


greater victoria coalition to end homelessness

hope has found a home

# Health & Housing Think Tank 2021 Summary Report

# A Vision for Greater Victoria

*April 12, 2021*

## Summary of Consultation Learnings and Recommendations

*Staff and Resident Feedback Survey*

*Health & Housing Think Tank Group Members*

*Victoria Inner City Medical Leaders Group Members*

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# 1. Introduction

Homelessness continues to be a complex issue in the capital regional district, with not enough affordable housing options along the continuum including supportive housing or affordable market rent spaces available. The COVID-19 pandemic highlighted capacity gaps in existing supportive housing and challenges in providing adequate and appropriate supports. As an emergency response to the pandemic, the province provided funding to support transitioning two significant encampments in Victoria. According to the *March 2020 Greater Victoria Point in Time Housing Needs Survey*, there were 1,523 individuals experiencing homelessness. Of these 1,523, it has been understood that approximately 736 persons were living in encampments. During the Spring of 2020, and as one part of the provincial emergency response, 466 individuals from encampments were offered spaces in hotels/sheltering sites with on-site harm reduction/overdose prevention, primary care, and peer support services, with approximately 270 individuals continuing to live unsheltered in Victoria parks, many of whom also experience numerous health challenges.

***There is a need for coordination across the development and implementation of health and housing services.***

There is also a need for sufficient wrap-around health, social, and cultural supports to support people with complex Mental Health and Substance Use (MHSU) challenges. The provincial government's coordinated cross ministry approach and the collaboration of local service providers and government organizations provides momentum to strengthen the model of services and supports for people experiencing homelessness. Stable, safe, and affordable housing is a critical determinant of health and a prerequisite for individuals to pursue their own goals for health, wellness, cultural safety, recovery, and purpose.

Since the decampment of the 466 individuals from Topaz Park and Pandora Avenue in Spring 2020, significant investments have already been made to increase supportive housing spaces and to develop and enhance wrap around services to support individuals who moved to the new housing sites and for those who remain in encampments. There have been significant improvements in services initiated in partnership with Island Health, BC Housing, and a range of not-for-profit service providers. It is recognized that ongoing and further work is required to implement new services and enhance new and existing services to bring into alignment with the Province of BC's Joint Provincial Framework for Emergency Response Centres and the Health and Housing Framework. These frameworks call for a coordinated approach to services and service delivery to optimize the provision of services as a shared responsibility across the public and not for profit health and human services sectors.

In an effort to develop a localized vision and framework, we convened a local Health and Housing Community "Think Tank" with individuals with diverse experience and knowledge to develop these 40 recommendations.

# Our Stakeholders

Our stakeholders brought diverse knowledge, experience, and representation to this consultation. They include people with lived experience, peer workers, administrators, researchers, medical service providers, and policy makers (see Appendix A). Our consultations included:

- **Staff and Resident Feedback Survey** of 125 residents and 52 staff members at the temporary housing sites set up as a response to COVID-19.
- **Health & Housing Think Tank Group**
- **Victoria Inner City Medical Leaders Group**

# Think Tank Desired Outcomes

a. **To develop a model of care for conceptualizing and planning health and harm reduction/overdose prevention supports in housing to complement services in community that allows for those residing in supportive housing to access individualized services that will further their opportunity for stability, safety, and wellness, including linkage and access to a variety of treatment services.**
b. **To develop recommendations that will inform health investment decision-making with an emphasis on the provision of primary care, harm reduction/overdose prevention, and mental health and substance use services including treatment and recovery, and supportive/supported housing.**

# Key Principles

These key principles reflect our values, philosophy, and aspirations. We believe that it is important to have health, housing, and social services that seek to meet these principles.

## Health is multi-sectoral.

It is important to understand contributions to health from sectors outside of health systems. The focus needs to be broadened to consider social determinants such as housing, community, cultural and spiritual connection, food, income, social supports, and transportation in addition to mental and physical health.

## Truth and reconciliation are crucial.

There is an overrepresentation of indigenous peoples who have lived or are living with homelessness as an outcome of both historical and ongoing colonization. We are committed to providing culturally safe care and increasing Indigenous-led services.

## Diversity matters.

People who have lived or are living with homelessness include a diverse spectrum of ages, genders, sexualities, and abilities. There should be consideration of this diversity in services, locations, cultural supports, and peer supports to meet unique needs.

## All people need community.

People With Lived Experience (PWLE) of homelessness often live in a context of stigma, criminalization, and medicalization. These factors create complicated and profound barriers to well being. Building community within housing and within neighbourhoods creates a healthier environment for all.

## Everyone has the right to self-determination.

At every level, self-determination, autonomy, and choice should be a fundamental starting point even if the choice remains aspirational in the housing context. We want to provide services and supports that are flexible, meet people where they are at, and allow them to choose the pace, type and location of services.

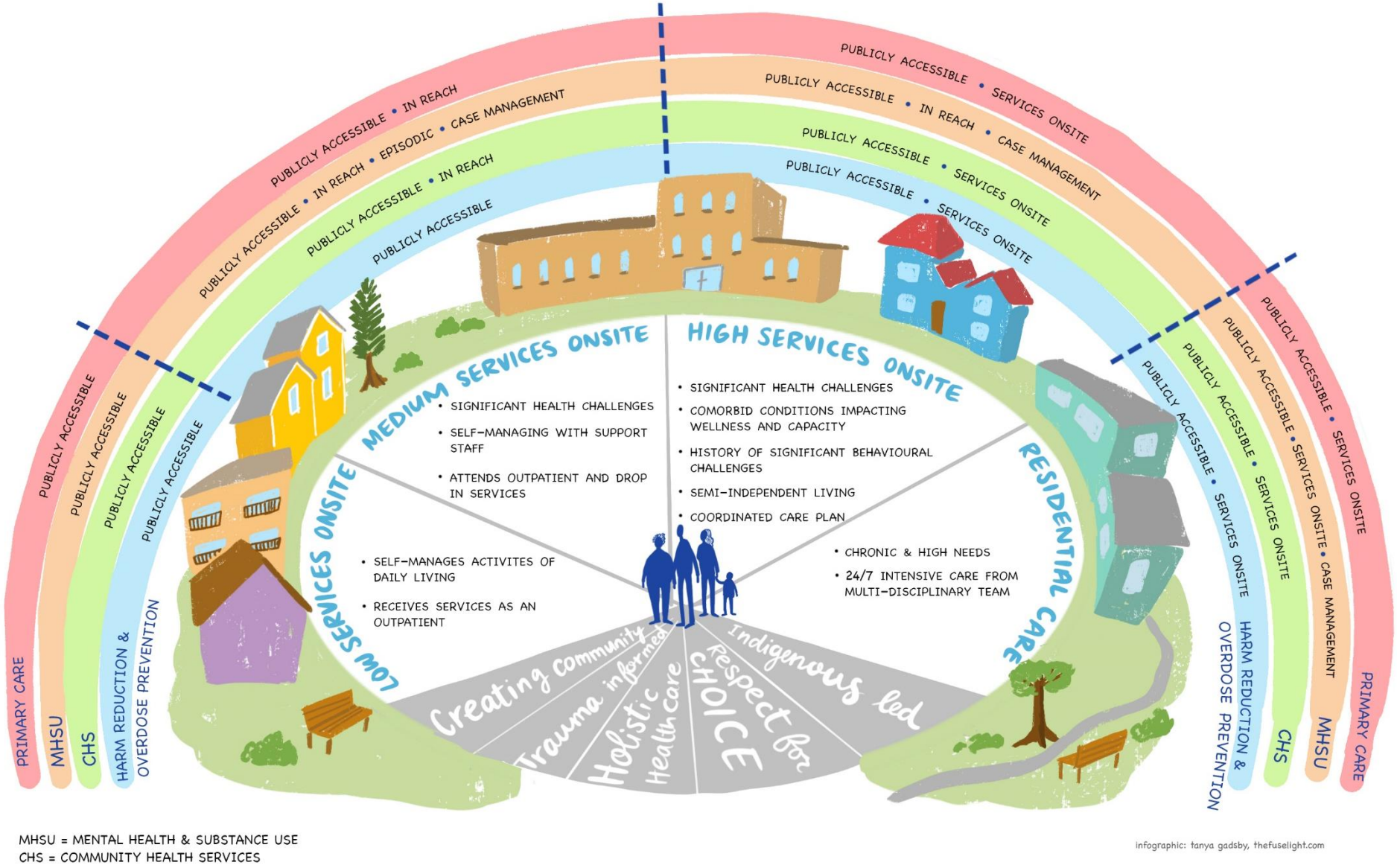
## Spaces and services should be trauma informed.

When people experiencing homelessness have repeated encounters with the service system, they may experience trauma related to accessing help. When spaces and services are designed, it is imperative to create positive spaces that promote dignity, harm reduction, safety, and flexibility.

## Services are connected to the person.

If services are centred around the person rather than the housing, people can take relationships with services providers with them, if they choose. This approach allows service continuity as individuals experience changes in their lives.

# Spectrum of Housing




**Publicly Accessible:** Person travels to a publicly accessible space to receive care **In-reach:** Services are brought to the person **Episodic:** Delivered as needed, not on a scheduled basis **Case Management:** Longitudinal, multidisciplinary team support, Assertive Community Treatment (ACT), Intensive Case Management Team (ICMT) **On-site:** Services are fixed on site and have regularly scheduled hours of services **Outreach/Mobile:** Services are delivered in community where people are **OPS:** Overdose Prevention Site / **SCS:** Supervised Consumption Site

# 2. Recommendations

## Overall System Planning

1. Provide a spectrum of housing, using a Housing First model, with a range of person-centred services either onsite or in the community.
   Recognizing that:
   a. Additional supports must be provided as the level of need changes over time, both increasing and decreasing in acuity.
   b. As care needs emerge in the community, we need to support local ability to shift funding from one area to another.
2. Incorporate primary health care, mental health supports and treatment, substance use treatment services including addictions medicine, and harm reduction/overdose prevention right from the beginning of planning for supportive housing sites. Recognizing that:
   a. Due to the extreme overdose risk, harm reduction and overdose prevention plans with varied approaches and strategies need to be a part of all supportive housing and in-reach service delivery models regardless of resident population.
   b. Health Services need to be flexible enough to be modified and mobilized over time to ensure they are being made available to the ones who need them.
   c. Community based, publicly accessible, and in-reach services are the preferred model for low- to moderate-need populations.
   d. Accessible primary, mental health, and substance use care is important where there is high complexity of care needs and multiple barriers to accessing care in the community.
3. Provide low barrier access to a range of services from primary health care, peer support, harm reduction, economic, and social and cultural support for residents of all sites across the housing spectrum.
   Recognizing that:
   a. Prompt access is integral to supporting tenancy.
4. Develop a distributed model of Service Hubs (on-site or community) as best practice with wraparound services that occur collaboratively.
5. Create a housing strategy that enables choice and compatible needs and preferences.
   Recognizing that:
   a. There are concerns from residents when people who use substances, people with mental illnesses, different genders, and age groups stay at the same site as determined by service providers. This homogenous grouping does not always respect human choice.
   b. When selecting housing site operators, housing funders should ensure housing operators are willing and able to provide housing that is low barrier and ensures quality processes and interventions for supporting eviction prevention and sustainment of tenure.
   c. This requires balancing personal choice about preferred cohorts or location with ensuring the right supports are readily available.
   d. Recognizing that smaller scale (30-50 individuals per site) is a critical aspect from which to build healthy communities that promote safety, wellness, effective service delivery, and continuity of care.

6. Provide access to the basic determinants of health and amenities (food, clean environment, laundry, Wi-Fi, secure storage) at all housing sites because when these needs are met there is less distress and positive health impacts which can contribute to fewer incidents.

## Health Services Planning

### Health: Physical Health

7. Deliver health and housing services (including harm reduction) as both onsite services and community services based on the level of need and preference (if possible) of the individuals.
8. Attach health and housing services to the individual so people can participate in creating person-centred care plans and sustain relationships with service providers through transitions.
9. Provide System Navigator/Resident Peer training to people with lived experience. They will be paid guides who can support others and share their lived expertise and understanding of systems. This can make it easier for people to access health and housing services.
10. Design supportive housing that can accommodate people with complex physical health needs and complex mental health needs long-term (such as nursing support and health care aids with a harm reduction approach).
11. Provide health care supports such as:
    a. Long-term care with harm reduction support for older or senior people.
    b. Sexual, reproductive, and prenatal health care at all housing sites.
    c. Health services designed to support the needs of those working in the sex industry.
    d. Accessible Community Health Services that can provide services to clients in low barrier housing sites.

### Health: Mental Health

12. Provide adequate resources to current mental health teams so they can deliver low barrier, culturally safe, trauma-informed mental health supports in housing and through outreach.
13. Create low barrier pathways and smooth transitions for residents to access acute psychiatric services.
14. Create separate, acute psychiatry spaces away from the housing site (like St. Paul's Hospital model) for emergency or crisis support.
15. Provide low barrier, responsive group programs for whatever residents identify as their needs, such as introduction to recovery, conflict resolution, gender specific, gender-based violence, etc.
16. Develop and implement multi-disciplinary crisis response services that are accessible and connected to sites.

    Recognizing that:
    a. Teams can be effective when they include multiple disciplines including peer support, clinical mental health supports and possibly plain clothed police officer (for potentially dangerous situations), with a shared practice and expertise in conversational conflict resolution, mental health assessment and a trauma informed approach.
    b. This approach would support maintenance of tenancy for those at highest risk due to mental health, substance use and behavioural challenges and avoidance of undue criminalization of individuals.

## Health: Substance Use & Harm Reduction

17. Integrate primary care, clinical counseling, and addictions medicine so it can be delivered holistically and create low-barrier access to harm reduction services through any health care service, if needed (i.e. no wrong door).
18. Increase access to a range of accessible harm reduction and treatment services including harm reduction/overdose prevention, supports, and embedded access to pharmaceutical alternatives (safe supply) and medication assisted treatment options.
19. Increase access and availability to overdose prevention services.
20. Provide the staff with training, space, and resources on-site for episodic overdose prevention.
21. Develop a medical intervention protocol for preventative treatment of substance-induced psychosis symptoms.
22. Support residents with creation of safety plans around their substance use and support them to activate these plans with on site supports.
23. Provide alcohol harm reduction and managed alcohol programs on-site and/or in community so drinking is not a barrier to people going to shelters or into housing.
24. Offer programs and supports for intimate partner violence whenever substance use and harm reduction programs are offered.

## Health: Social, Cultural and Spiritual Supports

25. Provide people with the choice of where to live (such as near their work, partners, family, or friends) by making in-reach supports readily available.
26. Connect people living in housing to their local community through events and sharing community spaces to try to reduce stigma.
    a. Focus cultural events, classes and space on healing, empowerment, and agency.
    b. Create opportunities for residents to engage in advocacy to reduce stigma and promote social justice.
27. Normalize and prioritize providing culturally informed and rooted services, supports, and housing.
    a. Create Indigenous-led healing teams connected to local territories and Lekwungen Peoples.
    b. Ensure that decisions about services, supports, and housing are informed by an understanding of Street Culture.
28. Design buildings with multipurpose, community spaces that can be used for organized or informal, peer-based and cultural gatherings or near community spiritual centres (accessible on bus routes).

