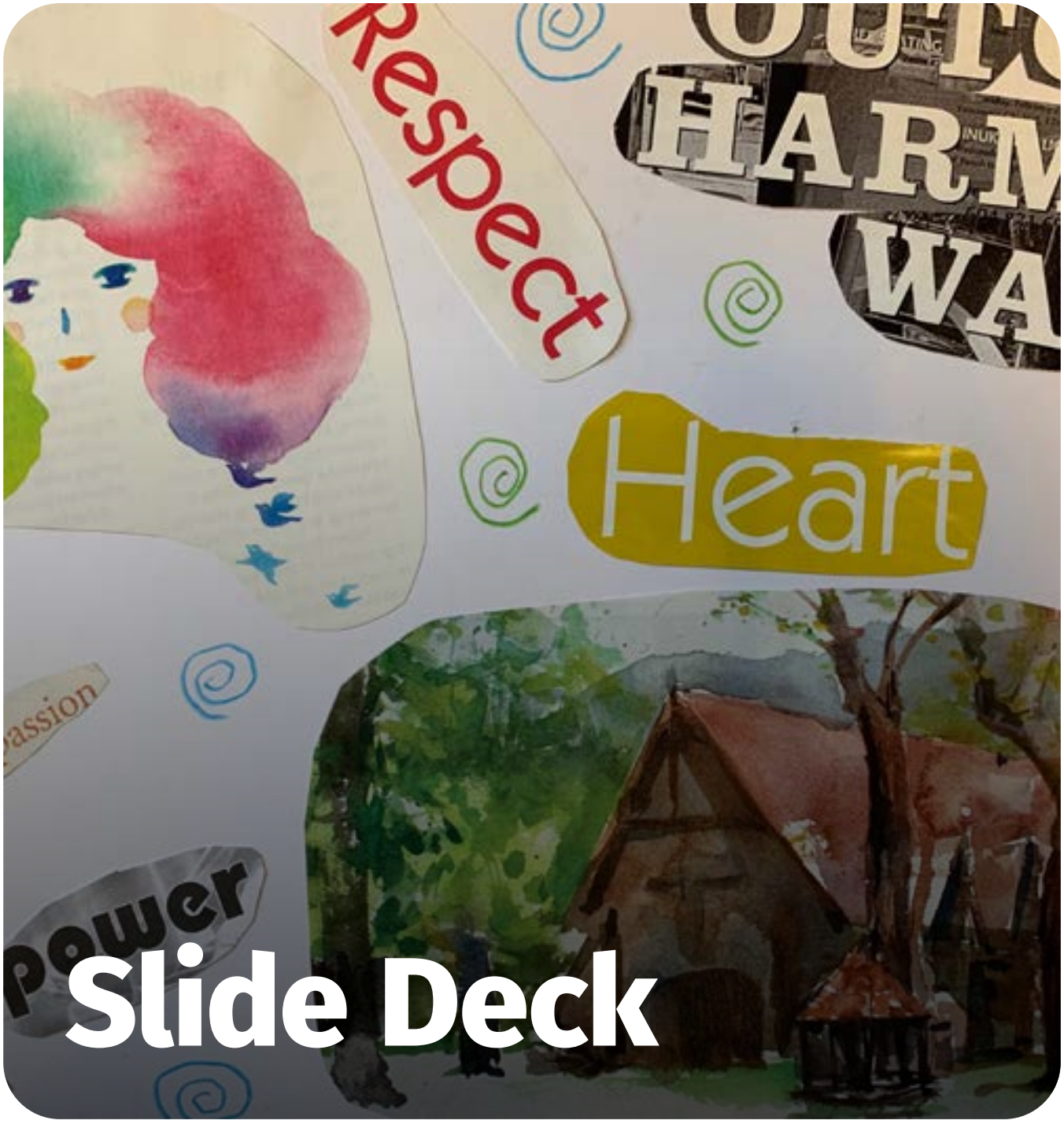
As a facilitator:

- remind participants that sharing is voluntary.
- allow people to step out if needed.
- encourage participants to support one another.

It is okay if conversations feel emotional, unfinished, or complex. These discussions are about learning together and supporting one another, not solving every challenge that arises.

Facilitator Reminder

- **You do not need to ask every question in the discussion guide or touch on every point in the slide deck. Connection and shared learning are more important than completing the guide.**
- **Focus on the key messages for the module and refer to the corresponding content in the Palliative Care Is... A collective response to death, dying, and grief in the inner city Resource Guide if you need more support.**
- **Create a safe space that honours workers' experiences and promotes opportunities for reflection and discussion.**



Slide Deck

Recognizing Community-Based Approaches to Palliative and End-of-Life Care in Homeless and Harm Reduction Settings



Palliative Approach to Care in Homelessness & Harm Reduction

Corresponds to Chapters 1 & 2 in the *Palliative Care Is... A collective response to death, dying, and grief in the inner city* Resource Guide.

Purpose of the Discussion

This module introduces the idea that a palliative approach to care already exists within homeless and harm reduction settings. It helps participants explore how their work supporting people through illness, decline, and loss aligns with the values of palliative care.

Key Messages

- Palliative care is not only about the last days of life. It focuses on reducing suffering and improving quality of life.
- Many frontline workers are already providing care that reflects a palliative approach.
- Housing, harm reduction, and community services are essential parts of a person's circle of support.

Before You Facilitate

- Reflect on who will be in the room (frontline workers, healthcare providers, people with lived experience, etc.).
- If healthcare providers are present, be prepared to highlight the expertise and relational knowledge frontline workers bring as well as the need to adapt practices to meet people where they're at.
- If working primarily with frontline workers, reinforce that this session is meant to highlight the value of their existing work as being aligned with the palliative approach to care. It recognizes and supports the work they are already doing, and is not meant to add new responsibilities.

During the Discussion

- Encourage participants to reflect on where they already see palliative values in their work (e.g., getting to know the person, finding out what matters, meeting people where they are at).
- Be mindful that the term palliative care may feel medicalized or intimidating to some participants.
- Allow space for participants to share examples from their work.

Closing the Conversation

- Reinforce that participants already play an important role in supporting people through illness and decline.
- Emphasize the importance of collaboration between health care and community-based services.

Download slide deck



Slide 1

[Welcome the group to the session.]

Whether you're a healthcare provider unfamiliar with the realities of structural vulnerability and harm reduction, or an outreach worker less familiar with palliative care, this presentation is meant to bridge those worlds and invite shared learning with the common goal of improving.

In this presentation, we will explore the meaning and relevance of a palliative approach to care in contexts of homelessness and harm reduction. We will discuss how a palliative approach to care can be used collaboratively to reduce suffering and improve end-of-life experiences for people facing poverty, homelessness, substance use, stigma, and other systemic barriers.

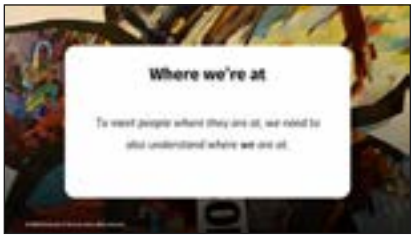


Slide 2

This curriculum was developed through the Palliative Approaches to Care in Aging and Community Health Research Program at the University of Victoria led by Dr. Kelli Stajduhar. We acknowledge and respect the Lək̓ʷəŋən (Songhees and Xʷsepsəm/Esquimalt) Peoples on whose territory the university stands, and the Lək̓ʷəŋən and W̱SÁNEĆ Peoples whose historical relationships with the land continue to this day.

Collectively, those involved in this curriculum commit to our own journeys of personal and professional decolonization and reconciliation with Indigenous Peoples through relationship building, mutual trust, and reciprocity in the many places where we reside, live, learn, and work. This curriculum honours and builds on the knowledge embedded in the Resource Guide: Palliative Care Is.... A collective response to death, dying, and grief in the inner city.

In addition to all those who contributed to the Resource Guide, there are many people who were involved in the development of this curriculum and several organizations who supported the development of this work (listed on the slide).



Slide 3

To meet people where they are at, we need to also understand where we are at (where we're coming from).

So, before we get started, we want to acknowledge that this work is grounded in both harm reduction and a palliative approach to care. These approaches recognize that suffering is shaped not only by illness, but also by poverty, homelessness, racism, colonialism, ableism, stigma, discrimination, and other systemic inequities.

Many of the people we support have experienced harm within health and social systems, and many workers have experienced the distress of witnessing preventable suffering and death while feeling unsupported themselves.

This curriculum is not about ignoring those realities. It is about recognizing them, learning how we can reduce suffering in the present, and considering how we can contribute to longer-term change. We hope these discussions help us better recognize the value of care work, strengthen collaboration, and support more equitable, compassionate responses to serious illness, dying, grief, and loss.

[Introduce yourself and any other co-facilitators involved. Let them know 'Where you're at'. (Think: who you are, what your experience has been in relation to this work, where you are situated, what you are bringing to the discussion today).

Next hear them out. Have participants introduce themselves. [Understanding and connecting with your audience is important. Hearing about what settings/contexts they work in and their experiences within this work, will help you meet them where they're at – just like we do with clients and communities we work with.]



Slide 4

In this presentation, we will explain what a palliative approach to care is and what it looks like within homelessness and harm reduction settings. Through this presentation, we hope to demonstrate:

- That a palliative approach to care is not only about the last days of life. It focuses on reducing suffering and improving quality of life.

- How many workers (health care providers, support workers, and other community caregivers) are already providing care that reflects a palliative approach by supporting people through illness, decline, and loss.
- That housing, harm reduction, and community services are essential parts of a person's circle of care.



Slide 5

Before we talk about palliative care, it's important to understand the context in which this work happens.

The people we support often face poverty, homelessness, racism, discrimination, criminalization, and stigma. These are all factors that significantly affect health and life expectancy. These realities create barriers to many of the things that help people stay healthy, such as safe housing, adequate income, nutritious food, social connection, and access to health care.

As a result, people are more likely to develop serious illnesses, have those illnesses go undiagnosed or untreated, and experience poorer health outcomes. Some people die from progressive illnesses such as cancer, liver disease, heart failure, or COPD. Others experience sudden deaths related to toxic drug poisoning, violence, or other preventable causes.

While governments often track and report certain public health crises the deaths caused by poverty, racism, discrimination, and social exclusion are often less visible. Yet these are the deaths many workers in this field witness every day.

Being homeless leads to poorer health - The cumulative impacts of homelessness and other structural inequities contribute to earlier illness, greater suffering, and shorter lives.



Slide 6

Because of this, we believe homelessness itself can be understood as a life-limiting condition.

When people are living with life-limiting conditions, whether those conditions are medical, social, or both, a palliative approach to care becomes relevant.

A palliative approach helps us recognize suffering, improve quality of life, support people according to their wishes, and

reduce unnecessary distress. Despite death and dying being all around us in these settings, it is rarely talked about, planned for, or adequately supported. We hope that through this education and our discussions, we can begin to change that.



Slide 7

So, we want to start getting into this conversation by asking you what it is like to support people who have serious conditions.

Either by putting your hand up or writing in the chat, let us know – are you seeing people who have serious illness? Cancers, lung diseases, heart issues, repeated overdoses?

What do you do in your role to support people with serious illness in contexts of homelessness and harm reduction?

Are death and dying already part this work?



Slide 8

Avoiding conversations about death and dying doesn't prevent suffering. The question isn't whether death and dying are part of our work. They already are. The question is whether we're going to acknowledge them, prepare for them, and support people through them.

One of the realities of working in in these contexts is that death and dying are all around us. Many of the people we support are living with serious illnesses in the context of poverty, homelessness, racism, discrimination, criminalization, and stigma. Conditions that might be manageable or treatable for some people can become life-threatening when people don't have stable housing, enough food, social support, or access to timely health care.

The deaths we witness are not just statistics. They are people we know. People we care about. People we work alongside. Friends, family members, neighbours, and community members.

Over time, the volume of loss can be overwhelming. Many workers describe feeling numb, angry, exhausted, or powerless. Others carry grief, frustration, or moral distress from repeatedly witnessing preventable suffering and death. Yet despite how common these experiences are, there are often very few opportunities to talk about them, prepare for

them, or receive support around them.

Death itself is difficult enough. But when there has been little planning, few conversations, and limited communication, the experience can become even more distressing. Workers, friends, and chosen family are often left out of decision-making, left without information, and left wondering what happened to people they cared deeply about

So why do we talk about it? Because avoiding conversations about serious illness, dying, and death does not prevent suffering (it often increases it). A palliative approach creates opportunities to recognize serious illness earlier, plan ahead, strengthen support networks, reduce unnecessary suffering, and ensure that people receive care that reflects what matters most to them.

Ultimately, this work is about helping people live as well as possible for as long as possible, while also supporting the workers, friends, families, and communities who walk alongside them.



Slide 9

Up until now we've talked about why this work matters. The next question is: What exactly is a palliative approach to care?

When many people hear "palliative care," they think about hospices or the last days of life. But a palliative approach is much broader than that.

It's an approach to supporting people who are living with serious or life-limiting illness. Rather than focusing only on curing disease, it focuses on helping people live as well as possible for as long as possible.

That means paying attention to pain and symptoms, but also to emotional wellbeing, relationships, housing, food security, culture, spirituality, autonomy, and dignity.

It focuses on what's most important to the person and supporting those needs, values, and wishes.

It can begin months or even years before someone dies and can happen alongside treatments intended to prolong life. It's not about giving up. It's about reducing suffering and improving quality of life in whatever way matters most to the person.



Slide 10

For many of you working in homelessness or harm reduction, this probably doesn't sound new. That's because a palliative approach fits really well alongside harm reduction.

Both approaches start from the understanding that people deserve dignity, compassion, and care regardless of where they're at in life.

Neither approach is about judging people or trying to control their decisions.

Instead, both ask things like:

- "What matters to this person?"
- "What barriers are they facing?"
- "How can we reduce suffering today?"

Just as harm reduction is much more than providing sterile supplies and safe spaces, a palliative approach is much more than managing pain in their last days.

Both a palliative approach to care and a harm reduction approach:

- recognize that health is shaped by housing, income, relationships, safety, trauma, culture, and community.
- value trust before intervention.
- understand that people are experts in their own lives.

For many of you, this isn't a completely new way of working. It's another lens that helps name and strengthen the work you're already doing.



Slide 11

Health and social care systems often assume that people have family members who can provide most of the care during serious illness.

The reality in homeless settings is often very different. Many people are estranged from biological family. Some have no one at all. Others rely on chosen family, peers, outreach workers, shelter staff, housing workers, support workers, harm reduction workers, and community organizations.

Because of this, workers often become the people who notice changes first.

- You're helping someone get food.
- You're arranging transportation.
- You're checking if they made it home after a hospital visit.
- You're sitting with them when they're scared.
- You're asking about their pain.
- You're helping them understand what the doctor said.
- You're advocating when they're dismissed.
- You're connecting them to other services.
- You're helping build a network around them.

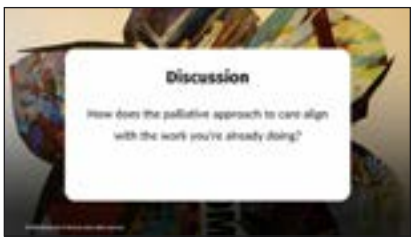
One thing that is certain is that if you are doing any of these things, you ARE part of the circle of care. A lot of this work happens quietly and often isn't recognized as healthcare. But it absolutely is part of a palliative approach.

In many cases, workers are occupying a space somewhere between family member and formal service provider. That position can be incredibly meaningful, but also emotionally demanding.

Workers often go above and beyond to fill gaps created by systems, yet they aren't recognized like healthcare professionals nor supported like family caregivers.

If we're serious about improving palliative care in these contexts, we can't just support people who are seriously ill. We also need to recognize, value, and support the workers who are already providing so much of that care.

A palliative approach to care is not provided by one person, it recognizes that caregiving for someone with a serious illness requires support from many. A palliative approach to care asks "How can we work together to reduce suffering?"



Slide 12

We've covered a lot in this discussion from the realities of homelessness and serious illness, to what a palliative approach is, how it aligns with harm reduction, and the important role that workers, peers, friends, and healthcare providers all play in supporting people.

We want to turn it back to you for a discussion. After hearing about a palliative approach to care, how does it align with the work you're already doing? [Invite participants to share in a format that's right for your group and setting].

It could be a new idea, something that challenged your thinking, something that affirmed the work you're already doing, or one small thing you'd like to try out.

As we reflect, it's also important to recognize that a palliative approach is not the solution to the structural inequities people are facing. It will not end homelessness, poverty, racism, toxic drug deaths, or the many barriers that prevent people from accessing the care they deserve.

What it does offer is another way of responding. It provides a framework for recognizing suffering earlier, supporting what matters most to people, strengthening relationships and collaboration, and reducing unnecessary distress wherever we can.

None of us can solve these systemic challenges on our own. But together, through compassionate relationships, collaboration, and collective action, we can make meaningful differences in people's lives.

A palliative approach is one tool, one perspective, and one step toward creating more compassionate, equitable care for people living with serious illness in our communities.



Slide 13

For more information, review the Resource Guide: *Palliative Care Is...A Collective Response to Death, Dying, and Grief in the Inner City.*



Slide 14

The rest of this curriculum is organized into five guided discussions that explore different parts of supporting people in homeless and harm reduction settings who are living with serious illness, dying, death, and grief. Each chapter is designed to create space for discussion, reflection, and shared learning.

The goal of these guided discussions is to validate our experiences, recognize what we already know, learn from one another, and identify practical ways to strengthen the care we provide and ways we can be better supported in this work.

The next set of slides, introduces each section, providing a summary of the key messages, a discussion question, and a case scenario.



Slide 15

Recognizing When Someone is Seriously Ill is a discussion guide that corresponds to Chapter 3 of the Resource Guide which is about learning to recognize people who may benefit from a palliative approach to care.

The first chapter focuses on noticing when someone's health may be changing or declining. Frontline workers often see changes before anyone else because they know the person, their routines, and what is normal for them. This chapter explores common signs of serious illness, different patterns of decline, and how knowing what to look for and can help someone receive care and support earlier.



Slide 16

Recognizing When Someone is Seriously Ill focuses on noticing when someone's health may be changing or worsening (including changes in appearance, behaviour, abilities, symptoms, or use of services). Workers often see changes before anyone else because they know the person, their routines, and what is normal for them.

The discussion introduces common patterns of illness decline (sudden, steady, roller coaster, slow). People experience illness and decline in different ways. When we can recognize the pattern, it can help us know when to lean in with more support, help people plan ahead, and connect them with services and people who can provide supports that improve their quality of life.

A key takeaway from this discussion guide is that you do not need to diagnose someone to recognize that they may be seriously ill. Being able to recognize these patterns and talk about these experiences with peers, can potentially help the person who is seriously ill get better care sooner, but it can also help workers feel more confident and supported in their roles.

Reflection Questions: What patterns do you see in the people you support? What changes tell you someone's health is getting worse?



Slide 17

Read James' story aloud and then present the following discussion questions to the group:

Have you worked with someone like James? What signs might tell you that someone like James is getting sicker?

If James went to the emergency room today, what do you think would happen?

What challenges might James face when trying to access care?



Slide 18

Talking About Hard Things explores conversations about health, illness, dying, and what matters most to someone. These conversations can feel uncomfortable, and workers may worry about saying the wrong thing or raising a topic the person does not want to discuss.

This discussion guide focuses on listening, noticing openings, asking questions respectfully, and following the person's lead rather than forcing a conversation.



Slide 19

We often think about these 'hard conversations' as being a one-time thing, but in contexts of homelessness, we find that people often offer up little bits of important information at a time. It is through long term relationships that we get to know more about people (like what they take in their coffee, what irks them, who their chosen people are). Talking about illness or death can open the door to care planning, symptom management, and less fear.