## Housing Site Operation

29. Prioritize safety for residents and ensure policies are in place to properly address interpersonal conflict, violence, and ability to have guests. Recognizing that policies should balance between safety and privacy.
30. Self-determination, autonomy, and choice should be a fundamental starting point at every level of need.
    a. Engage people in decision-making about their homes and health care through Resident/Tenancy Advisory Boards.
31. Support residents to become participants in their neighbourhood, including neighbourhood community groups and community advisory committees.

32. Supportive housing sites need to be well-resourced with staffing models that ensure that on-site staff are consistently accessible. Recognizing that:
    a. Staff need training and support to ensure they can provide a trauma-informed response to on-site situations of conflict, distress, and harm reduction.
    b. Staff should also be trained with basic knowledge (at least) in mental health and substance use.

## Housing Site Design

33. Ideal housing size is 30 to 50 people or units per site with smaller populations for people who require more intensive supports.
    Recognizing that:
    a. 20 – 30 is the maximum in higher services needs cohorts.
    b. Sites for low service needs cohorts are in mixed market so size can be variable.
34. Locate house sites so they are:
    a. Dispersed throughout the capital region to create mixed communities that have diversity.
    b. Located near bus routes.
35. Provide adequate site security and safety while balancing residents' privacy and dignity.
36. Design housing sites to be welcoming and attractive homes by including the following features:
    a. Aesthetics such as welcoming entryways and communal spaces in all buildings.
    b. On-site or nearby green spaces, outdoor social spaces, and community gardens.
    c. Good-sized rooms with adequate sound proofing, bathrooms, and privacy with accessibility for all.
    d. Pet-friendly features and nearby spaces for dog walking in all buildings.
37. Design spaces that can support community building for residents, their friends and family, and the greater community by including the following features:
    a. Multipurpose spaces and materials for creative and learning activities such as gardening, crafts, music, computers, and communal kitchens.
    b. Community spaces inside and outside to meet social interaction including space to meet with children and families and for community building events.
38. Design spaces with resources for a variety of health care providers to be able to access and provide care on site (such as doctors, nurses, pharmacists, psychologists, psychiatrists, harm reduction outreach workers, physio and occupational therapy services, etc.).
39. Design some buildings in the spectrum to include spaces for smoking and harm reduction inhalation on-site.
40. Create paid, on-site job opportunities for people to care and maintain the facilities (carpenters, welders, builders, artists, gardeners, etc.).

# Appendix A: Stakeholder Consultation

Our stakeholders brought diverse knowledge, experience, and representation to this consultation. They include people with lived experience, peers, administrators, researchers, medical services, and policy makers. Our organizations have services and supports for housing, harm reduction, substance use, the sex industry, mental health, HIV and Hep C positive people, indigenous people, and marginalized communities. We acknowledged the power inequities and gathered feedback from people with lived and living experiences of homelessness, mental health challenges, and substance use disorder.

## Staff and Resident Feedback Survey

A voluntary survey of 125 residents and 52 staff members was conducted in July 2020 at the temporary housing sites set up as a response to COVID-19. Peer organizations developed and administered the survey. Residents who completed the survey were given $20 for their time. The number of surveys completed was limited by the budget of the participating organizations who volunteered funds to the honorariums. The survey was conducted at the following sites:

Capital City Centre
Comfort Inn
Howard Johnson
Paul's Motor Inn
Save on Foods Memorial Arena
Travelodge

The following organizations helped to administer the survey:

Peers Victoria Resource Society
SOLID
The Greater Victoria Coalition to End Homelessness
Umbrella Society

## Health & Housing Think Tank Group Members

The Health & Housing Think Tank group met weekly from June 4, 2020 to August 14, 2020 for a total of 9 meetings. The meetings addressed a continuum of housing services for people with low- to high- needs up to residential care. It was an iterative and collective process that built on other work with BC Housing, our collective experience, and existing research.

Alison James, City of Victoria
Angela Moran, BCH
Angela McNulty Buell, GVCEH
Ashley Heaslip, PHS
Avery Taylor, PHS
Bernie Pauly, Island Health/UVic
Don McTavish, Cool Aid
Echo Kulpas, VIHA
Fran Hunt-Jinnouchi, ACEH
Janine Theobald, GVCEH
John Reilly, CRD
Katrina Jenson, AVI
Kelly Reid, VIHA
Kelly Roth, GVCEH
Lisa Crossman GVCEH
Leah Young, Our Place
Lois Gabitous, BCH
Mary Chudley, Cool Aid
Mary Morrison, VIHA
Sean Hand VPD
Monique Huber, ACEH
Rachel Phillips, Peers
Sharlene Law, Umbrella Society
Shannon Perkins, City of Victoria
Sophie Bannar-Martin, VIHA

## Victoria Inner City Medical Leaders Group Members

Dr. Anne Nguyen, Cool Aid, Island Health
Dr. Ashley Heaslip, Portland Hotel Society
Dr. Chris Fraser, Cool Aid, Island Health
Dr. Ramm Hering, Island Health

## Acknowledgements

The Greater Victoria Coalition to End Homelessness provided engagement and facilitation for this project.

Fuselight Creative created the *Spectrum of Housing* graphic on page 5 in consultation with the Health & Housing Think Tank group members.

# Appendix B: Consultation Reports

1. Victoria Inner City Medical Leaders Group (VIC-MLG) Recommendations on Principles and Priorities for Treasury Board Funding
2. Covid-19 Temporary Housing Sites: Staff And Resident Feedback
3. Health & Housing Think Tank Report

**Victoria Inner City Medical Leaders Group (VIC-MLG) Recommendations on Principles and Priorities for Treasury Board Funding**

Anne Nguyen, Ash Heaslip, Chris Fraser, Ramm Hering

August 20, 2020

**Principles for Housing:**

1) SCALE is important
    a. Ideal housing size is < 50 individuals
    b. Large scale makes responding to high burden of health care needs difficult
2) Embedded primary and addiction care is important in contexts where there is high complexity of care needs and multiple barriers to accessing care in the community

**Principles for use of funds:**

3) COVID Responsiveness is prioritized
    a. This means having a specific envelope of funds to rapidly respond to need to house, test, isolate and provide supportive services for PUI's and COVID+ patients that can be rapidly mobilized without needing extensive, multi-level approval process
4) Flexibility in terms of use of physician sessions based on community needs
    a. Physicians and team should be able to determine the times of day and days of week sessions are used to maximize responsiveness
5) Adaptability
    a. As care needs emerge in community, ability to shift funding from one area to another. E.g., to shift some funding previous allocated to Outreach physician coverage back into Inner City Primary Care at Cool Aid, PHS, VYC if needed.
6) Strengthening of Inner City Primary Care
    a. Recognition that Outreach to emergency sheltered and unsheltered sites needs to be supported with parallel investment into inner city primary care capacity which means physician sessions, nursing, MOA support, in order to provide robust ongoing follow up care.
        i. Building connections and eliciting support from Island Health Primary Care work stream
    b. System of care should include strengthening of "upstream" services such as Youth Primary and Addiction Care (VYC) and Perinatal Addictions

# COVID-19 Temporary Housing Sites: Staff and Resident Feedback

*Authored By: Leigh Elliott and Rachel Phillips on behalf of Peers Victoria Resource Society, and Jarvis Neglia on behalf of the Greater Victoria Coalition to End Homelessness*

peers VICTORIA RESOURCE SOCIETY

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# Acknowledgements

*We would first and foremost like to thank the residents and staff members of the temporary housing sites for taking the time to participate in this survey and share their experiences and knowledge. We would also like to thank the staff SOLID, of Peers Victoria Resource Society, The Greater Victoria Coalition to End Homelessness, and Umbrella Society for helping to administer this survey. Finally, we would like to thank the many individuals who provided us with invaluable feedback on survey development; the goal was to be brief, but also ask some key questions about this unprecedented housing initiative.*

## Overview

This report is based on findings from a survey that was filled out by both residents and staff members in July 2020 at the temporary housing sites set up as a response to COVID-19 (Save on Foods Memorial Arena, Capital City Centre, Comfort Inn, Howard Johnson, Paul's Motor Inn, and Travelodge). Overall, 125 residents and 52 staff members completed the voluntary survey. There was some representation from each site: the Save on Foods Memorial Arena was represented by 14 residents and 7 staff; Capital City Centre by 17 residents and 2 staff; Comfort Inn by 23 residents and 8 staff; the Howard Johnson by 16 residents and 9 staff; Paul's Motor Inn by 12 residents and 8 staff; and the Travelodge was represented by 43 residents and 14 staff.[1] As the numbers show, some sites had more representation than others. Residents who completed the survey were given $20 for their time; the number of surveys completed was limited by the budget of the participating organizations who volunteered funds to the honorarium pool. Staff at each site facilitated the honorarium distribution, and residents either self-completed or were assisted to complete surveys as was their preference. Staff were invited via successive email invitations to representatives of different agencies working within the temporary sites and completed the survey online. The surveys were almost identical apart from a few differences to acknowledge different contexts —i.e., your living site versus your work site.

[1] In addition to this, there were also four staff members who either did not give a location, gave Topaz park as their primary location, or gave more than one location as their primary location

The purpose of the survey was to gather basic feedback about some key areas of service within the temporary housing sites, in part to inform a local think tank convened by Island Health regarding supportive housing, and also to provide some insight into staff and resident perceptions and experiences of the temporary housing sites and services contained within. The sample reported on below was a convenience sample and in some cases the subsamples at each site are quite small, so the resultant information should be interpreted with caution. Overall the information reported below is intended to stimulate further discussion, point to areas that seem to be working well, others that need more work, and provide a platform for further discussion and input from people living and working in supportive housing sites. This report is a prelude to a more complete report that will follow; it is based on a subset of the questions asked in the survey.

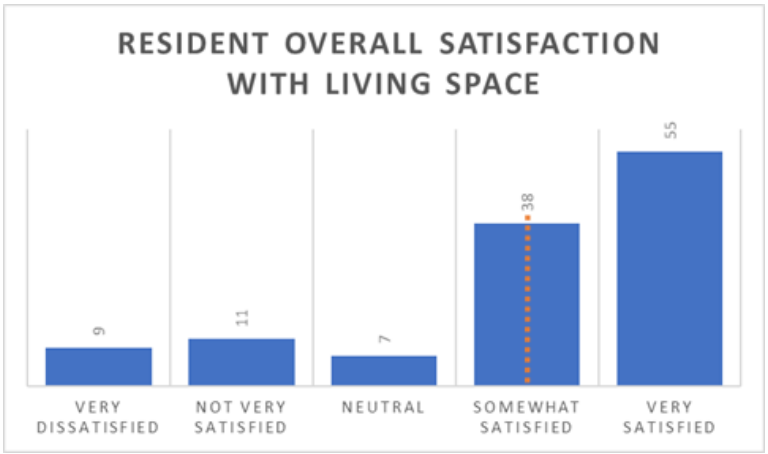
## Demographics

The demographic information collected for residents surveyed is as follows: 34% female or woman, 6% no response (to gender), and 60% male or man; 31% Indigenous, 9% no response (to Indigeneity), and 60% non-Indigenous. All demographic questions were posed as open ended, and respondents could choose not to answer. Gender was posed as an open-ended question to which people responded by identifying either their sex or gender, with most responding with their sex. No one in the resident sample identified as Trans or non-binary. This may indicate an underrepresentation in the sample of non-binary identities, an unwillingness to disclose this information in a survey, or individuals reported a binary gender identity for other reasons. The mean age for residents was 41, with an age range of 23 to 67.

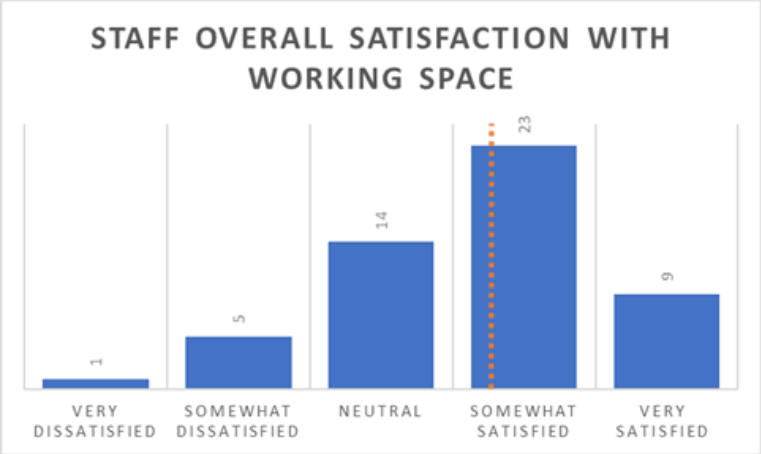
In terms of staff demographics, the results were as follows: 56% identified as female or woman, 10% as a non-binary gender[2], 12% did not respond, and 23% identified as male or man; 8% identified as Indigenous, 4% gave no response, and 87% identified as non-Indigenous. The mean age for staff was 36, with an age range of 20 to 60. These findings show that there is an underrepresentation of Indigenous staff members, especially in comparison to residents; and a larger representation of female/woman and non-binary staff in comparison to the residents surveyed for this report.

## Areas of Greatest and Least Reported Satisfaction

Overall satisfaction of residents in the housing sites was quite high: the mean overall satisfaction for residents was about 4/5, with 78% of residents giving either a 5/5 or 4/5 rating. In contrast, staff were slightly less satisfied than residents with their spaces, with an average overall satisfaction rating of 3.7/5.




[2] Gender was an open ended question. A few respondents wrote “NB”, or “something in-between”, but no staff or residents identified as transgender. As such, we have chosen to label this group as non-binary as it seems to more closely represent the identification chosen by respondents.