Talking About Hard Things offers strategies to help workers feel more confident and comfortable having conversations about illness, dying, and death.

In the discussion guide, we talk about how to recognize openings for conversation, ask questions in respectful and appropriate ways, listen without trying to fix everything, and follow the person's lead. We also make space for workers to reflect on their own readiness, role, capacity, and what to do when someone does not want to talk or accept additional support.

The key takeaway for workers is that you do not need to have all the answers or use perfect words. Difficult conversations often begin by noticing, listening, asking (thoughtfully), and creating space for the person to share what they want, when they are ready.



Slide 20

Read Arielle's story aloud and then present the following discussion questions to the group:

Have you worked with someone like Arielle? What changes made you feel like something might be going on with their health?

When you're unsure how to start the conversation, what stops you? What's helped you push through and start talking anyway?

What might happen if no one talks to her about what's going on? What could happen if someone does?



Slide 21

Planning for the Future, based on Chapter 5 in the Resource Guide, looks at how conversations can support planning and promote access to palliative care if/when needed. Conversations can include learning who a person trusts, who they consider family, who they would want involved in their care, and what would be important to them if their health changed.

The chapter introduces advance care planning and substitute decision-making while recognizing that planning may look different for each person and may happen gradually over time.



Slide 22

In Planning for the Future, we talk about how everyday conversations can help identify a person's wishes, values, relationships, care needs, and preferred sources of support.

Through guided discussion, we explore topics like chosen family and circles of care, who the person trusts to speak for them, advance care planning, and practical planning for changes in health, hospitalization, dying, death (and after death). We acknowledge that planning may happen gradually and that people may not always be ready or able to make

formal plans; so, we also discuss strategies for recognizing and documenting those important details as they come up.

A key takeaway from this discussion, is that planning is not about predicting or controlling what will happen. It is about learning what matters to the person so that workers, friends, chosen family, and healthcare providers are better able to respect their wishes and support them during a crisis or change in health.

Reflection Questions: Who do people trust to speak for them? What are the risks of not planning?



Slide 23

Read Tasha's story aloud and then present the following discussion questions to the group:

Have you worked with someone like Tasha? What changes made you feel like something might be going on with their health?

When you're unsure how to start the conversation, what stops you? What's helped you push through and start talking anyway?

What might happen if no one talks to her about what's going on? What could happen if someone does?



Slide 24

Getting More Support is based on Chapter 6 of the Resource Guide which focuses on building and strengthening the person's circle of care. Formal systems often overlook the importance of friends, chosen family, and other community organizations and workers.

In this chapter, we emphasize that care for serious illness should not rest with one person or organization. Workers are important members of the circle of care, but they should be recognized, included, and supported rather than expected to fill every gap alone.

The discussion guide based on this chapter offers strategies for workers to connect people with additional care, share important information, advocate within systems, and support collaboration without placing all the responsibility on one worker or organization.



Slide 25

In Getting More Support, we identify the care that workers, peers, friends, chosen family, and community members are already providing. Together we explore ways to strengthen a person's support network, connect with healthcare and palliative care services, share knowledge across sectors, advocate when barriers arise, and prepare for what may happen after a death.

It also considers the emotional and practical demands placed on workers who often fill gaps between family caregiving and formal service provision. Throughout the discussion, we emphasize that importance of teamwork and shared responsibility for reducing worker burden and validate worker distress/burnout as a compassionate response. In this discussion guide, Workers are important members of the circle of care, but they should be recognized, included, and supported rather than expected to fill every gap alone.

Reflection Questions: What supports are already in place? What's missing? What could help reduce burden on one person or system?



Slide 26

Read Marc's story aloud and then present the following discussion questions to the group:

What stands out to you about Marc's story? What makes you concerned?

If you were supporting Marc, what would be your first step? What would you want to know?

Have you supported someone like Marc before? What did you learn from that experience?



Slide 27

Grief & Resistance, based on Chapter 7 in the Resource Guide, focuses on the grief that workers, peers, friends, families, and communities carry when people become seriously ill or die. It recognizes that repeated and preventable deaths can lead to anger, numbness, exhaustion, moral distress, and other forms of grief.

This chapter creates space to acknowledge those experiences,

consider collective ways of responding, and understand care, remembrance, advocacy, and community connection as forms of resistance to systems that allow preventable suffering and death.



Slide 28

In the Grief & Resistance discussion guide, we reflect on how repeated, sudden, and preventable deaths affect workers, peers, friends, families, and communities. The guide acknowledges the many different types of losses people working in these settings experience and explores the many ways grief may appear, including sadness, anger, numbness, guilt, exhaustion, sickness, flashbacks, and moral distress.

It considers individual and collective responses to grief, and offers strategies for managing workers' grief, that were suggested by workers themselves including: opportunities for remembrance and public mourning, and the importance of finding supportive people and spaces. The discussion also considers how naming injustice, honouring people who have died, advocating for change, and continuing to care can be forms of resistance.

Grief is a normal response to loss and injustice, and it is not something workers or communities should have to carry alone. Making grief visible, supporting one another, remembering those who have died, and challenging the conditions that contribute to preventable deaths are all important parts of a palliative approach.



Slide 29

Read Ryan's story aloud and then present the following discussion questions to the group:

How do you feel about Ryan's situation?

Have you ever been excluded from the grieving process?

What makes grief harder when it isn't acknowledged?



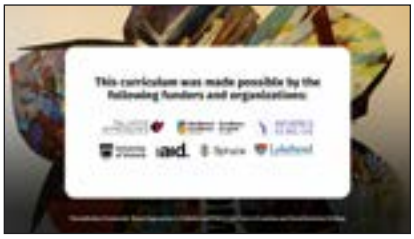
Slide 30

We want to wrap up by turning it back to you for a discussion – either by putting your hand up and unmuting when we call you – or putting it in the chat, what is one thing you are taking with you from this discussion about the palliative approach to care in homeless and harm reduction settings?.



Slide 31

Access the curriculum, including the facilitator's guide, slide deck, and discussion guide online!



Slide 32

Acknowledge the funders and organizations that made the development of this curriculum possible.

Notes



Discussion Guides

Facilitating a Discussion

Suggested Flow

These discussion guides are designed to support reflection, dialogue, and shared learning. The flow below offers a simple structure to help facilitators guide the conversation while remaining flexible and responsive to the group.

1. Open the Space (5–10 minutes)

Begin by setting the tone and intention for the conversation. The idea is to create a safe and respectful environment for discussion.

Consider including:

- A brief introduction of yourself and your role
- An overview of the purpose of the session
- Acknowledgement that the topics may be difficult or emotional
- An invitation for participants to introduce themselves if appropriate

You may also wish to remind participants that:

- Sharing is voluntary
- Participants can pass or step out if needed
- The goal is to learn from one another's experiences

2. Introduce the Topic & Case (5 minutes)

Briefly introduce the topic of the module and the case scenario. You might say something like: "Today we're going to explore situations where someone may be experiencing serious illness and how workers respond in these moments."

Allow participants a few moments to read or listen to the case scenario.

Encourage them to think about:

- What stands out to them
- What they notice about the situation
- What they might do if they encountered something similar



Remember

The goal is connection and reflection, not completing every question in the guide.

3. Guide the Discussion (20–40 minutes)

Use the discussion prompts in the guide to encourage conversation and reflection. Facilitators do not need to ask every question. Focus on the prompts that feel most relevant to the group.

Helpful facilitation approaches include:

- Asking open-ended questions
- Inviting participants to share experiences from their work
- Allowing space for pauses and reflection
- Encouraging participants to respond to one another

If the conversation begins to move off track, gently bring it back to the key themes of the discussion.



4. Reflect on Key Takeaways (10 minutes)

Before closing the session, take time to reflect together on the main ideas that emerged.

You might ask questions such as:

- What stood out to you from this discussion?
- What is one thing you might take back to your work?
- Did anything change the way you think about these situations?

This reflection helps participants consolidate learning and connect it to practice.

5. Close the Conversation (5 minutes)

End the discussion intentionally to help participants transition out of the conversation.

Consider including:

- Acknowledgement of the work participants do
- Appreciation for their openness and contributions
- A reminder that these conversations can continue beyond the session

If the discussion touched on emotionally difficult topics, you may also want to remind participants of available supports.

Closing with care helps participants feel recognized and supported in the work they do.



01

Recognizing When Someone is Seriously Ill

Corresponds to Chapter 3 in the *Palliative Care Is... A collective response to death, dying, and grief in the inner city* Resource Guide.

Purpose of the Discussion

This discussion explores how frontline workers can recognize early signs of serious illness and patterns of decline in the people they support. In homeless and harm reduction settings, workers often notice subtle changes long before healthcare systems respond. The goal of this conversation is to help participants reflect on their experiences identifying when someone's health is deteriorating, understand how illness trajectories look in real life, and consider how recognizing these patterns early can help people access care and support they might otherwise miss.

Key Messages

- Workers often notice health changes before medical professionals do.
- Small changes in behaviour, energy, appetite, or functioning can signal that someone's health is deteriorating.
- Recognizing patterns of decline can help reduce confusion and help workers move from *reacting* to crises toward *responding* to them and supporting someone earlier
- Recognizing serious illness is not about diagnosing or labeling someone as "palliative," but about helping ensure people receive the care and support they need.

Before You Facilitate

- Reflect on how illness and declining health shows up in settings where participants work.
- Be prepared for participants to share experiences where they noticed someone becoming more ill but struggled to get support or have their concerns taken seriously.
- Remind yourself that the goal is not to teach participants how to diagnose illness, but to help them reflect on how they notice change and how they respond.
- It may also be helpful to think about local health care supports or outreach services that participants could connect with if someone appears seriously ill.

During the Discussion

- Encourage participants to reflect on the kinds of changes they notice in the people they support.
- Many workers develop a strong sense of when "something isn't right," even if they cannot immediately explain why. Reinforce that this instinct and familiarity with people's daily routines can be very valuable.
- Participants may discuss challenges like people minimizing their symptoms, healthcare providers dismissing concerns, difficulty accessing care, and the complexity of supporting people with multiple health conditions.
- These experiences are common and can be acknowledged openly, but try not to get hung up on system barriers – rather do your best to have a strengths-based approach (i.e. what we are doing, what we can do, what is in our control).
- You may also notice that participants begin sharing stories about people they have supported who experienced serious illness. Allow space for these reflections, as they often lead to meaningful learning.

Closing the Conversation

- Reinforce that participants already play an important role in supporting people through illness and decline.
- Emphasize the importance of collaboration between health care and community-based services.





Facilitator Note:

Explaining Illness Trajectories

The discussion guide introduces several patterns of decline (illness trajectories). These concepts are meant to help participants recognize patterns they may already see in their work.

You do not need to explain these trajectories in clinical detail. The goal is simply to help participants think about how illness can unfold over time.

You might introduce the section by saying something like:

"People don't all get sick in the same way. Sometimes someone's health declines steadily. Sometimes they go through cycles of getting sick, going to the hospital, and coming back a bit weaker each time. Other times, the decline is slow and gradual."

Encourage participants to focus on:

- patterns they have noticed in people's health over time
- signs that someone may be recovering less fully after each health crisis
- subtle changes that accumulate over months or years

Understanding these patterns can help workers recognize when someone may benefit from additional care, planning, or support earlier, rather than waiting for a crisis.

Discussion Guide

Trust your gut — if something feels wrong, it might be worth asking about.

Purpose

This discussion guide is designed to help frontline workers reflect on the importance of identifying serious illness early, recognizing patterns of decline, and advocating for appropriate care. By sharing experiences and discussing real-life scenarios, workers can develop practical strategies to support people who may otherwise be overlooked or dismissed in healthcare settings.



Introduction: Why it Matters

As frontline workers, you often spend more time with people than medical professionals do. You may notice small changes-someone isn't eating as much, is getting more tired, or just seems "off." These signs can indicate serious health concerns, but if they go unnoticed or unspoken, people may not get the care they need.

Many of the people you support are living with serious illness in the context of poverty, homelessness, addiction, racism, and discrimination. Additionally, some illnesses that are manageable for a well housed, well resourced person, may become serious for people in these more complex contexts. They face major barriers to care and are often dismissed in health care settings or blamed for their conditions. Recognizing when someone is seriously ill and helping access care or communicate their needs to healthcare providers can be the difference between receiving proper care or being ignored.

Frontline workers are often familiar with the contexts of people's lives (how they are living, what resources they have access to, etc) and so they are often the first to see changes. Early recognition of illness, and identifying someone as being on a "palliative trajectory," can open the door to support they might not otherwise receive.

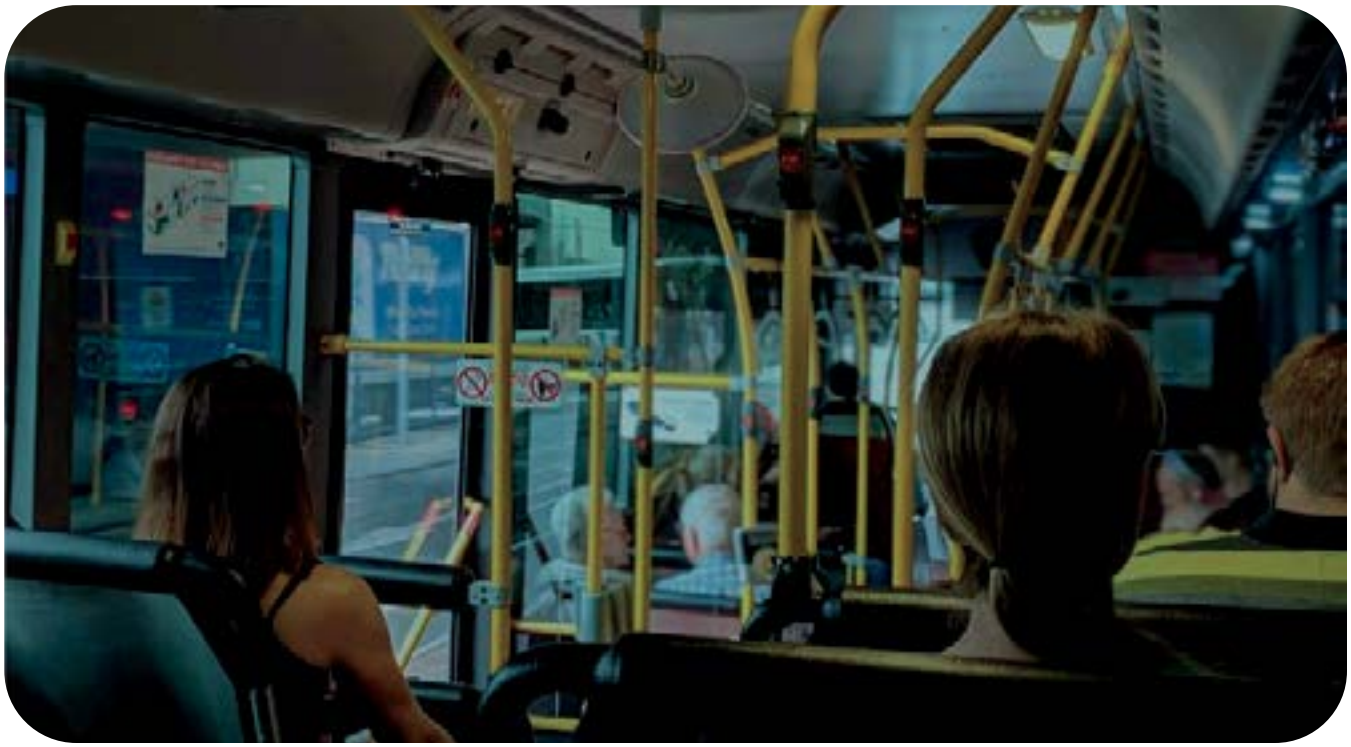
Case Scenario

James' Story

James is a 52-year-old man who has been living in a shelter for the past few months. He has a long his-tory of alcohol use and was recently hospitalized for a severe infection in his leg. Since being discharged, you've noticed some changes. He used to be social, sitting outside and chatting with others, but lately, he's been staying in his room more. He looks thinner, is coughing a lot, and seems confused at times. He says he's just tired, but something doesn't seem right.

Discussion Questions:

- What signs might tell you that someone like James is getting sicker?
- If James went to the emergency room today, what do you think would happen?
- What challenges might James face when trying to access care?



Recognizing Illness as Part of a Palliative Approach to Care



Many people we support live with serious illness alongside poverty, homelessness, racism, and stigma that can make illness worse. While their deaths may not be a surprise, they are often unsupported; not because people don't care, but because key signs of decline go unnoticed. As a result, many people who may be on a "palliative trajectory" (meaning they're living with serious, life-limiting illness) don't get access to the support that could improve their quality of life.

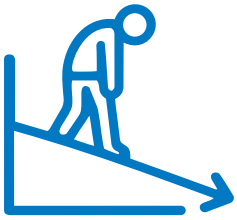
While palliative care 'services' in the health care system often have life expectancy eligibility require-ments, a palliative approach to care doesn't apply only to the final days of life. It can start early and focuses on comfort, dignity, and what matters most to the person. It includes managing symptoms like pain and shortness of breath, but also supporting housing, nutrition, social connection, and emotional needs.

Frontline workers like you are key to this approach. You often know people's baselines and can spot when something changes. Your social knowledge is critical in identifying people who may benefit from a palliative approach and helping them get the care they need and deserve.

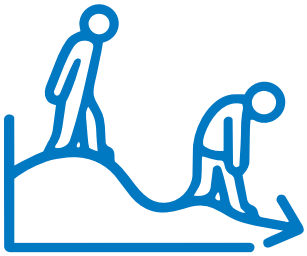
Discussion Questions:

- How do you recognize when someone's health is deteriorating? What signs make you worry?
- What can get in the way of noticing people who could benefit from a palliative approach to care?
- Have you ever supported someone who needed more care but didn't receive it because their illness wasn't taken seriously? Were there actions that you took that helped that situation?
- What misconceptions exist about palliative care in contexts of homelessness and structural vulner-ability?
- Have you seen someone get better care once a palliative approach was in place? What helped make that happen?

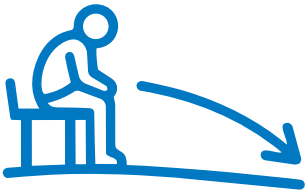
Understanding Illness Trajectories and Patterns of Decline



Steady Decline



Roller Coaster Decline



Slow Decline

People experience illness and decline in different ways. When we can recognize the pattern, it can help us know when to lean in with more support, help people plan ahead, and advocate for care.

1. **Steady Decline**

   Seen in some cancers, people may manage symptoms for a long time (sometimes even years), then decline more quickly. In conditions of unstable housing, poor nutrition or without access to care, their health can worsen rapidly.

2. **Roller Coaster Decline**

   (Most common in homelessness settings) People go through waves of being sick, getting treatment, and bouncing back, but not quite to where they were before. Over time, they recover less fully after each health crisis. Eventually, these episodes become more frequent, more serious, and harder to bounce back from. Common in people with chronic illness like heart, kidney, or lung disease.

3. **Slow Decline**

   Subtle and gradual. Seen in conditions like dementia, Parkinson's, or general frailty. May look like increased tiredness, more falls, changes in memory, poor balance, difficulty doing daily activities. In your settings, slow decline may start at a younger age and unfold quicker.

Recognizing these patterns helps us move from reacting to crises, to supporting someone more proactively.

Discussion Questions:

- Thinking back to people you've worked with, do any of these patterns remind you of someone? How did their health change over time?
- How might understanding different patterns of decline help you in your work supporting individuals in your settings?
- What are some signs of declining health that are often overlooked in the people you work with?
- What are some challenges you might face identifying patterns of decline?

When you notice patterns of decline in people you support, what are the next steps you would take in your role?