Based on responses to the question, “How satisfied are you with _____”(which included a broad range of services and resources either in the housing sites currently, or widely regarded as basic needs or rights), the five greatest reported areas of satisfaction for residents (on average) were:

1. access to harm reduction supplies (4.4/5)
2. relationships with support workers (4.3/5)
3. access to medical care (4.2/5)
4. satisfaction with safer injection site (4.2/5)
5. satisfaction with safer supply (4.1/5)

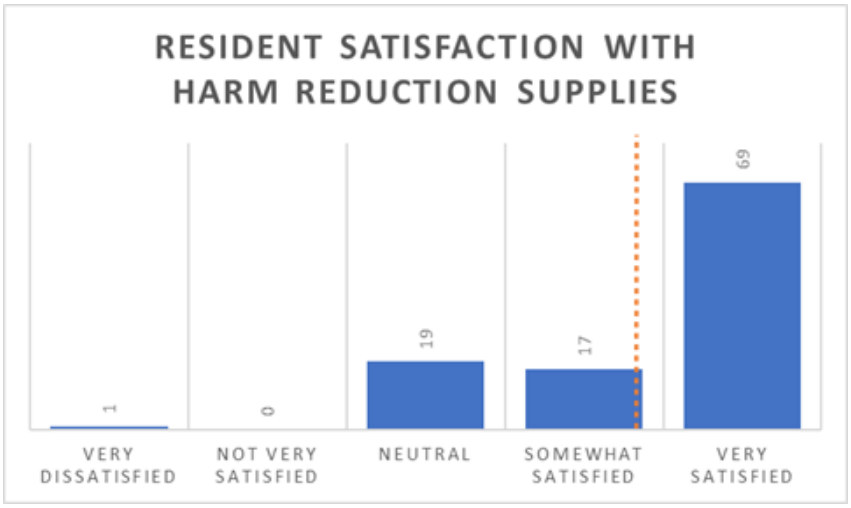
Interestingly, staff and residents share three of five areas of greatest satisfaction: harm reduction, relationships with staff, and access to medical care. Overall staff responded as follows:

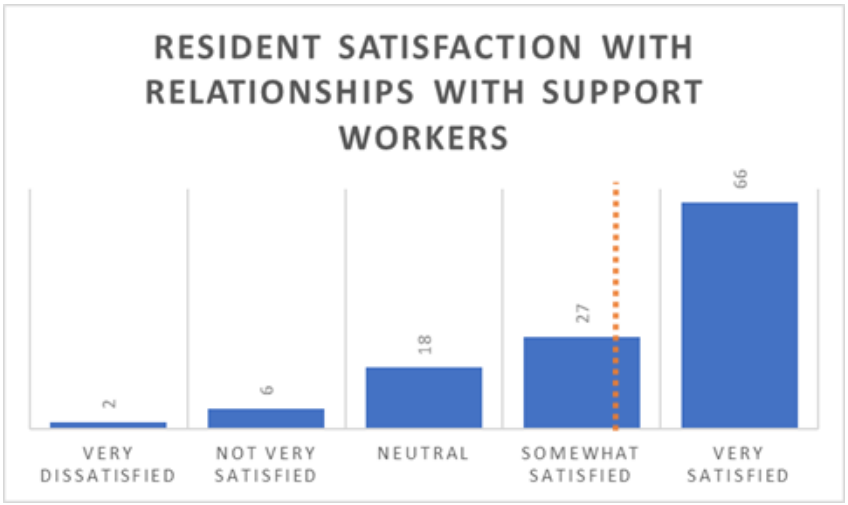
1. access to harm reduction supplies (4.6/5),
2. relationships with other staff members (4.4/5)
3. relationships with residents (4.1/5)

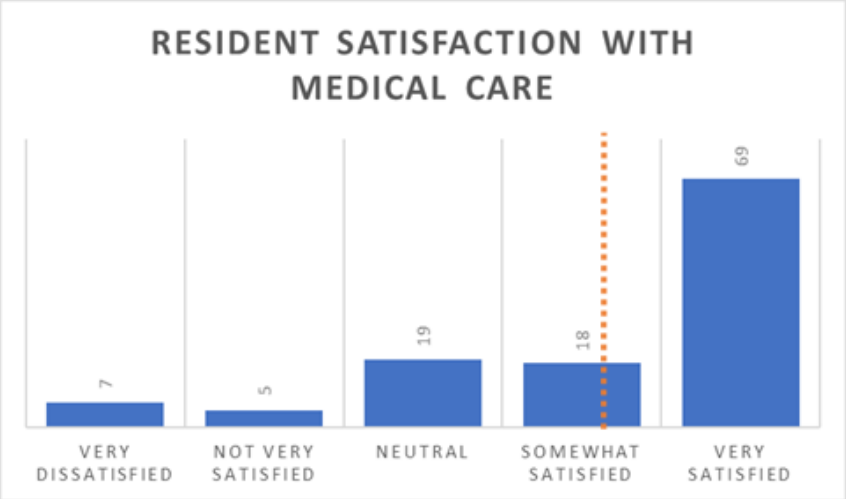
4. access to medical care (3.9/5)
5. access to prescriptions (3.9/5)

## Top Five Satisfaction Rates for Residents:

*With #1 having the greatest satisfaction rating.

1. 


2. 

3. 


4. 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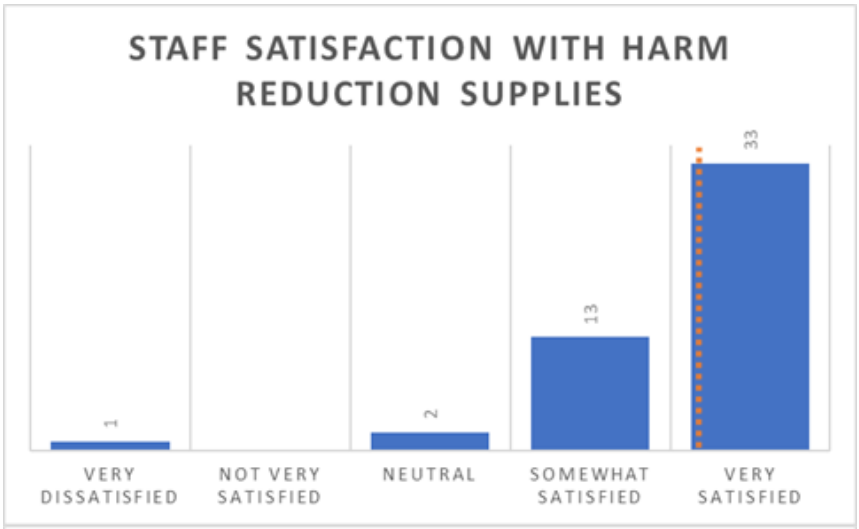
<u>Top Five Satisfaction Rates for Staff:</u>

1. 
STAFF SATISFACTION WITH HARM REDUCTION SUPPLIES
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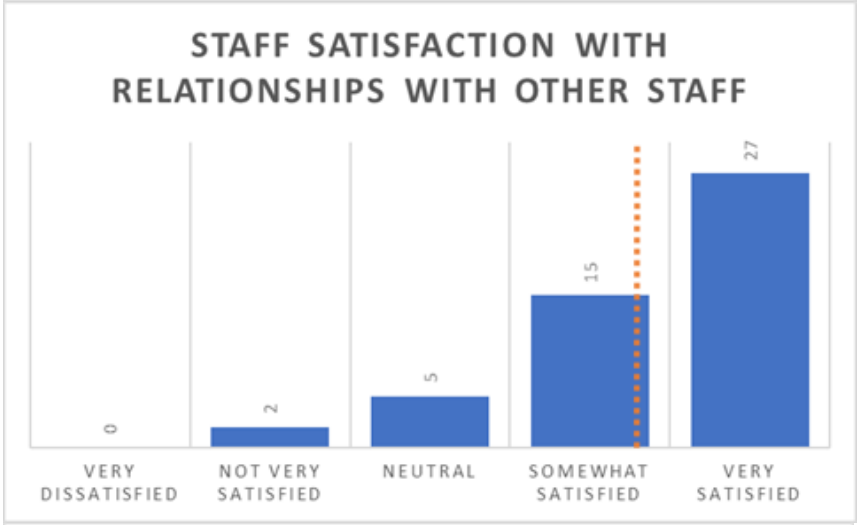
SOMEWHAT SATISFIED
VERY SATISFIED

2. 
STAFF SATISFACTION WITH RELATIONSHIPS WITH OTHER STAFF
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STAFF SATISFACTION WITH RELATIONSHIPS WITH RESIDENTS
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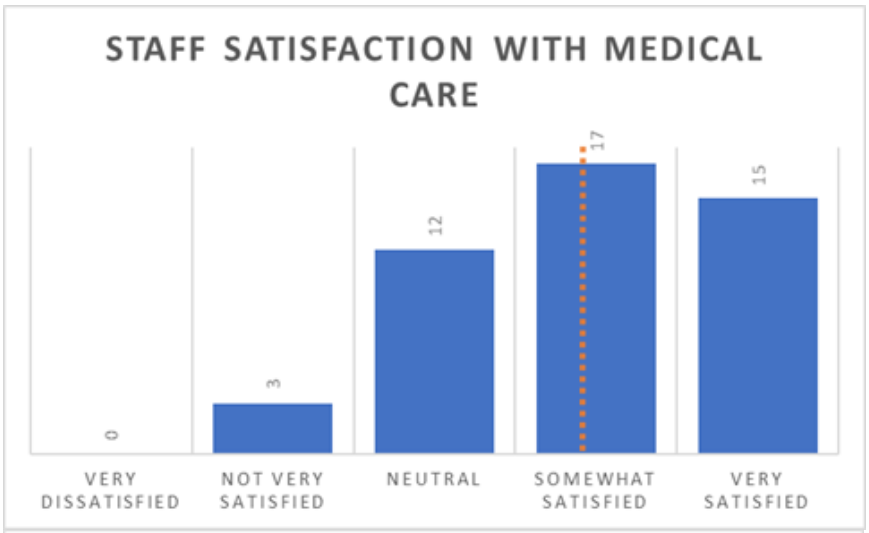
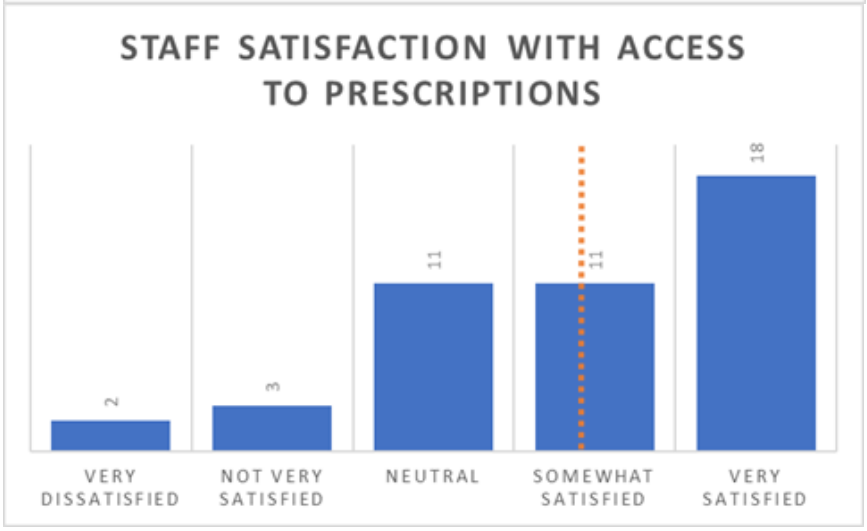
4. 


5. 


The five areas of least satisfaction for residents were:

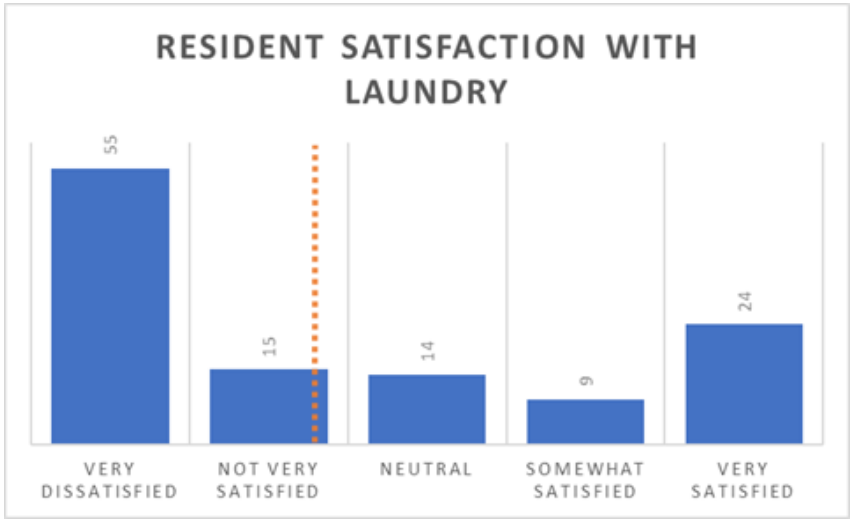
1. laundry services (2.4/5)
2. access to community spaces (2.6/5)
3. access to storage (2.7/5)
4. access to computers (2.8)
5. support for intimate partner violence (3.1/5).

Once again staff shared three of five of the residents' areas of least satisfaction, including access to community spaces, access to storage, and laundry services. Overall staff's areas of least satisfaction were:

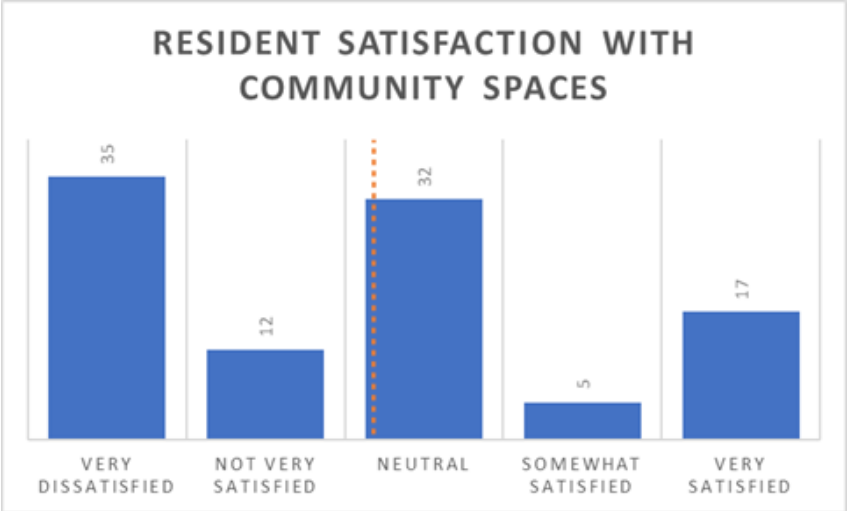
1. access to community spaces (2.2/5)
2. access to cultural supports (2.6/5)
3. laundry services (2.6/5)
4. access to Indigenous led supports (2.6/5)
5. access to storage (2.8/5).

## Lowest Rated Areas of Satisfaction for Residents:

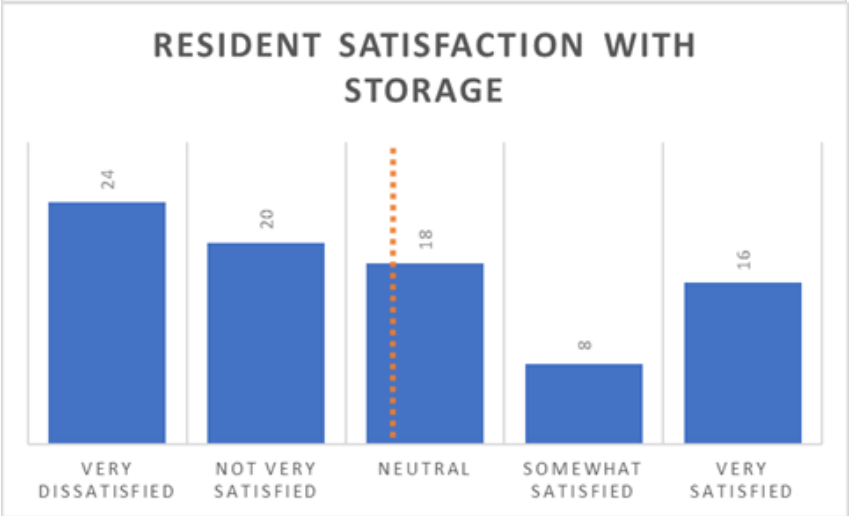
*With #1 having the lowest rating in terms of satisfaction.