Putting It Into Practice: Illness Trajectories in Real Life



An optional exercise: Use these short case examples to reflect on how different patterns of decline might show up in your work. For each, consider what clues were present, how you responded, and what challenges emerged.

- Andre is 47 and recently diagnosed with cancer. He lives in supportive housing but has missed several appointments. You notice he's more tired, eating less, and his hygiene has slipped. He tells you, "I'm just worn out."
- Lisa has COPD and is housed in a rooming house. She has been in and out of hospital several times over the last year. After each visit, she seems weaker and takes longer to recover. She's now having trouble managing stairs and says, "I just can't catch my breath anymore."
- Peter is in his early 60s and has been living on and off the street for years. He's becoming more forgetful, sometimes seems lost in familiar places, and has had a few minor falls. He brushes it off, saying, ''I'm just getting old."

Discussion Questions:

- What made you think this person's health was changing?
- Which illness trajectory does this case seem to reflect (steady, roller coaster, slow)?
- Do you think this person could be on a palliative trajectory?
- What challenges might you face in acting on this concern, in your role?

In contexts of homelessness and structural vulnerability, we often work with people experiencing multiple illnesses that can make illness trajectories difficult to pinpoint. Someone with a terminal illness may also be dealing with other chronic conditions or wounds that do not fully heal. It is not uncommon to be supporting people who are overdosing and sustaining progressively worse brain injuries that are impact their daily functioning and decision making.

- Do any of these complex examples sound familiar to you in your work? Are there any complex cases you have found challenging that may be helpful to work through?
- What should we be considering in these complex cases to recognize whether someone could be on a palliative trajectory?

Closing Reflection

Trust your instincts! If something feels wrong, it probably is. Recognizing these patterns isn't about labeling someone as "palliative" or assuming they are dying; it's about making sure they get the care and dignity they deserve while they're still here. By noticing, being curious, and responding in ways that make sense for you and your role, you are doing your part to help prevent people from being ignored or left to suffer.





02

Talking About Hard Things

Corresponds to Chapter 4 in the *Palliative Care Is... A collective response to death, dying, and grief in the inner city* Resource Guide.



Purpose of the Discussion

This discussion focuses on building comfort and confidence in having conversations about health changes, serious illness, and care needs.



Key Messages

- Conversations about illness and care often begin informally.
- Trust and relationship are key to these conversations.
- You do not need to have perfect words to begin a meaningful conversation.



Before You Facilitate

- Reflect on your own comfort level with conversations about illness and death.
- Be prepared for participants to share experiences where conversations were difficult or avoided.
- Remind yourself that the goal is not to teach scripts, but to encourage self-reflection, build comfort and confidence, and explore approaches to support conversations.



During the Discussion

- Normalize uncertainty and discomfort.
- Reinforce that these conversations are invitations, not obligations.
- Encourage participants to reflect on moments when they noticed changes in someone's health and responded with care.

Participants may express concerns such as:

- "What if I say the wrong thing?"
- "What if I open something I can't fix?"

These concerns are common and can be acknowledged openly.



Closing the Conversation

- Reinforce that showing care and curiosity can make a meaningful difference.
- Remind participants that conversations about illness and care often happen gradually over time.

Discussion Guide

You gotta talk about it!

Purpose

This guide is designed to help frontline workers explore their unique role in having conversations about health, decline, dying, and support needs with people who are often excluded from care. These conversations can feel heavy, but they're also powerful.

Talking about hard things is already part of what you do, and your ability to build trust makes a huge difference in whether someone gets the care they need.



Introduction: Why it Matters

You don't need to be a nurse, a doctor, or a case manager to support someone who's seriously ill. Often, your relationship with someone puts you in the best position to notice when something is changing and to talk about it.

These conversations don't always lead to big decisions or clear plans. Sometimes, it's just about saying: "I've noticed something. How are you feeling about it?" When someone is dealing with chronic illness, mental health challenges, addiction, or housing instability, even small conversations can open the door to connection, planning, and dignity. We also recognize that given the different roles, responsibilities, and environments you are working in, that you might not be able to have these conversations in the moment, but we want to make sure that what people are saying is acknowledged and that there is follow up later.

It all starts by noticing. And then opening the door to conversation. *(Remembering it's an invitation, not a demand).*

Case Scenario

Arielle's Story

Arielle is in her early 40s and staying at a women's shelter. She is a sex worker, has a history of substance use, and recently mentioned she was feeling "off." You've known her awhile. She's usually sharp, funny, and active, but lately she seems more tired. She told you she's been in and out of hospital and isn't sure what the doctors are saying. She waved it off, but you're still thinking about it.

Discussion Questions:

- Have you worked with someone like Arielle? What changes made you feel like something might be going on with their health?
- When you're unsure how to start the conversation, what stops you? What's helped you push through and start talking anyway?
- What might happen if no one talks to her about what's going on? What could happen if someone does?

Reflecting on Your Role

Sometimes you are the right person to have the conversation. Sometimes you're not. Both are okay. What matters is reflecting on your role and what support you can realistically offer emotionally, practically, and organizationally.

As part of reflecting on your role, it can be important before jumping into conversation to pause and get clear on the purpose of the conversation. Some suggestions to ask yourself are: is work asking me to find something out? am I just curious? do I feel emotionally ready to have this talk today? If not, who else do I need to bring in? Do I have supports or referrals to offer if needed?

Discussion Questions:

- Have you ever avoided a conversation because you felt unsure of your role or worried about what might come up?
- What helps you decide when you are the right person to talk to someone? When might it be better to bring someone else in?
- What do you need (from your team, supervisor, or community) to feel more supported in having these conversations?

How to Lean in to Hard Conversations

You already have the skills. You listen without judgment. You meet people where they're at. That's the foundation of a palliative approach. The goal isn't to "fix" things, it's to give space for people to talk about what matters to them. That might mean:

- Picking up on natural prompts ("Yeah, I've been feeling tired a lot lately.")
- Asking open-ended questions ("Do you have a sense of what's going on?")
- Not pushing when someone isn't ready
- Knowing it's okay not to have answers

Discussion Questions:

- What are some things you've heard from people or noticed in people that made you think something was going on?
- How do you usually respond when someone brings up their health, their fear, or the future?
- Have you ever had a conversation like this that really stuck with you? What helped it go well? What made it difficult?
- What steps do you take to check in with yourself to make sure you're keeping the person's values, beliefs, and needs centred, especially in difficult conversation topics (like death and dying, end-of-life care planning, etc) where your beliefs, values, and positions may differ from theirs?

What if They Don't Want to Talk?

Sometimes, people won't want to talk and that's okay. They may fear losing housing, being judged, or being forced into a system they don't trust. Some folks just aren't ready. Your role isn't to push, it's to stay open and be there when and *if* they are.

Discussion Questions:

- Have you ever supported someone who didn't want to talk about their health? How did you stay connected?
- What are your strategies for offering care and support when someone avoids talking about what's going on?
- What do you do with your own feelings when someone doesn't engage? How do you take care of yourself in those moments?

Closing Reflection

Even when it feels like you're "just talking," you're making a difference. Opening up space for someone to name what they're going through can be the first step to getting help or simply feeling seen. You don't have to have all the answers. Whether you are helping people to start the conversation or you show them you are committed to listening (not shutting down the conversation when people come to you), you are playing an important role. You just have to start the conversation.

Discussion Questions:

- What's one conversation you've had that changed the way you think about your role in this work?
- How can we support each other in leaning in, staying open, and being okay with not having the answers?



03

Planning for the Future

Corresponds to Chapter 5 in the *Palliative Care Is... A collective response to death, dying, and grief in the inner city* Resource Guide.

Purpose of the Discussion

This module introduces advance care planning in ways that reflect the realities of homelessness and harm reduction settings.

Key Messages

- Planning can happen through informal conversations and relationships.
- Understanding someone's wishes can help guide care later.
- Planning is about dignity, voice, and respect.

Before You Facilitate

- Familiarize yourself with any local advance care planning tools, policies, or substitute decision-maker/proxy/care directive laws relevant to your region.
- Consider what resources exist locally that participants could refer to.
- Be aware that planning conversations may raise questions about roles, responsibilities, and legal processes.

During the Discussion

- Emphasize that planning does not need to be formal to be meaningful.
- Encourage participants to reflect on moments where someone shared wishes, values, or concerns that later helped guide care.
- Acknowledge that planning can be difficult in contexts where life circumstances are uncertain.

Closing the Conversation

- Reinforce that even small conversations about wishes or values can help guide care.
- Encourage participants to continue noticing and documenting these moments when appropriate.

Discussion Guide

Talking about death can't change what's already happened, but it can change what happens next

Purpose

This guide is designed to help frontline workers reflect on why talking about and planning for the future, especially around illness, dying, and death, matters in your work. While advance care planning may seem far off or irrelevant in crisis-driven environments, you are often already having these conversations in informal ways.

This guide helps deepen that awareness and equips workers to support the people you care for in naming their wishes, identifying who they trust, and making even small plans for when they may not be able to speak for themselves. It also highlights how workers themselves are a vital part of the circle of care, and that supporting planning doesn't mean having all the answers. It means making space for what matters.



Introduction: Why it Matters

In frontline work, death is often sudden, unjust, and unsupported. People die in hospital without their friends knowing. Belongings are lost. Pets are left behind. Wishes are never known, let alone respected. This takes a toll on everyone, including workers.

Talking about death won't stop it, but planning can help people live with more choice and dignity, and it can ease the pain and confusion that often follows. While it may be overwhelming when you feel like you have to 'do it right' it's much more about having these conversations before a crisis happens. You may already be the one hearing the most important things: who someone trusts, what they fear, what they don't want. This guide will help you turn those conversations into plans (big or small) that reflect the person's voice and values.

Case Scenario

Tasha's Story

Tasha is 38 and has been living in an encampment for the past year. She uses opioids and occasionally accesses the drop-in where you work. She's told you she's scared of hospitals because of how she's been treated in the past. Lately, you've noticed she's coughing more and seems more tired. One day, she says offhandedly, "ff I ever end up in a coma or something, don't let them do anything weird to me."