1. 

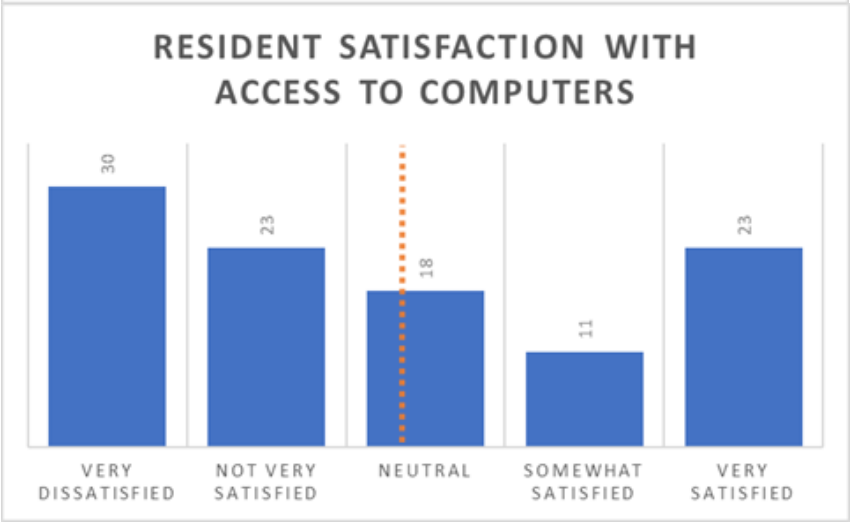
2.

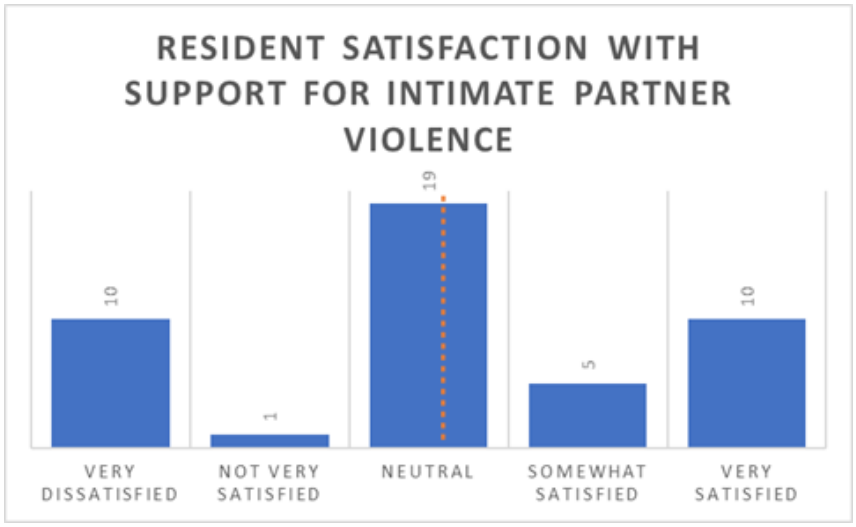

RESIDENT SATISFACTION WITH COMMUNITY SPACES
35
12
32
5
17
VERY DISSATISFIED
NOT VERY SATISFIED
NEUTRAL
SOMEWHAT SATISFIED
VERY SATISFIED

3.


RESIDENT SATISFACTION WITH STORAGE
24
20
18
8
16
VERY DISSATISFIED
NOT VERY SATISFIED
NEUTRAL
SOMEWHAT SATISFIED
VERY SATISFIED

4.

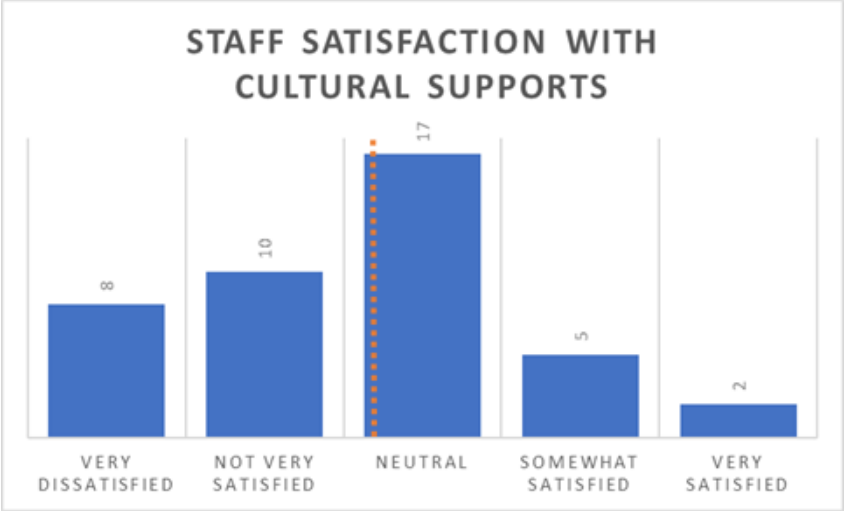

RESIDENT SATISFACTION WITH ACCESS TO COMPUTERS
30
23
18
11
23
VERY DISSATISFIED
NOT VERY SATISFIED
NEUTRAL
SOMEWHAT SATISFIED
VERY SATISFIED

5. 

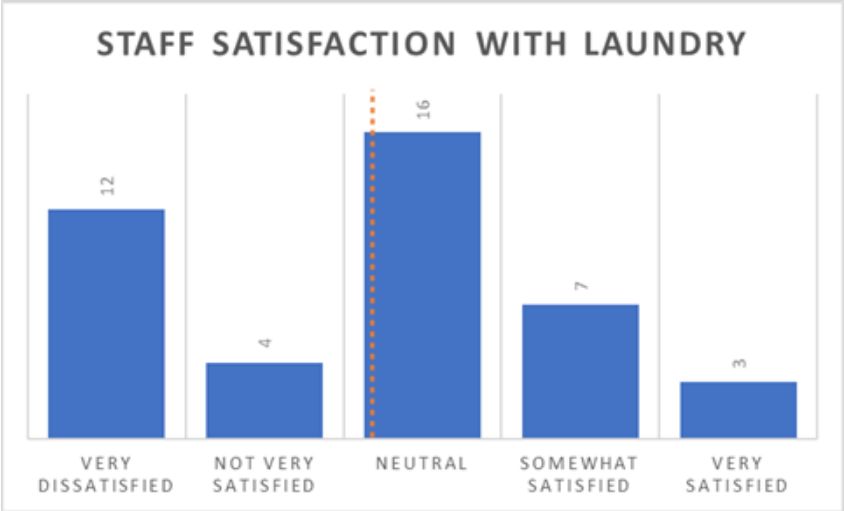

Lowest Rated Areas of Satisfaction for Staff:

1. 

2.

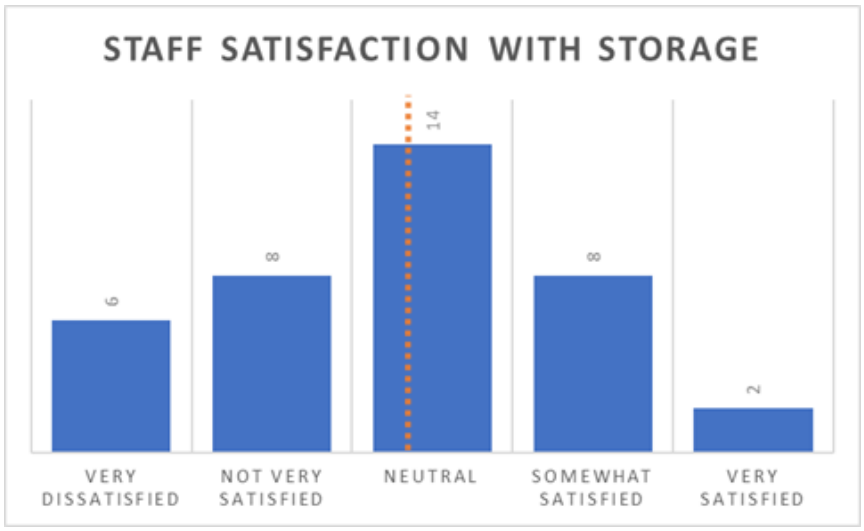

STAFF SATISFACTION WITH CULTURAL SUPPORTS
8
10
17
5
2
VERY DISSATISFIED
NOT VERY SATISFIED
NEUTRAL
SOMEWHAT SATISFIED
VERY SATISFIED

3.


STAFF SATISFACTION WITH LAUNDRY
12
4
16
7
3
VERY DISSATISFIED
NOT VERY SATISFIED
NEUTRAL
SOMEWHAT SATISFIED
VERY SATISFIED

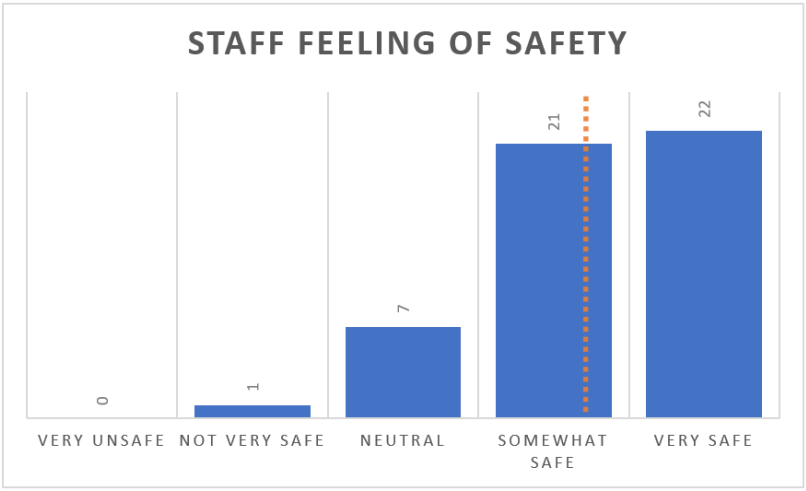
4.

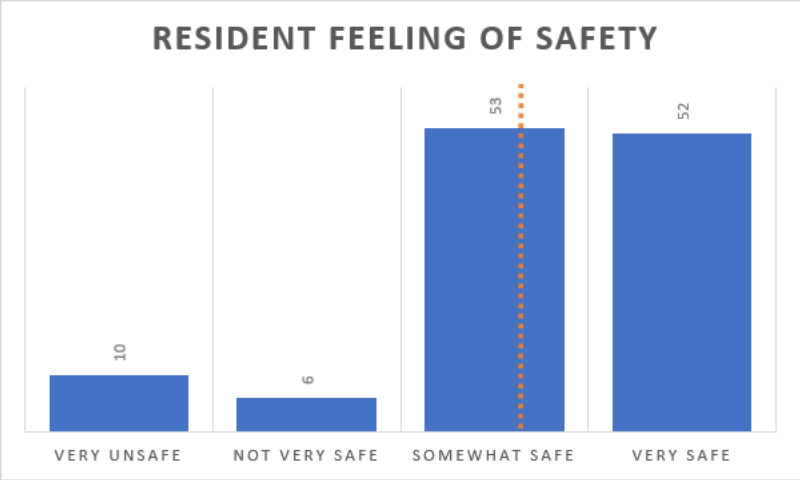

STAFF SATISFACTION WITH INDIGENOUS-LED SUPPORTS
7
11
19
7
1
VERY DISSATISFIED
NOT VERY SATISFIED
NEUTRAL
SOMEWHAT SATISFIED
VERY SATISFIED

5. 


## Feelings of Safety for Staff and Residents

As the charts demonstrate below, both staff and residents reported fairly high levels of satisfaction regarding feelings of safety, with staff on average feeling slightly safer (4.3/5.0; 8.6/10) than residents (3.2/4.0; 8/10). It is worth noting that ten residents responded feeling "very unsafe", and four reported that they felt "not very safe". In contrast, zero staff members responded feeling "very unsafe" and only one member of staff reported feeling "not very safe".






Importantly, there was a moderate difference in residents' feelings of safety between sites. The Arena reported significantly lower ratings in this category, averaging a score of 2.5/5. One contributing factor is likely the physical limitations of the Arena. The Arena is a temporary site and is set up as a large open space that does not provide the residents with their own secure rooms (unlike the other housing sites), which undoubtedly contributes to a lower sense of security. There has also been some theft reported at the Arena, which may have influenced this lower rating.

## Qualitative Follow Up Responses to Select Survey Questions

### 1. <u>What are the main things you like about your space?</u>

Overall, residents are most happy with their access to a private bathroom, support staff, and sense of privacy. Many stated that just being indoors in a space that they can call their own is their favourite aspect of their living space. Additionally, many residents appreciated the size and cleanliness of their space.

- *"That it's safe + clean and that I feel welcomed and that I won't be kicked out for being me."*
- *"I have a chance to address health issues."*
- *"The staff being here it makes for a feeling of family."*

Asked a similar question about their workspace in the sites, staff highly value spacious and comfortable workspaces, as well as access to the outdoors (some staff members commented that they enjoy being able to work outside, while others wrote that they like having windows in their offices). They also appreciate workspaces that are well organized and equipped, have a low barrier for access to safe drug supplies, and are easily accessible for clients. Most staff members speak very positively about their fellow workers, the residents, and interagency support.

- *"Residents are positive and more receptive creating better building atmosphere generally. Staff are great and having multiple organizations onboard and on-site creates dynamic and progressive community to help those in need"*
- *"Easy access, lots of outdoor time, highly visible/safe*

2. <u>What are the main things you dislike or find challenging about your space?</u>

The most common challenge for residents was living and interacting with other residents, with many frustrated by the mental health issues, substance use, and interpersonal violence among other residents. Food quality was a major issue at specific sites and was exacerbated by limited access to cooking facilities. A sizeable portion stated that not being able to have guests was the main thing they dislike about their living space.

- *"Having to deal with some of the other tenants who have mental health issues."*

- *"Food (not enough) laundry (none)."*
- *"The only thing I'm not used to is the domestic disputes. They're quite loud and with anxiety, it's tough for me."*

Asked a similar question about what they dislike or find challenging about their workspaces, some staff noted their working spaces are too small, which made social distancing and confidentiality an issue. Cleanliness is cited as an issue at some locations (especially at the Travelodge); theft is reported to be problem at the Arena; and wifi is reportedly not working properly at some locations (Arena, Howard Johnson, etc.). Many staff members voiced that security needs to be improved, especially for enforcing the "no-guest policy" (which is a controversial issue among staff and residents alike). A few also wrote that they feel some hotel and housing support staff are not being thoroughly trained. Medical staff state that their spaces are not being properly set up (equipment, printers, etc.) and secured. In addition, some staff reported that interagency mandates conflict at times, which makes it hard for workers to make and effect decisions, ultimately impacting the wellbeing of residents and staff alike.

- *"There's no overdose prevention unit, clients aren't supposed to use in their room, and hotel and security have been asking clients to leave when they use in the smoke pit in the parking lot"*
- *"The hotels are understaffed, sometimes the workplace feels unsafe. Inter-agency mandates when they conflict. Makes it hard to present a unified front and potentially compromises relationships with residents"*

3. <u>What kinds of changes or supports would you like to see in this space in the future?</u>

Considering changes for the future, the most common resident requests were for resident groups and improved access to laundry. Resident leadership, allowance of guests, and a sense

of permanency and/or transparency regarding the length of their stay were also important. Some residents discussed needing access to more peer support, mental health care, and increased harm reduction services.

- *"Group meeting & programs to change."*
- *"More laundry. Men's night."*
- *"More trained staff; more lived experience; staff … that have walked the walk … more intensive supports; people that work there need to be able to deal with support needs … Lack of relatability, poor decisions etc., lack of experience."*

Asked the same question, staff at the Arena want to focus on their location being shut down and moving their residents into more stable housing; while Capital City Centre staff would like to focus on getting a drop-in space with more privacy for residents. Staff at the other locations all specified that they would like more on site harm reduction (extended hours for those that have overdose prevention, and development of overdose prevention spaces for those that do not have them) and mental health supports (including on site access to crisis counsellors, as well as psychiatrists/therapists that can help residents with on-going mental health issues). Staff would also like to see more community activities and group work, more initiatives "by and for" residents, more common areas, increased staffing, improved communication and conflict resolution processes, proper building maintenance, and regular meetings where residents provide feedback and influence operations.

- *"More common areas, increased staffing, more social events, improved communication and conflict resolution processes"*
- *"Weekly or monthly meetings or a community board within the building so the residents can be heard and feel like they have a greater share of the space"*

- *"Longer safe injection site hours, more community spaces, laundry, and better food"*

4. <u>More housing facilities with supports are being planned for this region; what do you consider to be the most important features, services, or design details to pay attention to?</u>

Among the residents, the most common suggestion was for high-quality support staff to be consistently accessible. Residents also stressed the importance of safety; access to mental health care; and either nutritious food delivered, or in-suite kitchenettes. A common theme was concern about different populations (people who use substances, people with mental illnesses, different genders, age groups) staying at the same site; with many suggesting a triaged or deliberate housing strategy based on grouping people with compatible needs and preferences.

- *"Onsite 24/7 workers! Having someone to talk to, even for a short time can help so much."*
- *"Placing certain people in a more appropriate place, as in elders"*
- *"The no guest policy has proven to be ineffective …"*

Asked the same questions, staff consider the following to be the most important features and services to pay attention to: more peer run programs; cultivating an environment of openness and trust with residents; lessening limits on the residents and increasing their autonomy (monthly meetings so that residents shape decisions regarding site and services, reconfiguring the no-guest policy, etc.); prioritizing safety for residents and having policies in place to properly address interpersonal violence; mental health, medical, and substances use supports and treatments on-site; thoughtful placement offers to residents; increased staffing;

creating a nice outdoor space for residents; and having access to a wide variety of services in reach to the housing site (i.e., ministry support, ID clinic, peer support, employment support, etc.).

- *"Low barrier and limit permanent eviction. Clients want more privacy. Bring every service to the housing site - support to complete taxes, ministry support, ID clinic, healthcare, peer support, employment support and so on. Also would be nice to have clients have a say in their own space - i.e. a weekly peer led meeting about what's working and not working. More access to cultural support especially with indigenous folks."*

- *"Peer-run programs, stipends/living wages"*

5. <u>What kinds of spaces for learning and creativity would you like to see in housing (art spaces, carpentry spaces, photography, cooking groups, etc.)?</u>

While many residents said that they would appreciate any kind of creative space whatsoever, by far the most consistent choice was a space for visual arts like drawing, painting, and crafts. Cooking groups, carpentry/woodworking, and photography were also very common choices; with gender-specific groups, spaces for physical exercise, and employment skills training also mentioned.

- *"Anything would be great as currently there is nothing of the sort."*

- *"I'd like to see spaces for all these things, music and art especially as the only way to navigate out of trauma is to find an outlet."*

Asked the same questions, many staff members state that It would be good to talk to the residents to see what they want. Overall though, the most popular suggestions were: art spaces, bike repair stations, a community kitchen and cooking classes, carpentry shops, yoga, an outdoor garden, any sort of life skills workshops or classes, recovery meetings, etc.

- *"Art, cooking and job skill development would all be helpful."*

- *"All of the above! Including garden spaces in the summer."*

6. <u>What is your top priority right now?</u>
7.

The top priority for most residents was to get into secure and stable housing. The second most common priority was managing their substance use/dependence, with many also identifying overall health as their number one goal. Maintaining ties with family, overall self-improvement, managing mental health, and staying safe for now were also common themes.

- *"To get into independent housing & to get off drugs."*
- *"Trying not to kill myself." (x2)*

The most common response for staff is that their top priority is to support residents; both in general, as well as specifically through harm reduction services and by finding them permanent housing. Other top priorities were attaining more staff and medical support, increasing access to safe supply and effective harm reduction strategies, attaining a bigger budget, creating more community activities, and meeting residents' needs while simultaneously promoting their autonomy.

- *"Safety and comfortability for the residents. Namely, safe injection site, food option/improved food and community spaces."*
- *"Meeting the daily needs of everyone, supporting when and where asked or needed, and promoting a space for autonomous realizations for next steps."*

## Significant Site by Site Differences

A series of statistical tests[3] were performed to determine whether there are significant differences in satisfaction with services between individual sites. These tests only include feedback from residents, as there were not enough staff responses in most locations to justify statistical analysis. Only differences which met the threshold of adjusted $p < 0.05$ were included. Claims of "moderate" or "relatively strong" come from a measure of effect size ($\varepsilon^2$) and give an indication for how different the sites are likely to be from one another.

- Move-In: There was a moderate difference in resident satisfaction with the move-in process. Howard Johnson stood out as having the highest mean satisfaction (4.88/5), which was significantly greater than the Arena (3.77/5) and the Travelodge (3.95/5).

[3] All questionnaire items were analyzed using a Kruskall-Wallis test, a non-parametric analysis of variance which tests whether we have reason to believe that there may be differences in the distributions of scores between sites. The Kruskall-Wallis test was chosen due to the different sample sizes of each site and the non-normal distributions of raw scores, as it uses ranked scores rather than raw data. These analyses are tentative and should not be taken as definitive given that the informal sampling strategies used at each site as well as the overall low number of respondents makes errors (especially failing to detect true differences between sites) likely. If the Kruskall-Wallis test was significant at $p = 0.05$, follow-up comparisons between specific sites were made using the Dunn test with a Bonferroni correction for multiple comparisons. This is a conservative test which sets the bar higher for detecting differences between sites by accounting for the higher chance of finding an effect when you make multiple comparisons. Follow-up tests were reported as significant if the adjusted p value was less than 0.05. If these test parameters were used continuously, false positive results would occur less than 1 in 20 times. However, the way the data were collected as well as the low number of residents responding at some sites may still result in false positives despite these statistical corrections. All claims of strength are adapted from Rea' and Parker's (1992) rule of thumb for interpreting effect sizes by squaring the bin bounds to allow direct interpretation of Kelley's epsilon square ($\varepsilon^2$).

- Overall Satisfaction: There was a relatively strong difference in resident satisfaction between sites. Arena had the lowest satisfaction rate (2.5/5), with the next lowest being the Travelodge at 4.00/5, and the highest being the Howard Johnson (4.63/5).
- Food: There was a relatively strong difference in resident satisfaction with food between sties. Comfort Inn (2.32/5) reported significantly lower satisfaction than Travelodge (3.79/5), Capital City Centre (4/5), and Howard Johnson (4.25/5).
- Safer Smoking Area: There was a relatively strong difference in resident satisfaction regarding harm reduction for safer smoking. Paul's had the lowest satisfaction rating (2.29/5), while Howard Johnson had the highest (4.92/5).
- Laundry Services: There was a moderate difference in resident satisfaction with laundry between sites. Comfort Inn (1.58/5) reported significantly lower satisfaction than Howard Johnson (3.5/5); though laundry was an area that required improvement at all sites.
- Cleaning Services: There was a moderate difference in resident satisfaction with cleaning between sites. Travelodge (3.05/5) reported significantly lower satisfaction than Capital City Centre (4.4/5).
- Access to Computers: There was a moderate difference between sites in resident satisfaction in this category; Arena (1.92/5) reported significantly lower satisfaction than Capital City Centre (4.08/5).

- Access to Storage: This was a category most sites did not get high satisfaction ratings for. However, there also was a moderate difference between sites: Paul's (1.70) had the lowest rating, and Arena (3.78/5) had the highest.
- Self-Isolation and Social Distancing: Most sites tested between 3.5-3.9/5 in these two categories; the one site that demonstrated significantly lower results was the Arena (self-isolation: 2.14/5 and social distancing: 2.79/5). However, it is important to note that the Arena has been set up as a temporary site and presents structural limits which the other sites are able to overcome (i.e., individual rooms for the residents).

Site to site differences should be interpreted cautiously given the smaller sample numbers; further these differences likely relate to a confluence of factors – including physical limitations of sites - that require a operations level, or multi-organizational response to change.

## Summary of Findings So Far and Considerations Going Forward

The findings so far highlight high levels of satisfaction with residents, with the five areas of greatest satisfaction including: access to harm reduction supplies, relationships with support workers, access to medical care, satisfaction with the safer injection site, and satisfaction with safer supply. In contrast, the five areas of least satisfaction for residents were: laundry services, access to community spaces, access to storage, access to computers, and support for intimate partner violence.

There were common themes that arose between staff and residents in the qualitative findings. Firstly, the need for more mental health supports on site was brought up often by staff as well as residents. There is a desire from both groups to see counselling services on site, as well as access to crisis intervention experts. In addition, both staff and residents identified the need to set up support and self-governance/feedback groups on site for the residents.

Increased access to harm reduction supports and safer supply was another common theme that surfaced in the qualitative responses. Longer access hours for the safer injection site, as well as for the safer smoking site, were requested by both staff and residents (ideally 24/7 access, and at a minimum longer evening hours). As well, having more options for residents in terms of safer supply appeared to be a consistent theme (for example, having alternatives to Dilaudid).

Many residents and staff also spoke about problems associated with interpersonal violence at the housing sites. Residents found it to be one of the more challenging aspects about their living space. Similarly, staff also see interpersonal violence as a problem that is not currently being properly addressed. Some have suggested implementing policy and guidelines on how to deal with interpersonal violence, so that staff can better support residents experiencing it.

Another common theme is the desire for improved access to basic resources such as laundry, food, cleaning support, storage and basic housing supplies (computers, printers, etc.) which was brought up frequently throughout the survey by both residents and staff. Connected to this, is the need for community spaces where residents can visit with friends and

family, and engage in communal activities, art, workshops, etc. There are various suggestions and opinions on the subject of guests from both residents and staff and is thus an area that requires more attention to navigate differing, and sometimes incompatible, opinions (need for guest access, but also concerns regarding safety and capacity).

Furthermore, resident autonomy came up frequently throughout the survey in numerous ways. Staff and residents both would like to see the residents contribute more to the decision-making processes, have more influence at the sites, and be able to contribute more to community building. Suggestions to help achieve these initiatives include regular meetings, a job pool, community events, creative/learning spaces and workshops, more common spaces, etc. In addition, residents expressed the desire to enact more agency over food and laundry services (more meal choice, kitchenettes in order to cook food themselves, increased access to laundry machines, etc.).

Finally, a sizeable portion of residents commented that the no guest policy was the main feature that they disliked about their space. Residents feel that it limits their agency to not be able to visit with family and friends, and a few staff members commented that it forces sex workers to work on the street. Consequently, enforcing the no guest policy also creates tension between staff and residents (as well as between staff members with conflicting views and/or agendas).

This survey has demonstrated that the residents are not a homogenous group and have many different needs, perspectives, and goals. Resident and staff opinions converge in many areas. Overall, residents are quite satisfied with the support and services provided thus far,

however there is room for improvement. The report that follows will include more information on other items of satisfaction that fell into neither the areas of greatest and least satisfaction, but rather the middle; as well as more summary analysis of the textual commentary provided; and associated recommendations and action for improving services and supports at these sites.

# Health & Housing Think Tank Report

*Last Updated September 9, 2020*

## Contents

# Background Information

The Provincial Government has provided ongoing funding to Island Health and BC Housing related to health care and housing for people experiencing homelessness. Island Health is inviting the community to influence how these funds are used. This is a new approach to funding that will invest new funding in a different way with the local Health Authority.

This Health & Housing Think Tank advisory group will be working together to provide recommendations to Island Health about how this funding could be used to provide primary care including supports for mental health, substance use, harm reduction, and housing. We are not a decision-making group. The recommendations will focus on the vision and the model of care rather than the budget or details of execution. In addition to this group, an advisory group of physicians is also developing recommendations and related Ministries are developing standards.

We've never seen this level of ongoing investment in programming that addresses housing, health, and harm reduction to this extent. This is a unique opportunity to take some time to imagine what our community can do. It will be an iterative process plan that will stand on the shoulders of other work with BC Housing, our collective experience, and existing research.

## Health & Housing Think Tank Members

Our team is excited to be working together collaboratively. They bring a diverse set of knowledge, experience, and representation to the Think Tank. After the experience of working together through the COVID-19 pandemic, we hope that is this space to further break down barriers continue to build trust so we can help the people who need us most.

Our team includes people with lived experience, peers, administrators, researchers, medical services, and policy makers. Our goal is to learn from this collective experience to build recommendations. Our organizations have services and supports for housing, harm reduction, substance use, the sex industry, mental health, HIV and Hep C positive people, indigenous people, marginalized communities.

**When a diverse group can ask for change in one voice, it is a true collaboration and reflection of community.**

| | | |
|---|---|---|
| Alison James, City of Victoria | Fran Hunt-Jinnouchi, ACEH | Mary Chudley, Cool Aid |
| Angela Moran, BCH | John Reilly, CRD | Mary Morrison, VIHA |
| Angela McNulty Buell, GVCEH | Katrina Jenson, AVI | Mike Brown, VPD |
| Ashley Heaslip, PHS | Kelly Reid, VIHA | Monique Huber, ACEH |
| Avery Taylor, PHS | Kelly Roth, GVCEH | Rachel Phillips, Peers |
| Bernie Pauly, Island Health/UVic | Lisa Crossman GVCEH | Sharlene Law, Umbrella Society |
| Don McTavish, Cool Aid | Leah Young, Our Place | Shannon Perkins, City of Victoria |
| Echo Kulpas, VIHA | Lois Gabitous, BCH | Sophie Bannar-Martin, VIHA |

**Facilitators:** Mary Morrison, Kelly Roth & Janine Theobald | **Notes & Report:** Annette Wierstra

The group also followed this recommended plan for collecting further information from Peer Organizations:

1. The health and housing think tank recognizes that peer-run and informed community organizations in Victoria are, in their collaboration over the previous months, developing culturally appropriate and trauma informed methods for engaging people with lived experience of health and housing services, to ensure these experiences guide the development and delivery health and housing services in Victoria.
2. The health and housing think tank is committed to receiving guidance and input from these organizations in whatever form is deemed most appropriate by these organizations (This could include written guidance documents in response to weekly meeting outcomes to identify gaps or issues, or a guidance document submitted by collaboration among these organizations in response to initial drafts of the final think tank report, or other methods as determined by these organizations).