Discussion Questions:

- Have you worked with someone like Tasha? What might be some follow up questions you could ask her?
- If you have heard someone say something similar in the past, what did you do or wish you had done?
- What made you feel like it was a problem Did you notice any opportunity for support or planning here?

Recognizing Planning in Ordinary Conversations

Many people we support live with serious illness alongside poverty, homelessness, racism, and stigma that planning doesn't always start with paperwork. It starts with trust, with listening, and with the casual things people say that hint at deeper wishes, fears, and needs.

Discussion Questions:

- How comfortable are you having that conversations? In times when you have felt concerned, how
- comfortable are you asking for help?
- How do you hold and remember those details?
- What's one small way you've helped someone plan, even informally, for what might come?

Who's in the Circle of Care?

In the health care system, there's a lot of focus on next of kin and legal family. But many people you support have chosen families, street families, or estranged relationships. Knowing who matters to a person is foundational to good care.

Discussion Questions:

- What could be important to consider when asking people about their family and circle of support?
- How could you help someone map out their circle of care, even informally?
- Have you ever advocated for a chosen family member to be recognized in a care setting?

Decision-Making & Substitute Decision Makers

If someone becomes too sick to make decisions, the health system will look for a legal or biological family member. That can leave out people that they would wish to make decisions for them. Supporting someone to choose a decision maker ahead of time can make all the difference.

Discussion Questions:

- What would you do or how would you feel if someone asked you to make decisions for them? How can you inform yourself about the work involved in this commitment?
- Are there legal or organizational policies where you work that affect your ability to act as a decision maker?
- In the case a person is expressing interest, how can you support someone to name their decision maker, even if it's not you? (Note: There are processes in government when a person doesn't have a decision maker (e.g., Public Guardian) so you shouldn't feel pressured to take on this role or that you are required to identify another decision maker for them.)



Planning for Death and After Death

It can feel hard or even taboo to talk about what someone wants after they die. But for many people, it's a relief to know they have a say about their belongings, pets, rituals, or final resting place.

Discussion Questions:

- Have you ever seen someone's death create confusion or distress because no one knew what they wanted?
- What kinds of things have people told you they want done with their stuff, their body, or their memory?
- How does it feel talking with someone about their plans for after they die?
- Have you experienced situations where someone knows what they want in the case of their expected death, but their needs or values are different in the case of a sudden, unplanned emergency (like someone who does not want resuscitation as part of their cancer treatment, but if they were to overdose would still want resuscitation)?

Closing Reflection

Advance care planning can feel formal or intimidating, but it's often already happening in small, meaningful moments. When someone says "Don't let them put tubes in me," or "Give my stuff to Jodie if anything happens," they're trusting you with something important.

You don't have to do it all. You just have to start the conversation, or hold space when it happens. You can help people think through their choices, write things down, or get connected with someone who can help with forms and decisions.

We can only do what we can. Often having something written down or expressed is better than nothing, but sometimes in cases of family complication, pets, belongings, what we write down in our informal notes doesn't always hold up in legal/health systems. This shouldn't discourage your efforts.

You're already part of the circle of care. Helping someone plan, whether it's a formal document or a conversation on the front steps, is one more way you walk with people through life, death, and everything in between.



04 Getting More Support

Corresponds to Chapter 6 in the *Palliative Care Is... A collective response to death, dying, and grief in the inner city* Resource Guide.

Purpose of the Discussion

This module explores how to build stronger circles of care and connect people with additional resources when someone is seriously ill.

Key Messages

- Frontline workers often provide significant care and support.
- No one should carry this work alone.
- Building relationships with healthcare providers and community services can strengthen support for people who are seriously ill.

Before You Facilitate

- Reflect on local resources that may support people who are seriously ill (e.g., outreach healthcare teams, palliative care services, hospice programs).
- Be prepared for participants to share frustrations or barriers they have experienced when trying to access support.

During the Discussion

- Encourage participants to reflect on what a strong circle of support might look like.
- Acknowledge the reality that systems do not always work smoothly.
- Focus on strategies for collaboration, advocacy, and teamwork.

Participants may share experiences where:

- referrals were difficult
- systems did not respond quickly
- workers felt they were carrying too much responsibility

These conversations are important and should be acknowledged.

Closing the Conversation

- Reinforce that even small conversations about wishes or values can help guide care.
- Encourage participants to continue noticing and documenting these moments when appropriate.

Discussion Guide

The support you're already giving IS a palliative approach to care.

Purpose

This discussion is meant to help frontline workers recognize the essential role they play in a palliative approach to care (often without realizing it). It encourages workers to reflect on the ways they're already supporting people through serious illness, dying, and grief, and how their knowledge of people's lives, needs, and community ties makes them a vital part of the circle of care. We'll reflect on how to strengthen support networks, collaborate with healthcare systems, and navigate barriers to accessing palliative services. It also opens space to think through what happens when someone dies and how we care for each other in the aftermath. The guide emphasizes that you are part of the circle of care and you don't have to do it all alone.



Introduction: Why it Matters

As a frontline worker, you've probably helped someone find housing, access food, get to an appointment, or reconnect with a family member. You might've seen someone through a hospital discharge, or been the one person they could count on when no one else showed up. So, you've provided a palliative approach to care.

The work you do meets people where they're at and responds to what they need. That is the heart of a palliative approach and it's especially important in the face of poverty, discrimination, substance use issues, homelessness, and trauma.

This discussion guide about recognizing that the work you're already doing matters, and looking at ways to build support around you and the people you care for. Because no one should have to do this alone; not the person who's dying, and not the person supporting them.

Case Scenario

Marc's Story

Marc is 59, living in supportive housing, and dealing with advanced liver disease. He trusts you, but he's stopped going to see a doctor because he says he feels judged every time. He's getting thinner, spending more time in his room, and says, "I just want to stay home, with my dog and my people." You've helped him get meals and rides to appointments before, but now it feels like he might need more support. You're not sure who else is in the picture or how much longer he'll be able to stay on his own.

Discussion Questions:

- What stands out to you about Marc's story? What makes you concerned?
- If you were supporting Marc, what would be your first step? What would you want to know?
- Have you supported someone like Marc before? What did you learn from that experience

Recognizing What You're Already Doing

You may not see yourself as a care provider, but you are an important part of a palliative approach to care. Supporting someone with meals, housing, connection, advocacy, dignity, and comfort is foundational to a palliative approach.

Discussion Questions:

- How does it feel to hear that your work is part of a palliative approach to care? Positive or negative?
- What kinds of things are you already doing that you recognize improve people's quality of life?
- When you've recognized that someone was on a "palliative trajectory" does that change your approach? What kinds of supports do you feel you have to help you navigate next steps in supporting that individual?

Being in the Circle: Reflecting on Your Role

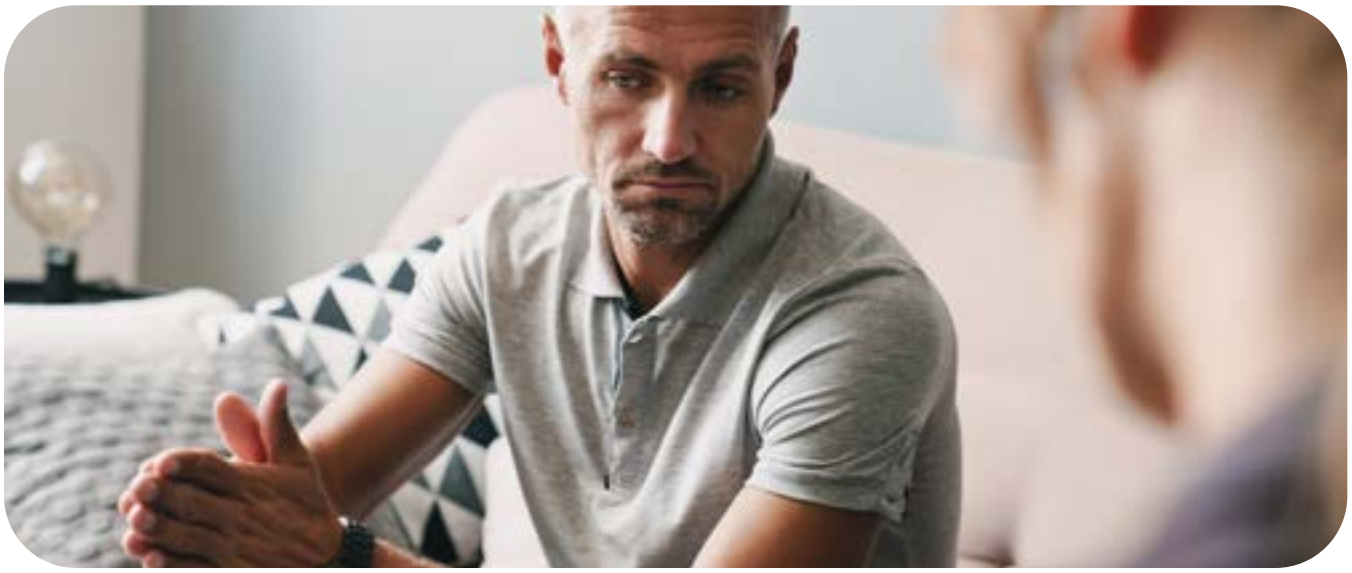
Frontline workers are often drawn into someone's circle of care because they're trusted, because there's no one else, or because it's part of the job. And sometimes, it's a deep expression of the relationship you've built over time. It's a role that can carry deep meaning, but also a lot of emotional and practical responsibility.

You might be asked to help make decisions, share insight with healthcare providers, or simply be there when things get hard. These roles aren't always straightforward, and they often aren't easy. It can stretch your role beyond what feels sustainable. And it's not something that should be done in isolation.

This next set of questions is an invitation to reflect on your own experiences being in that circle. How it feels. What it takes. And whether you're getting the support you need.