## Our Desired Outcomes

1. **A model of care that meets people with lived or living experience needs where they are at.**
2. **Recommendations that will inform health investment decision making with an emphasis on the provision of harm reduction services and supportive/supported housing.**

**Our Think Tank members will:**

- Bring our passion, unique perspectives, knowledge, and experience to create a collaborative approach to designing our recommendations.
- Acknowledged the power inequities and engaged feedback and insight from people with lived and living experiences of homelessness, mental health challenges, and substance use disorder.

**Our Recommendations will:**

- Advocate for a human focused approach for member driven service that has public or low barrier access.
- Reflect that people with lived or living experience have a diverse spectrum of needs and preferences.
- Inform and integrate with the ongoing planning and system development related to creating a Coordinated Assessment and Access System through the existing CRD, BC Housing and Island Health partnership.

**Our Model of Care will:**

- Include a model of supportive/supported housing with an emphasis on health and harm reduction services.
- Be based on our collective wisdom, proven best practices, and research of current successful practice models.
- Address gaps in the system and advocate for services that are missing.
- Create a more seamless experience for people with lived or living experience so they can access services with a continuity of care.
- Create a collaborative partnership that integrates health and housing because *housing is one of the fundamental factors contributing to the social, physical, mental, emotional, and spiritual health of populations.*
- Offer ideas for services and housing that are both immediate and look to serving people with lived or living experience long-term needs.

## Principles of Engagement

1. Respect the process.
2. Assume best intent.
3. Please don't use acronyms; we don't all speak the same 'language.'
4. Engagement approach:
    a. Appreciative inquiry.
    b. Solution focused.
    c. Brainstorming, creative, blue sky thinking welcome!

To ensure equal opportunity for participation we are utilizing a timed 'circle' or 'talking stick' format.

Janine will call your name in rotation to keep us organized, on track, and on time. Janine will be timekeeper, if needed 😊
Mary, Kelly, and Janine will rotate facilitation.

## Spectrum of Housing Services

Our discussion was framed by the following break down of the spectrum of housing needs. Our vision includes addressing this spectrum of needs through a spectrum of services and spaces.

| Housing Type | A. Low Needs Housing | B. Moderate Needs Supportive Housing | C. High Needs Supportive Housing | D. Residential Care |
|---|---|---|---|---|
| **Needs** | • Financial supports (rent subsidy)<br>• Housing specific and otherwise low support needs<br>• Lives independently, manages activities of daily living<br>• Can receive services and supports in community on outpatient or drop in basis<br>*Example:*<br>*CRD/Housing First* | • Significant health challenges (physical, mental health, substance use)<br>• Self managing most personal needs and living semi independently, with support of on-site staff and in reach health services<br>• Attending some outpatient and drop-in services<br>*Example:*<br>*Cool Aid Cedar Grove* | • Significant health challenges (physical, mental health, substance use)<br>• Other comorbid conditions that impact wellness and capacity, which could include brain injury, developmental disabilities, complex trauma, cognitive impairment, chronic physical disabilities<br>• History of significant behavioral challenges such as violence, fire setting<br>• Can live in congregate setting or semi independent with supports and services available on site offering a variety of services.<br>• Coordinated overall care/service plan<br>*Example: Johnson Street Community* | • Chronic and high needs<br>• Require 24/7 intensive care from multi-disciplinary/multi-experiential support team |

## Weekly Agenda

| Date & Time | Week | Discussion Focus |
|---|---|---|
| Thursday, June 4<br>10:00 – 11:30 am | Week 1 | Introductions and Planning Session |
| Thursday, June 11<br>10:00 am – Noon | Week 2 | Design Housing Type C \| Focus: High Needs<br>• Holistic Needs<br>• Location of Services<br>Bricks and Mortar |
| Thursday, June 18 & June 25<br>10:00 am – Noon | Week 3&4 | Design Housing Type B \| Focus: Moderate Needs<br>• Holistic Needs<br>• Location of Services<br>• Bricks and Mortar |
| Thursday, July 2<br>10:00 am – Noon | Week 5 | Design Housing Type A \| Focus: Low Needs<br>• Holistic Needs<br>• Location of Services<br>a) Bricks and Mortar |
| Thursday, July 9<br>10:00 am – Noon | Week 6 | Design Housing Type D \| Focus: Residential Care Needs<br>• Holistic Needs<br>• Location of Services<br>a) Bricks and Mortar |
| Thursday, July 23<br>10:00 am – Noon | Week 7 | Review and discussion<br>• Principles and Key Themes<br>• Summary Recommendations |
| Thursday, Aug 6<br>10:00 am – Noon | Week 8 | Wrap up and Review the Consultation Report |
| Thursday, Aug 14<br>10:30 am – Noon | Week 9 | Wrap up and Review the Draft Report |

# Summary of Think Tank Discussions

## Key Principles

These key principals reflect our values, philosophy, and aspirations. We believe that it is important to have health, housing, and social services that seek to meet these principles.

**Health is multi-sectoral.**
It is important to understand contributions to health from sectors outside of health systems. The focus needs to be broadened to consider these broader social determinants such as housing, community, cultural and spiritual connection, food, income, social supports, and transportation in addition to mental and physical health.

**Truth and reconciliation are crucial.**
There is an overrepresentation of indigenous peoples who are have lived or are living with homelessness as an outcome of both historical and ongoing colonization. We are committed to providing culturally safe care and increasing Indigenous-led services.

**Diversity matters.**
People who have lived or are living homelessness include a diverse spectrum of ages, genders, sexualities, and abilities. There should be consideration of this diversity in services, locations, cultural supports, and peer supports to meet unique needs.

**All people need community.**
People with lived experience (PWLE) of homelessness often live in a context of stigma, criminalization, medicalization. These factors create complicated and profound barriers to wellbeing. Building community within housing and within neighbourhoods creates a healthier environment for all.

**Everyone has the right to self determination.**
At every level, self determination, autonomy, and choice should be a fundamental starting point even if the choice part remains aspirational in housing context. We want to provide services and supports that are flexible and meet people where they are at, and that allow them to choose the pace, type, location of services.

**Spaces and services should be trauma informed.**
When people experiencing homelessness have repeated encounters with the service system, they may experience trauma related to accessing help. When spaces and services are designed it is imperative to create positive spaces that promote dignity, harm reduction, safety, and flexibility.

**Services are connected to the person.**
If services are centred around the person rather than the housing, people can take relationships with services providers with them, if they choose. This approach allows service continuity as individuals experience changes in their lives.

# Recommendations

## Holistic Needs

**Physical Health**

1. Ensure building designs include multipurpose spaces, furniture, and resources that can be used by a variety of health care providers to meet patients onsite (such as doctors, nurses, pharmacists, psychologists, psychiatrists, physio or occupational services, etc.).
2. Ensure that health and primary care needs are offered to people as soon as they enter transitional sheltering sites.
3. Build long term care facilities with harm reduction support for older or senior people.
4. Create a hub model of care (either onsite or community) that includes access to as many wrap around supports as possible, such as health, social, educational, etc.).
5. Provide flexible health and housing services that allow people to choose the pace, type, location of services.
6. Attach health and housing services to the person instead of the housing facility so people can build and sustain relationships with services providers.
7. Design supportive housing that can accommodate people with complex physical health needs and complex mental health needs long term (such as nursing support and care aids with a harm reduction approach).
8. Provide training to people with lived experience System Navigators, so they can be paid guides who are understand the system which can make it easier for people to access health and housing services.
9. Provide training for all housing staff, health care providers, and peer and support workers in trauma informed and harm reduction care.
10. Provide access to the basic determinants of health and amenities (food, clean environment, laundry, Wi-Fi) at all housing sites because when these needs are met there is less violence and fewer mental health concerns.
11. Ensure that people have access to sexual, reproductive, and prenatal health care at all housing sites.
12. Deliver health and housing services (including harm reduction) as both embedded services and outpatient services based on the level of need and preference of the individuals.
13. Integrate Primary Care and Addictions Medicine so it can be delivered holistically.
14. Provide health care supports that specifically support those working in the sex industry.

**Mental Health**

15. Train the current Mental Health teams to deliver low barrier, trauma informed mental health supports.
16. Create separate, acute psychiatry spaces away from the housing site (like St. Paul's Hospital model) for emergency or crisis support.
17. Provide low barrier group programs for whatever residents identify as their needs, such as introduction to recovery, conflict resolution, gender specific, gender-based violence, etc.
18. Provide access to low barrier clinical counseling for people who use substances (Peers model).
19. Create opportunities for residents to work in advocacy for stigma reduction and social justice.

**Substance Use & Harm Reduction**

20. Create a multi-disciplinary team (health care, peers, mental health, police) for rapid conflict resolution to avoid criminalization of people using substances or alcohol.
21. Develop a medical intervention protocol for preventative treatment of substance induced psychosis symptoms.

22. Engage people in their own healthcare by giving them choice about the type, pace, and location of harm reduction program delivery.
23. Integrate harm reduction into all healthcare services, a person can access or be directed to harm reduction services through any health care service, if needed (no wrong door).
24. Design buildings that include spaces for smoking and inhalation onsite.
25. Provide the staff training, space, and resources onsite for episodic overdose prevention.
26. Provide alcohol harm reduction and managed alcohol programs either onsite or in community, so drinking isn't a barrier to people going to shelters or into housing.
27. Ensure that programs and supports for intimate partner violence are offered whenever substance use and harm reduction programs are offered.

**Social**

28. Create Resident Councils or Advisory Boards at each housing location so residents can engage in decision making about their homes; onsite and in-reach services; and social, cultural, and spiritual programs.
29. Provide people with the choice of where to live (such as near their work, partners, family, or friends), by ensuring that in-reach supports are readily available.
30. Provide low barrier access to employment programs that help people seek, obtain, and maintain employment.
31. Connect people living in housing to their local community through events and sharing community spaces to try to reduce stigma.

**Cultural**

32. Create Indigenous led healing teams connected to local territories and Lekwungen Peoples.
33. Normalize and prioritize ensuring all services, supports and housing is culturally informed and rooted.
34. Ensure that decisions about services, supports and housing are informed by an understanding of Street Culture.
35. Focus cultural events, classes, and space on healing, empowerment, and agency.
36. Design building with multipurpose, community spaces that can be used for organized or informal, peer-based cultural gatherings.
37. Give lots of choice, self determination about the social, cultural, spiritual events, classes, and spaces so residents have choice and power over own futures.

**Spiritual**

38. Locate buildings near community spiritual centres or near bus routes for affordable transportation to spiritual centres.
39. Design building with multipurpose, community spaces that can be used for organized or informal, peer-based spiritual gatherings.
40. Give lots of choice, self determination about the spiritual events, classes, and spaces so residents have choice for their spiritual well-being.

## Bricks & Mortar Needs

41. Design housing site based on the following features:

| | |
|---|---|
| Aim for 30 to 50 people or units per site with Smaller populations for people who require more intensive supports. | Disperse housing sites through out the CRD to create mixed communities that have diversity |
| Located near bus routes | Onsite or near green spaces, outdoor social spaces, and community gardens. |
| Aesthetic, welcoming entryways and communal spaces in all buildings. | Pet friendly features and nearby spaces for dog walking in all buildings. |
| Good sized rooms with adequate sound proofing, bathrooms, and privacy with disability access. | Adequate security and safety while balancing residents' privacy and dignity. |
| Multipurpose spaces and materials for creative and learning activities such as gardening, crafts, music, computers, communal kitchens. | Community spaces inside and outside to meet social interaction including space to meet with children and families. |
| Create paid, onsite job opportunities for people to care and maintain the facilities (carpenters, welders, builders, artists, gardeners, etc.). | |

## Holistic Needs

This table describes our vision of how we can provide services that promote healing, community, and independence. The table shows the foundational needs for all types of housing support needs with additional supports as the level of need rises from low need (Type A) to acute need (Type D). See the Spectrum of Housing Services for more detail on each level of need. For a more detailed discussion of these needs see Appendix A1: Holistic Needs.

| A<br>Low Needs Housing | B<br>Moderate Needs Supportive Housing | C<br>High Needs Supportive Housing | D<br>Residential Care |
|---|---|---|---|
| • Opportunities for outside work<br>• Financial and income supports<br>• Flexible support as needs change<br>• Ability to quickly re-access supports, if needed<br>• Involved in community events<br>• Places to prepare food<br>• Bus passes, transportation (appointments, social events) | • Follow up care post hospital or life change<br>• Onsite harm reduction and overdose prevention sites<br>• Episodic OPS or peer witnessing.<br>• Well resourced staff, trained in responding to conflict, distress, harm reduction.<br>• Groups spaces for informal and organized socializing, education, cultural and spiritual gatherings<br>• Places to prepare food<br>• Bus passes, transportation (appointments, social events) | • Embedded health care services<br>• On-site access to medical, mental health services<br>• Community based IV therapy options for folks<br>• Outpatient AntiMicrobial Therapy clinic (OPAT)<br>• Supports for brain injuries<br>• Integration/ community for people who live outside<br>• Staff specialized in mental health supports<br>• 24/7 mental health, medical and harm reduction support<br>• 24/7 access to healthy, nutritious food | • Specific focus on trauma informed healing spaces and services<br>• Both short-term and long-term space available for acute support |

### UNIVERSAL NEEDS

| | | |
|---|---|---|
| • Person centered approach<br>• Choice in care and supports<br>• Culturally aware and accessible care.<br>• Assertive Community Treatment Teams<br>• Transitional supports from hospital, tent city, to own apartment, etc.<br>• Community Health Centre model of care (legal aid, social workers, financial, social, and cultural supports<br>• Food security | • Peer supports/ System Navigator<br>• Consistent, accessible Information<br>• Culturally appropriate food<br>• Access to mental health, medical, harm reduction services.<br>• Accessible Safe Supplies<br>• Resident Advisory Group as a safe space for concerns/suggestions<br>• Land based traditional healing is integrated into how we physically heal | • Collaborative, holistic care plan<br>• Assessing for dual diagnosis<br>• Secondary medical supports (physio, OT, pregnancy, etc.)<br>• Accessibility for people with physical mobility needs or medication needs.<br>• Social, community, spiritual connections<br>• Ability to participate in community activism.<br>• Pet friendly spaces |

## Location of Services

This table describes our vision of where we can deliver services that promote healing, community, and independence. The table shows potential services and whether they would best be delivered:

**On-site:** Permanent locations for services for regular/scheduled times in a designated space assigned for this purpose.
**In-Reach:** Service providers come to the location to provide services on a scheduled or as needed bases, in a shared space at the locations.
**Community:** Services that are available and accessible in the community. System Navigators, Support Works, Service Provides can help the residents access and find these services.