Discussion Questions:

- How does it feel when someone considers you part of their circle of care?
- Have you ever felt like healthcare providers dismissed or undervalued your contributions or insights?
- When someone asks you to take on more responsibility (like being a substitute decision maker or helping with medical forms), how do you decide what's within your role or capacity? Have you ever felt pressured to show up beyond your scope, time, capacity?

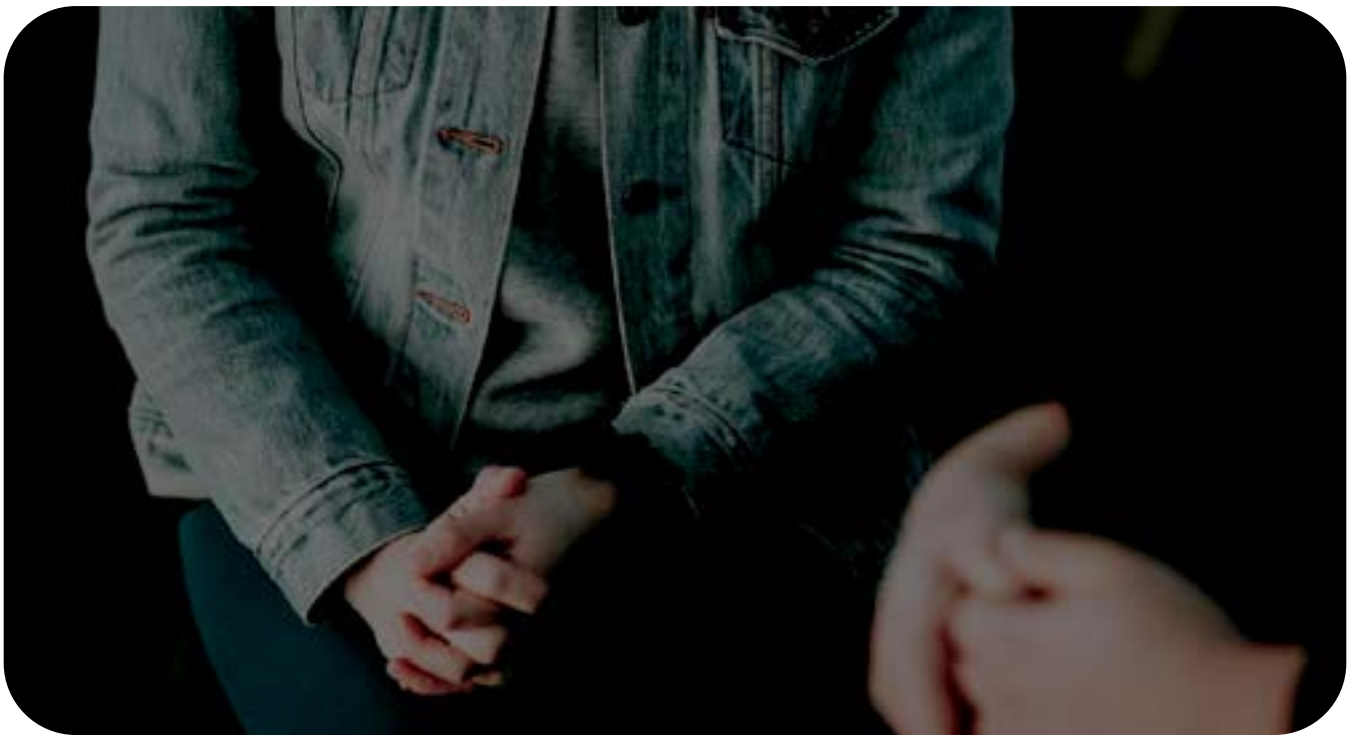


Strengthening the Circle: Building Community Support

When someone becomes seriously ill, it can be hard for one or two people to meet all of their needs. That's why building a broader circle of support is so important. As a frontline worker, you likely already know who a person trusts, who checks in on them, or who they wish they had around. Strengthening these ties, whether through family, friends, or community, is part of a palliative approach to care. It also means recognizing and working around the barriers that might be preventing others from stepping in.

Discussion Questions:

- What is your experience navigating those circle of care discussions with the people you are supporting? If helpful, refer back to Marc's Story: Who might Marc trust or rely on? Who may already be in his circle? Who else could be?
- In your work, have you identified any barriers keeping people from showing up (e.g., housing rules, strained relationships, distance, etc.)?
- How might you help someone map out who they want or don't want involved?
- Have you ever had to advocate for someone's friends or chosen family to be recognized? What happened?



Connecting the Circle: Health & Palliative Care Involvement

Many of the people we support aren't connected to healthcare or palliative care, often because of past harms, access barriers, or a lack of trust in the system. But healthcare providers can become powerful allies when they "get it" and understand the person's context. As someone who knows the person and their life well, you can help bridge that gap. You don't have to be a medical expert to be an advocate.

Your social knowledge is essential to shaping a care plan that makes sense for the person.

Discussion Questions:

- In your role, what have your experiences engaging with health care and other formal systems been like?
- Have you ever felt a provider didn't understand or respect the person's situation? What did you do?
- Have you ever seen a palliative care provider or team "get it"? What made them trustworthy or helpful?
- What has helped you (or not helped) when trying to connect someone to health care or palliative supports?
- What would help you feel more confident advocating for someone's palliative care needs? Have you felt supported to provide this type of support in the past?

Thinking About What Happens After Death

Supporting someone through serious illness sometimes means supporting them as they die, or after they've died. This can be emotional, confusing, and difficult, especially without a plan in place.

Discussion Questions:

- How does your team or organization prepare you for experiences of death, dying, and loss in your work? Do you have people, resources, or supports to help you navigate these experiences? Are they helpful?
- Would you know what to do if someone you were supporting died? Who would you call? Are there any policies or protocols you're supposed to follow?
- How involved do you want to be, or are allowed to be, in after death support?
- What are your strategies for sharing news about death in your workplace?

Closing Reflection

You're Part of This

Providing support through illness, dying, and loss is deeply human work, and it's work you're already doing. Whether you've helped someone seek out care, get to an appointment, reconnect with family, or simply feel less alone, you've been practicing a palliative approach to care.

This guide is a reminder that what you do matters. Your role in someone's life, especially at the end of life, is significant, even when it's complicated, overwhelming, or goes unrecognized. You are often the constant presence when systems fail, the person who notices when something's wrong, and the bridge that connects people to care they might not otherwise receive.

You are part of the circle of care. And just as the people you support deserve dignity and comfort, so do you. You should not have to carry this work alone. It's okay to ask for more support for yourself, for your team, and for the people you walk alongside.





05

Grief & Resistance

Corresponds to Chapter 7 in the *Palliative Care Is... A collective response to death, dying, and grief in the inner city* Resource Guide.



Purpose of the Discussion

This module creates space to acknowledge the grief and emotional, mental, physical, and spiritual toll that can come from supporting people through illness, decline, and death.



Key Messages

- Grief is a natural response to caring for others.
- Loss and grief are often cumulative in this work.
- Supporting one another is an important part of sustaining this work.



Before You Facilitate

- Recognize that this topic may bring up personal and emotional responses.
- Consider what supports exist within your organization if participants need additional support after the discussion.



During the Discussion

- Create a supportive environment where participants can share experiences if they choose.
- Remind participants that sharing is voluntary.
- Acknowledge that grief can show up in many ways, including sadness, anger, or exhaustion.

Avoid trying to solve or resolve grief during the discussion. The goal is to recognize and normalize these experiences. If participants seem to be struggling with their grief, be sure to connect them with resources to support.



Closing the Conversation

- Thank participants for their openness and willingness to reflect.
- Acknowledge the emotional labour involved in supporting people in these situations.
- Encourage participants to continue supporting one another and making space for grief within their teams.

Discussion Guide

Grief is not yours to carry alone.

Purpose

This discussion guide helps frontline workers reflect on the role of grief in their work—both their own grief and the grief of those they support. It invites honest, non-judgmental conversation about how grief shows up, why it's so complicated in street-based and system-challenging work, and how workers can move from isolation toward collective care.

The guide also explores how resistance (through public mourning, mutual support, and community advocacy) can be part of grieving. Ultimately, this guide is about naming grief not as a weakness or individual failure, but as a natural, valid, and shared response to injustice, love, and loss.

Introduction: Why it Matters

Grief is everywhere in this work. It might look like burnout. Or compassion fatigue. Or numbness. Or rage. Or pushing through without a break.

But rarely is grief named directly. And even more rarely is it understood as a shared response to unjust systems. Instead, it's often treated like an individual problem-with self-care as the only solution.

This chapter asks: What if grief wasn't just something to manage on your own? What if grief (like care) was something we could hold and deal with together?



Case Scenarios:

Alanna's Story

Alanna is 46 and has worked in housing and harm reduction for 8 years. In the last year, she's lost six people she was close to, including a former client who died in hospital without anyone being notified. She's exhausted, distracted, and says she's just "not herself," but when coworkers check in, she says, "It's just what this job is."

Discussion Questions:

- What do you think Alanna is carrying?
- Have you ever felt—or heard someone say—"It's just part of the job"?
- What might Alanna need that she's not getting?

Damon's Story

Damon is a peer support worker who has lost more than 20 people to drug poisoning in two years. He keeps showing up, saying "We don't have time to fall apart." Lately, he's drinking more and missing shifts.

Discussion Questions:

- What are the signs that Damon is grieving?
- Have you felt pressure to "keep going" even when grieving?
- What kind of support might actually reach Damon?

Ryan's Story

Ryan has been working as a support worker at a women's shelter for about a year now. A resident they were close to died suddenly in hospital. Ryan wasn't notified and is haunted by the feeling they didn't do enough. They haven't told their team—they're worried it would make them seem "too attached" or that it is not an appropriate way to respond in their role.

Discussion Questions:

- How do you feel about Ryan's situation?
- Have you ever been excluded from the grieving process?
- What makes grief harder when it isn't acknowledged?