The types of housing support range from those with low need (Type A) to acute need (Type D). See the Spectrum of Housing Services for more detail on each level of need. For a more detailed discussion of these needs see Appendix A2: Location of Services.

| Services | A Low Needs Housing | | | B Moderate Needs Supportive Housing | | | C High Needs Supportive Housing | | | D Residential Care | | | Services |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | On-Site | In-Reach | Community | On-Site | In-Reach | Community | On-Site | In-Reach | Community | On-Site | In-Reach | Community | |
| Care Coordination (dual diagnosis, assessments) | | | ● | | ● | | ● | | | ● | | | Care Coordination (dual diagnosis, assessments) |
| Medical Clinics | | | ● | | ● | ● | ● | | | ● | | | Medical Clinics |
| Pharmacy | | | ● | | ● | ● | ● | | | ● | | | Pharmacy |
| Supplemental Health Services (physical therapy, occupational therapy, home care, pregnancy) | | ● | | | ● | ● | | ● | | | ● | | Supplemental Health Services (physical therapy, occupational therapy, home care, pregnancy) |
| Support Workers | | ● | | | ● | | | ● | | | ● | | Support Workers |
| Peer Supports/ System Navigators | ● | ● | | ● | ● | | ● | ● | | ● | ● | | Peer Supports/ System Navigators |
| Resident Advisory Board | ● | | | ● | | | ● | | | ● | | | Resident Advisory Board |
| Community Integration Specialist (income assistance) | | | ● | | ● | | | ● | | ● | | | Community Integration Specialist (income assistance) |
| Integrated social enterprise opportunities | ● | | | ● | | | ● | | | ● | | | Integrated social enterprise opportunities |
| Mental Health Harm Reduction | | ● | | | ● | | ● | | | ● | | | Mental Health Harm Reduction |

| Services | A Low Needs Housing | | | B Moderate Needs Supportive Housing | | | C High Needs Supportive Housing | | | D Residential Care | | | Services |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | On-Site | In-Reach | Community | On-Site | In-Reach | Community | On-Site | In-Reach | Community | On-Site | In-Reach | Community | |
| Psychiatrist/ Social supports | | | ● | | ● | ● | | ● | | ● | | | Psychiatrist/ Social supports |
| Drop in Facilitated Groups (mental health, harm reduction, substance abuse, hoarding, etc.) | | ● | ● | | ● | ● | | ● | | | ● | | Drop in Facilitated Groups (mental health, harm reduction, substance abuse, hoarding, etc.) |
| Overdose Prevention & Supervised Consumption Site | | ● | | ● | | | ● | | | ● | | | Overdose Prevention & Supervised Consumption Site |
| Inhalation Site | ● | | | ● | | | ● | | | ● | | | Inhalation Site |
| Gyms, Recreation Facilities | | | ● | | | ● | ● | | ● | ● | | ● | Gyms, Recreation Facilities |
| Life Skills Training | | | ● | | ● | ● | | ● | ● | | ● | | Life Skills Training |
| Library with Computer/Internet Access | | | ● | ● | | ● | ● | | ● | ● | | | Library with Computer/Internet Access |
| Creative Supplies & Tools (Art, gardening, music, bike maintenance, cooking, etc.) | | | ● | ● | | | ● | | | ● | | | Creative Supplies & Tools (Art, gardening, music, bike maintenance, cooking, etc.) |
| Social and Educational Events (creative classes, spiritual or cultural events, peer events, community events) | | | ● | | ● | ● | | ● | ● | | ● | ● | Social and Educational Events (creative classes, spiritual or cultural events, peer events, community events) |
| Community Garden | | | ● | | | ● | | | ● | | | ● | Community Garden |

## Brick & Mortar Needs

This table describes our vision of how we can create buildings that promote healing, community, and independence. The table shows the foundational needs for all types of housing support needs with additional supports as the level of need rises from low need (Type A) to acute need (Type D). See the Spectrum of Housing Services for more detail on each level of need. For a more detailed discussion of these needs see Appendix A3: Bricks & Mortar Needs.

# Appendix A: Meeting Notes from Think Tank Discussions

## Appendix A.1: Holistic Needs

### General Discussion about Holistic Needs

**Principles and Key themes**

- We have a section of the report that identifies the key determinants and then a section that outlines the principles such as "At every level, self determination, autonomy and choice should be a fundamental starting point even if the choice part remains aspirational in housing context :)"
- Some of this information will be relevant to the current funding but all of this contributes to how we do our work and have broader implications for how we can work. It may take time to shift into this direction. Goal of continual improvement for all of the partners.
- Goal to make the information is available so we can also use it as information to inform our work.
- All groups (A, B, C, D) can be self determining and they know what they want. People want more than anything to be self determining that they will stay outside because that is the only way to hold on to that. That is what they want to be able to do.
- Importance of understanding the important contributions to health from sectors outside of health systems. Many systems contribute to the social determinants of health. The contributions of other sectors to health who may or may not see themselves as contributing but in relation to the SDOH they are. Our health systems are much more focused on acute and chronic care not so much on the broader determinants such as housing, income, social supports and transportation
- The categories could be based on primary, secondary and tertiary care needs which is a class public health framework
- Thinking of the **staircase of the needs** for each group. That there are common needs and there is a foundation but there are more need or different needs for each levels. We're thinking about how this weaves together. There are things that are the same for each and there are different for each group. There are universal aspects and tailored/specific pieces.

**Transition/Flexibility**

- The issue of people having to move out of supportive housing when their health care needs go down (physical, mental, substance use) and they are stable often comes up. Are we talking about them having to move? Moving will disrupt their stability and in some cases they will not be able to afford other housing. So, as I think I want to get clear on the assumption that people in these groups can maintain their housing even when their needs change.
- Transition to independence: making sure that they are connected. The long term and support doesn't stop. So if they need help again due to a change in circumstances it is easy to access and get back into programs and services that help them sustain.
- There need to be help getting into the supports as they need them when things come up and need that extra support.
- Connect people to a support person/group/service that is their preference: Choice in support: peer, nurse, etc. With goal to get them to supports so they don't get missed. Timely support and check-ins. Long term is longer than 6 month or a year.
- People need to have the option to move out of supportive housing if they desire a move to a different environment
- I wonder if by the end of this if we can think about how to better frame the typology, bearing in mind stigma that surrounds supportive housing. We've talked about on-site, built in, more intensive supports versus in-reach, community based, supports. Would be nice to think about it as supports across the board but just modelled different based on where people's health and wellness is. At every level, self determination, autonomy and choice should be a fundamental starting point even if the choice part remains aspirational in housing context :)

aspirational in our housing context largely due to the lack of housing

**Meeting Needs of Groups**

- Indigenous and gender-based considerations should go across the levels of housing support. For example: safer sex, gender based violence should be considered across the continuum.
- And it is good to think about where sex workers fit across the continuum because their needs are almost never named within housing settings, even though they are a significant minority of residents
- Access to cultural supports should be across the continuum.
- Access to peer-based supports should be across the Continuum

## Table 1: Holistic Health Needs

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| **Choice in Care**<br>• People not being required to move but absolutely having choice to move. So, this is your housing until you want to move. That means discharge from services does not mean discharge from housing. | **Choice in Care and Supports**<br>• Care should be self directed / defined / determined. This can<br>• is really important because people feel stigmatized by living in supportive housing<br>• Relational approach<br>• Providing options for care | **Choice in Care and Supports**<br>• Create a spectrum of opportunity for people who are ready to move have some choice as much as possible.<br>• Locations can feel like home even if they could transition to a different building.<br>• Moving is a high stressor for all people. Relocating is a way of life for PWL but can require time. |
| **Access to Housing**<br>• ACT teams: there are people who have lower needs but are living in the housing because it is the only housing subsidized that they qualify for and don't have other options. Having affordable housing for all populations who are stabilized and ready for it. | • peer are critical in reducing stigma ….<br>• service providers are limited in facilitating self determination when there are systemic gaps in resources available.<br>• Some of the issues we face where we feel really helpless include: stimulant induced psychosis, hoarding<br>• Meeting people where they are at<br>• Don't push people into things before they are ready for it | • Support for people where they are at and where they want to go.<br>• Choice in care<br>• Rental subsidies with comprehensive health and community supports to compliment the buildings. Smaller building with rental subsidies as an option. |
| **Flexible Support**<br>• This is the point where the social supports become imperative and can make or break their journey related to the substance/mental health. There is a lot of celebration around how far they have come, but it can be a precipice of someone feeling isolated and disconnected from the community they have been participating in. Medical supports can be come more difficult to access.<br>• We don't see what we're talking about is not necessarily a responsibility of IH but need to have connection to health programs and social supports that don't have significant diagnosis of mental health or substance use. This may require different sources for this group.<br>• Community oriented support are not just professional services delivered to. There is | **Flexibility of Support**<br>• Critical analysis can be helpful for improvement. We can't always help people in the way that they need. Until it gets to be a point that emergency services are needed.<br>• Intensive community support teams and the ability to reengage with them when people are cycling through and not just a one time experience. Coordination between housing staff and emergency services<br>• This group is flexible and needs a lot of adaptation. They will have a variety of needs on a day to day basis. Can be mostly stabilized but also have times when they need supports for people to come to them. To meet the needs of the people on a day to day basis.<br>• How do we be flexible to reopen doors so doors are not really closed. People do their own | |

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| evidence that these populations are resilient and capable and they are able to come together to determine their own futures. This needs funding and space. | progress.<br>• Layout of the building and develop the model of support to change and be flexible based on the people who are there. | |
| **Financial Support**<br>• The low needs group have less needs for health supports or on site supports, but they will need financial supports because we know that they are living on social assistance or disabilities.<br>• Needs are around community and finances and food. | **Transitional Supports**<br>• Transition from hospital and knowing they have a place to go afterwards. Timely access when a person is ready for the support.<br>• Need to be able to return to their housing once they have been stablilized and not fear of losing housing.<br>• Follow up services as people are being discharged from the hospital. And not always enough supports for that transition. The resources are often not there long enough for full stabilization. And to bring them back into to hospital if needed.<br>• What is an effective point/way to help people when they are in crisis.<br>• When are they ready to return to housing.<br>• follow up care while in and when leaving hospital is defn an issue;<br>• Transition to supports from in the house to the community.<br>• Coming from tent city and getting used to schedules and structure. That is very different. Peer support can help transition. | **Transitional Supports**<br>• Transitional supports especially when the move is mandated quickly (i.e. from tent city)<br>• Wider access to health services can help to reach more people. What are different ways of matching people to health services without the building? What is sustainable?<br>• Look at the flow of people though the building/program. There is a time when it is needed and need to be there and a time to move to a location where they don't need as much support day-to-day. |
| **Re-access Support When Needed**<br>• Move from specialized supports to primary care is the fundamental support service: this might be some form of a discharge or transition of care. Finding a way when we have been supporting for a long time and know them well/constructive relationship, to have a way to rapidly reaccess services when/if they are needed. Have an ongoing and enduring relationship. To be able to come back swiftly.<br>• Need to be supporting quickly when needed and quick access back into the programs and services. | **Collaboration for Continuity of Care**<br>• No wrong person. Information that is accessible and consistent. Not always getting the same info from all sources. This could be solved with training and clear understanding of basic pieces.<br>• Coordination of services needs to involve the people themselves. With a peer or on their own. They participate in their own plans and support. | **Collaboration for Continuity of Care**<br>• Risk assessments for people who are likely need more help.<br>• Collaboration across organization is helping continuity of care: We need to work across silos to support through stages and levels of care or types of need<br>• Continuum of housing options and primary care services.<br>• A holistic care plan that addresses all the domains of needs and coordination to meet all the needs (continuity of care). |

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| • When people go into independent housing, their circumstances change. They do well with mental health or substance use to this point and then they do less well. We need someone to check in regularly so we know and can help before things get to bad. | | |
| | **On-Site Services**<br>• Depending on the number of residents, I would say a social worker (onsite) with access to income assistance and varied physical and mental health care resources is important. | **On-Site Services**<br>• Embedded pharmacy services: daily dispense, insulin support, etc.<br>• Integrated mental health services where needed: ICMT, ACT, etc.<br>• HIV etc. medical needs are critical<br>• Integrated primary and addiction care; specialist services on site (i.e. internal medicine, gyne/women's care clinic, etc.)<br>• Immediate access to physical needs (nurse or doctor who can address needs quickly)<br>• If health care services are all embedded, if they are evicted they lose their home and access to services |
| **Community Health Center model of care**<br>• Don't have a ton here in BC. Not clinical/medical/primary care as the key. It has connections to legal aid, social workers, to most appropriate services/people/groups.<br>• They don't need services brought to them but can get to them with transportation. Access to a range of services where they are culturally safe, safe generally.<br>• Free of stigmatism and prejudice.<br>• An integration of services and case management in a single location outside of the housing.<br>• Hubs of services. A hub within the community. | **Access to Medical Care**<br>• need to have some supports to o talk with residents about sex and sexual health. I think that is mental, physical, and social. I know that many of us do that as part of our work. just want to articulate it as a priority<br>• There are also other services like physio, acupuncture, OT, mental health supports and counselling, social workers employment, wrap around support that is accessible and low barriers<br>• Being able to link pregnant women quickly to services. | **Access to Medical Care**<br>• Access to safe and appropriate medical care that will address their ongoing chronic health issues.<br>• The physical environment and mental health all contribute to our physical health. This underlines an integrated approach.<br>• Access to nursing and physician care<br>• Community based IV therapy options for folks<br>• Outpatient AntiMicrobial Therapy clinic (OPAT)<br>• People with brain injuries often have specialized needs.<br>• Integration and community for people who live outside.<br>• It can be hard to meet all the needs within the building. Having community-based services for cultural and spiritual aspects. |
| **Transportation**<br>• Transportation to appointments, social events, | **Accessibility & Transportation**<br>• Model of care like Cool Aid that could provide | **Accessibility & Transportation**<br>• Easy access to appropriate transportation if |

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| group meetings. | transportation to clinics and to bring the service (mobile) to the site.<br>• Decreasing barriers to access to clinical and medical services.<br>• There is a good thing about going into the community spaces but with covid there is a need to go to the people where they are.<br>• No wrong door is really important and need the right pieces in place so they know what doors are there and how to open them when they need them (repeatedly if needed). Building on services already in place and making sure people get to them. | service is not on site<br>• Accessibility for people with physical mobility needs or medication needs.<br>• Outreach capacity to care (ability to go to people where appropriate. |
| **Ready Access to Mental Health Supports**<br>The building of community and isolation influences people health. | **Ready Access to Mental Health Supports**<br>• Relationship driven care that have regular times for drop in.<br>• So many times, peoples mental health is impacted by having a critical structural analysis but people telling them there is something wrong with them. It is one of the reasons people find living in supportive housing difficult because they have to let go of their critical analysis to survive when in fact that this a therapeutic strategy<br>• Really agree with need for mental health support including both peer based social support and more clinical approaches.<br>• There can be some in reach done, but the way we engage people with mental health needs to come with a dual diagnosis lens with casual conservations. People are flexible and their needs change over time. They go up and down with mental health.<br>• Island health who can do intake directly to reduce barriers to care.<br>• No wrong door model.<br>• Need for relationship effectiveness: resolve issues with people they are living with | **Ready Access to Mental Health Supports**<br>• Increase access to mental health supports, beyond police intervention and traditional psychiatric interventions/supports.<br>• Holistic mental health support that extends beyond the medical model of intervention and treatment.<br>• Staff on site who are specialized in mental health supports.<br>• Counselling support services<br><br>**Quick Response Times**<br>• Ability to respond to a crisis (Mental or physical or emotional) in a relational approach<br>• 24 hr. Supports and harm reduction support.<br><br>**Separate Mental Health Programs**<br>Need a place for addiction recovery and mental health support that is supportive but not linked with substance use |
| | **Peer Supported & Person Centred** | **Peer Supported & Person Centred** |