Mikey's Story

Mikey, 31, lost his street sister to overdose. Since then, he's withdrawn and using more. "Doesn't matter anymore," he says. You're worried, but not sure if or how to bring it up.

Discussion Questions:

- How is Mikey's grief showing up?
- What might be stopping him from naming or expressing it?
- How could you gently open the door to conversation or care?

Understanding Grief in the Work

Grief in this context is cumulative, ongoing, and deeply tied to injustice. It may not look like sadness. It may look like chronic pain, insomnia, overwork, withdrawal, or self-blame.

Discussion Questions:

- What does grief look or feel like for you (or your team)?
- Have you ever realized something you were feeling was actually grief?
- What helps you recognize grief in yourself or others?

When Grief is an Injustice

Most people you lose aren't dying of old age. They're dying because of colonialism, criminalization, racism, poverty, and policy failure. That changes the shape of grief.

Discussion Questions:

- How does grief feel different when a death was preventable?
- What systemic barriers do you see playing into these deaths?

Relational Complexity and Role Blurring

You might be called "staff;' but you're also a friend, advocate, surrogate family, or cultural kin. That makes grief harder to categorize and harder to talk about.

Discussion Questions:

- How do your personal and professional roles get blurred?
- Have you ever wondered if you were "allowed" to grieve someone?
- How do conversations about "boundaries" land with you?

Grief as an Individual Responsibility

Often, workplace culture frames grief as a personal problem with self-care as the only acceptable solution. This leaves workers isolated and unsupported.

Discussion Questions:

- What support (if any) does your workplace offer around grief?
- Have you ever felt blamed or isolated for struggling?
- What kinds of grief support feel real, safe, or meaningful to you?

What Helps: Worker-Informed Grief Practices

Many workers have shared the things that help. Not as fixes, but as ways of surviving grief together.

- Finding Your People: Whether it's a grief group or your roller derby crew, what matters is being with people who get it. Community matters more than format.
- Benefit of Preparing: Knowing someone's wishes in advance can reduce moral distress. It helps you feel like you honoured what mattered to them.
- Getting People Support Helps You Too: Connecting someone to palliative or wraparound care doesn't just help them, it lightens your load and affirms that you didn't carry it alone.
- "I'm Not Crying, You're Crying": You don't need a formal group to feel supported. Often, support shows up in jokes, shared silences, or small check-ins with people who understand.
- Memorial Spaces at Work: Memorial walls, banners, zines, or rituals can offer space for grief and remembrance, especially when optional and culturally safe.
- Collective Debriefing: Talking about a death as a team (what happened, what was hard, what went well) can shift grief from silent shame to shared learning and healing.

Closing Reflection

Grief is Real. So are we.

Grief isn't something to fix. It's something to feel, name, and carry together. In this work, grief is constant. It's tied to injustice. But it's also tied to love, to meaning, and to relationships that matter.

You're not broken for feeling it. You're not weak for needing support. And you're not alone in carrying it.

Grief is not just yours to carry — it's ours.



Common Participant Concerns

Participants may arrive at these discussions with uncertainty or hesitation. The concerns below are common when talking about serious illness, death, and care in homelessness and harm reduction settings. Facilitators can help by acknowledging these concerns openly and normalizing them.

"What if I say the wrong thing?"

Many workers worry about starting conversations about illness or dying because they don't want to cause harm or make someone uncomfortable.

Facilitator response:

- *Acknowledge that this fear is common.*
- *Emphasize that conversations do not need to be perfect.*
- *Remind participants that listening, curiosity, and compassion are often more important than having the right words.*

It can also help to remind participants that people often bring these topics up themselves in small ways. Simply noticing and responding with care can make a difference.

"Is this really part of my job?"

Workers may feel unsure whether conversations about serious illness or dying fall within their role, especially when healthcare systems are expected to provide this kind of support.

Facilitator response:

- Reinforce that this curriculum is not asking workers to become healthcare providers or take on new responsibilities.
- Emphasize that workers often already support people through illness and decline by building relationships, noticing changes, and helping people access care.
- These discussions focus on supporting workers in the situations they are already encountering.

"What if someone asks for help I can't provide?"

Participants may worry about opening conversations that lead to needs they cannot meet.

Facilitator response:

- Acknowledge that this is a real challenge.
- Remind participants that they do not have to solve everything themselves.
- Conversations can help identify when additional support may be needed and who else could be involved in a person's circle of care.

Sometimes simply listening and recognizing someone's concerns can be meaningful.

"I see a lot of death and loss in this work."

Workers in homelessness, harm reduction, and community settings may experience repeated loss and cumulative grief.

Facilitator response:

- Acknowledge that this work can carry a significant emotional toll.
- Emphasize that grief in this work is not a sign of weakness, but a natural response to caring for others.
- Encourage participants to share strategies for supporting one another and creating space for collective care.

"The system makes it hard to help people."

Participants may express frustration with healthcare systems, policies, or barriers that prevent people from receiving the care they need.

Facilitator response:

- Validate these experiences.
- Recognize that many challenges come from broader structural issues.
- Encourage discussion about how workers support one another and advocate for people within these constraints.

Naming these realities can help reduce isolation and strengthen collective understanding.

Further Reading & Resources

Practical Tools & Resources

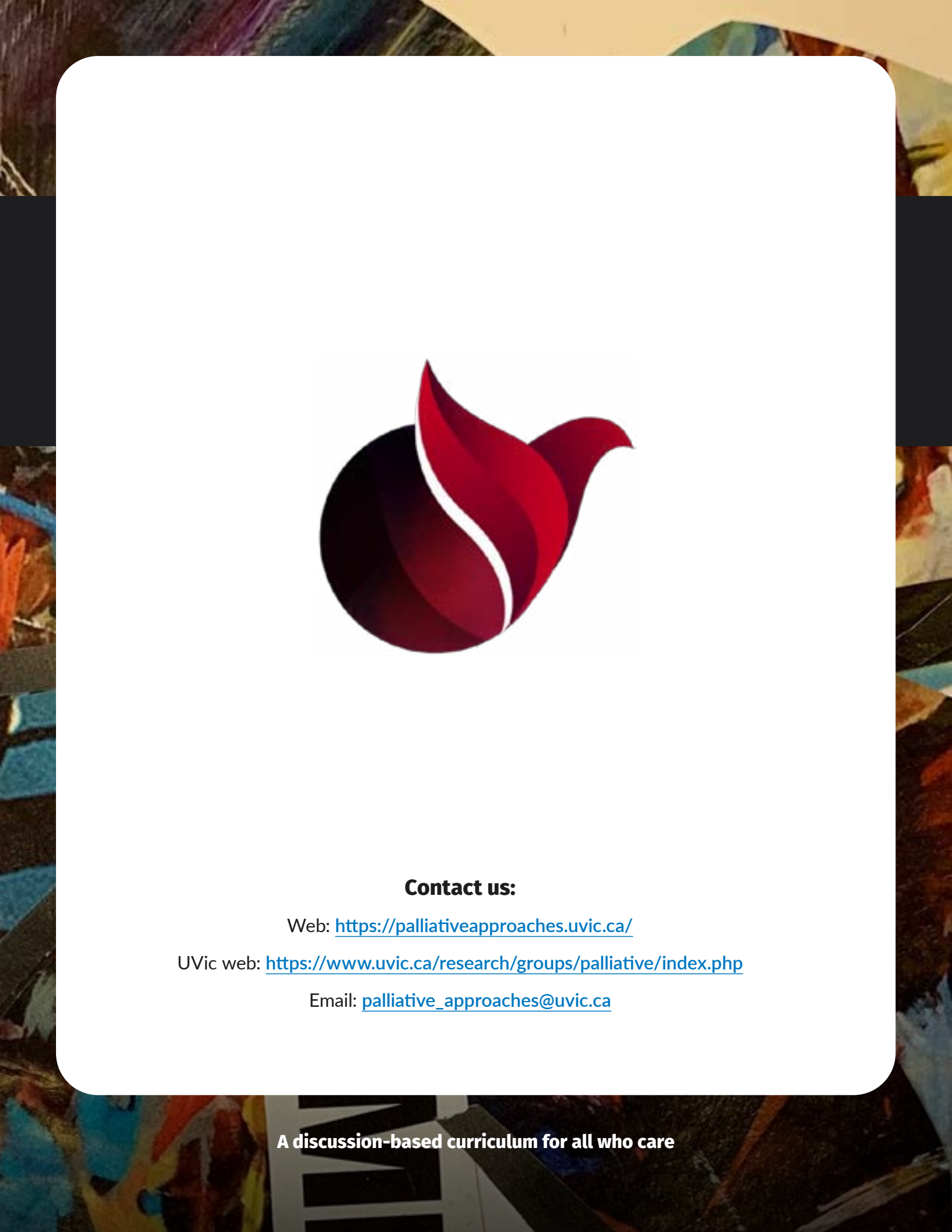
- A guide for serious illness conversations with structurally vulnerable patients in hospital
- Palliative Care Is... A Collective Response To Death, Dying, and Grief In The Inner City
- Equity-informed advance care planning
- Homeless Palliative Care Toolkit

Articles

- "Once you open that door, it's a floodgate": Exploring work-related grief among community service workers providing care for structurally vulnerable populations at the end of life through participatory action research
- A critical examination of 'family' caregiving at the end of life in contexts of homelessness: Key concepts and future considerations
- Walking Alongside Indigenous Peoples who are Seriously Ill: Education for Community Caregivers
- "Everybody in this community is at risk of dying": An ethnographic exploration on the potential of integrating a palliative approach to care among workers in inner-city settings
- Caregiving at the margins: An ethnographic exploration of family caregivers experiences providing care for structurally vulnerable populations at the end-of-life
- Work-related grief and bereavement experiences of inner-city workers working with people experiencing social disadvantage: A rapid scoping review



Notes



Contact us:

Web: https://palliativeapproaches.uvic.ca/

UVic web: https://www.uvic.ca/research/groups/palliative/index.php

Email: palliative_approaches@uvic.ca

A discussion-based curriculum for all who care