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| | • Having time to transition with peer support and in reach services until they are ready to go into community services and events. | • Peers are supports in accessing this care.<br>• Low barrier care, integrated, peer driven harm reduction services<br>• Person centered approach for medical care and receiving/accessing services |
| | **Food**<br>Some form of food security programming is needed. | **Food**<br>• Food is familiar and culturally appropriate.<br>• Access to food is a critical factor in many of our locations and has been highlighted through the COVID response. This needs to be high quality care that is nutritional<br>• 24/7 access to healthy, nutritious food that is appropriate to their needs. |
| | **Partner Violence**<br>Gender based and intimate partner violence are common concerns | **Security**<br>• Secure access to protect them, safe space<br>• Space for storage safely<br>• Safety for people on building (staff, supports, tenants). Fire, floods, violence etc.<br>• Balancing security and low barrier access<br>• Privacy in housing provided.<br>• Opportunities for outside workers etc. of getting to know people who live at various sites. These are important for creating realistic perspectives on safety. As a researcher who has gone into every kind of housing, shelter, tent cities and harm reduction services you can imagine across Canada. My feelings of safety are related to how I enter, who introduces me and getting to know people |
| | **Safe Venue for Feedback**<br>Address issues such as broken sinks etc without fear of reprisal or fear of eviction for 'complaining'. | **Safe Venue for Feedback**<br>Tenant Advisory Group will be a safe space for bringing forward concerns and information to help shape their space. |
| | **Trained Staff**<br>• Team that can be responsive to needs that are ongoing or upcoming.<br>• Well resourced housing supports, with robust number of staff, need to have good training and supports for the frontline work. Responding to | |

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| | conflict, distress, harm reduction.<br>• Training training training for staff.<br>• Provide professional development. Infrastructure for PD that we can learn from each other<br>• it is good to have an onsite leader (with social work or similar expertise/training) who can support staff in service planning and approaches. I often feel there is something missing among housing staff, even at the team lead level, in terms of a therapeutic perspective on supports for residents and staff<br>• Considering how trauma is induced within current systems, and how do we train and support our staff.<br>• An acknowledgement of the problems with the system is helpful to supporting residents. This is a discomforting place for service providers to acknowledge that there may be challenges. Train people to be able to work with that. | |
| | **Culturally/Diversity Appropriate Care**<br>• We need more culturally aware and accessible care. With a mental health issue lens.<br>• One of the things we have done at peers to acknowledge the diversity of people accessing services is to have dinner groups for specific subpopulations - Mens group, Indigenous women's group, Trans and Non Binary group, Indoor workers group, stroll-based group. There are challenges with doing this successfully, but there are also lots of positives that come out of people meeting with others with similar experiences in some areas. We always acknowledge people's time participating in programming with cash or other gifts to acknowledge the expertise and labour involved participating in peer-based programming (any programming really). | **Culturally Based Healing**<br>• Land based traditional healing is integrated into how we physically heal.<br><br>**Cultural & Inclusive Approach**<br>• Harm reduction with an indigenous and cultural focus. This is a holistic approach and very integrated.<br>• Access to a safe and inclusive environment where personal empowerment and self-determination is practiced as a general rule. |
| | **Choice in Treatment**<br>• People designing their own plans. Education for | **Choice in Treatment**<br>• Choices for how to access their services (on-site |

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| | all kinds of substance and harm reduction. This can be peer led.<br>• Common space for people to come into. | and in-reach and in community)<br>• Mixed population can help to reduce the stress of living all high needs together.<br>• Placement of available services: available but not in their face if this is service they no longer need any more.<br>• Build on the 10-point plan for this section (attached). |
| **Substance Use & Harm Reduction**<br>• Overdose prevention, safe supply, OAT also needs to be consider in these sites because there is a significant risk of overdose and barriers to prevention<br>• Agree that access to harm reduction needs to be available maybe as in-reach<br>• Many people who are at highest risk of overdose are at this level, and living on their own or working. Low needs doesn't equal low risk.<br>• They need less health care on site but still need to be able to access them when they need them.<br>• Needs are being determined as low, so they are recovering and are stable. But as a system we need to think about what is next and how do we keep them independent and in their home. In-reach/community supports are important.<br>• Primary care with addictions and medicines. A primary care physician | **OSP**<br>• OPS for this group this might be more of a community service and not on-site.<br>• Need services for harm reduction for elicit substances, OPS<br>• Episodic OPS or peer witnessing. This needs a space (i.e. harm reduction room and/or peer witnessing room) within the location. For storage and distribution of supply that is not in the rooms. There are good examples of this that exist.<br>• Supervised consumption would depend on the population in the site, inhalation that has some monitoring. Very common for people to smoke and a high risk for overdose.<br>• Are more likely to be using in their rooms and can have people check on them in their rooms or use together.<br><br>**Diagnoses**<br>Are there diagnosis being overlooked for people who are using substances. | **Quick Response**<br>• Regular naloxone training on-site for residents.<br>• 24 hr. access to overdose prevention services and spaces.<br>• Peer witnesses for being there for when people are using so they are not having to use alone. (Honorarium paid position)<br>• Everyone should have a cell phone with access to Lifeguard app.<br><br>**Separating Substance and Alcohol Programs**<br>• Substance and alcohol needs are different and need to be addressed as separate.<br>• Managed alcohol program<br>• People who use substances are not all in the Type C category and not always need the same space.<br><br>**Prevention Programs**<br>• Upstream prevention<br>• Wellness checks |
| | **Accessible Safe Supplies**<br>• Managed alcohol component: often the ability to self managed and don't need the intensive map. Helping people to store their alcohol and education on drinking safely.<br>• People WLE will be able to assist with distribution of supplies and peer witnessing. Living and working within this community. | **Accessible Safe Supplies**<br>• Safe supplies available<br>• Easy access to safe supply and have a delivery service in place for safe supply.<br>• Embedded Pharmacy |

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| | • Delivery to the location<br>• Safe supply and prescribing safe supply. | |
| **Group Spaces**<br>• The building of community and isolation influences people health.<br>• Community space but a challenge is lack of funding for these spaces because it is not typical. Hard to make that viable even if it is desirable. Especially indoor spaces, outdoor spaces are more commonly part of the building. (This is a good recommendation to bring forward, there is a business case for why this matters,) | **Group Spaces**<br>• There is a lot of drinking and that can get loud and still is social.<br>• There is food and clothing that people can't get: nice shampoo and soap. How can we make the service and space attractive to them. | **Group Spaces**<br>• Increased social connection for play, income generation.<br>• Meal preparation and meal gatherings<br>• Safe spaces for animals and people to be together.<br>• Socialization for the groups. People want to live close to their community (friends, family).<br>• Opportunities for supportive gatherings. |
| **Skill Building**<br>• Employment is so important. And education. They are critical and need investment.<br>• Tenancy skills and success so they can continue to develop and maintain the housing. Making sure that they are doing well. | **Skill Building**<br>• Talk about goals and what they want to see for themselves in the future.<br>• Ideally they get more connected and build skills and live more independently in the future. | **Skill Building**<br>• Life skills<br>• Employment skills<br>• Creative skills |
| | **Creative Spaces**<br>• Providing things that people want to help them engage in social rooms and activities.<br>• A balance of activities on and off site with a variety of activities. | **Creative Spaces**<br>• Access to music and musical instruments/spaces to gather and play/listen to music.<br>• Access to crafting, games |
| **Resident/Tenancy Advisory Board.**<br>• A body that can set up and manage social events or learning sessions.<br>• Advocate for residents and try to resolve challenges.<br>• Cool Aid does this at their sites and a Client Engagement working Group. Representatives come together to work with leadership and staff at CoolAid.<br>• There are also lots of examples of self organizing groups in housing through a variety of methods.<br>• CRD have different tenant's groups that form in different ways and reasons. Both formal and informal, From organization and from the residents. | **Tenant & Peer Led**<br>• We lack a flexible peer support map program.<br>• Set up the peer support organization.<br>• Subpop's and that engagement with food or activity is a great process for folks | **Tenant & Peer Led**<br>• Tenant-led committees and activities<br>• Peer Support<br>• Community space that is lead and driven by the residents who are vulnerable. |

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| • The east coast orgs: Have peer organizers, paid and do some maintenance and connecting with the residents. How to manage conflict | | |
| **Connection to the Community**<br>• Having the in-reach support and creating community. Where is the rec centre and connecting with family. Perhaps it is about how most people connect and make community outside of the building and making sure that residents can connect to those too. It is all about the space/unit and common spaces are not part of the deliverables for Housing First projects. There may be small offices on site that may be available. Small spaces but not substantial.<br>• We also want to make sure that we are connecting them to the community so they go beyond the building too, we don't want them to be dependant on the building for community. Should be both not either/or.<br>• Social piece for people to engage into the community. May be moving into a new area of town and need to be moving in and meeting people: ie rec centre pass subsidy. | **Involved in Community Events**<br>• Creating opportunities for community and relationships especially for peer led and collaborative supports can be fostered. Creating internal community.<br>• There needs to be a space for these types of meetings and socialization.<br>• This underlies the other pieces and is a critical foundational piece to have a strong and interconnected community.<br>• Some mechanism to help people link into the broader communities: play floor hockey or do yoga. Should be able to do more types of activities in the community. | **Involved in Community Events**<br>• Activities driven by what people want to do.<br>• Access to information regarding social resources that are available locally.<br>• Group opportunities to let them be part of the community and community building<br>• Transportation<br>• Can they have their own opportunities to volunteer and contribute. |
| | **Cultural**<br>• Indigenous elder available as a support<br>• People are can look at their connection and how they relate to the community and their culture. They have the space and energy to look beyond their initial needs<br>• Indigenous programming and peer-based programming is important, some peers could be working on site whereas others might be invited in. | **Cultural**<br>• Culturally/spiritually supportive housing and creating a sense of belonging, Native art, dividers, smudging, etc.<br>• Land based traditional healing is integrated into how we physically heal.<br>• Appropriate cultural supports that meet individual needs.<br>• Access to information/resources regarding local cultural supports.<br>• Access to a safe and inclusive culture that eliminates power imbalances.<br>• Hard to meet all the needs within building. |
| **Activism**<br>• Their ability to participate in community and can | **Activism**<br>• A role for activism. A lot of people have many | **Spiritual**<br>• Employment opportunity for the mental/spiritual |

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| be more able to engage with activism or community and social events<br><br>**Stigma**<br>• Destigmatize the supports and make space for communities can be available to keep people in the dialogue about safe use<br>• There are some people who may be ready for this level of housing and are stabilized but are not accepted because there is a worry that if they destabilize there won't be support for them and it blocks their access. We need to address this concern and the stigma towards them. And to make sure that they have the supports when they are needed so it makes it easier for them to get into and retain these homes. There is work on this already but it needs to be continued to be addressed. | things they have witnessed: grief and anger and channelling that into activism.<br>• Movement into broader perspective: Healing centred engagement. This related to the activism. Instead of trauma inform care as an individual but looking at trauma as a community experience. Healing centred to look at this context. Healing centred engagement: https://medium.com/@ginwright/the-future-of-healing-shifting-from-trauma-informed-care-to-healing-centered-engagement-634f557ce69c<br>• People don't want to be defined by their trauma. They are more than their trauma. Healing is a different perspective.<br><br>**Stigma and Isolation**<br>Trauma, substance use, social isolation, stigma are important | side as much as other reasons<br>• Information and resources for local programs/services/ organizations/churches, etc.<br>• Peer Support<br>• Access and connection to Traditional Territories/Cultures/Elders/ Language/Art/Animals/Family/Medicines etc.<br>• Connection and access to the natural world outside of the concrete and institutionalized spaces. |

## Holistic Needs of Residential Group D

These are the people who are evicted from every home they are put in. Why are they getting evicted? And don't maintain supportive housing that speaks to a need that isn't being met in health or in housing.

**Hard to House Group with High Ability for Independence**

- There are people who are living outdoors, who they lived in multiple housing sites and not successfully housed, but they are a resourceful, smart, and capable group. The options available to them in supportive housing is not what they need/want. They want independent with autonomy.
- They want community and housing but don't want all the supportive. It's different than the Group A but don't quite fit in the category. There are some who are waiting lists for 4-7 years.
- They do need services but can be community services. But they don't fit in the housing in the same way.
- Research (Chez Soi) shows having their own space and financial supports and assertive in reach services like an ACT team can work for them.
- This group needs support with getting ID (this is a big barrier to access) and getting disability sorted out. And more basic things but they can be time consuming. This may be in place already but they need access.
- There is a relief about not having to move in Beacon Hill Park.

**Brain Injury Developmental Challenges**

- This group can have brain injury or developmental challenges that require specific supports.

- There may be different team required that go across their needs: Medical, mental health.
- CLBC criteria people, need daily supports, multiple times a day. This is currently a contract position that is frequently burnt out. This may need a team not one person but still relational.
- An apartment building that lets them live independently with a lot of support.
- 7 Oaks can't take short term stays because people need the longer term supports. There may be a gap for people who need the intensive support in shorter terms before accessing other sites or services. They are both necessary depending on the person.
- Collaboration between Brain injury/development and other concurrent challenges

**Mental Health Supports**

- Mental health and substance use needs to be addressed at the same time when they are entwined.
- Acute care for people having a hard time in community in: St. Paul in Vanc. There is an addiction/psychiatry lens and connect them into services in the Community. Ensuring ongoing referrals and supports. Different from general psychiatry. Look at their best practices to support people in the crisis moment and transitional supports to provide wrap around care once they are stabilized.
- really agree that there is a gap for supports when drug induced psychosis/dual diagnosis has reached point of imminent threat to self or others. Reg psych approach is not a fit.
- Need to do everything possible to provide things in an in-reach situation to keep them in housing as much as possible. While acknowledging that they need a short term 24/7 place to stabilize while maintaining housing (same or a better fit) so they can transition back to housing with a supported/team to help them back in their home.
- We want to keep them out of the criminal system, which is not appropriate. They do not belong in a jail. There are consequences for the person and their families.
- People aren't getting ongoing support.
- The Coordinated Access Committee is looking at these issues too and hopefully this will be happening. The challenge is always the resources and people being available/trained to be the support.
- There are matters related to legislation and practices. Hopefully a coordinated system will help fill these gaps.
- CRHC supports in social housing agreement: between service provider and housing provider that has been a good model that we can build on.
- The admission to these types of short stay assessment units should include a pathway for housing providers and other community services to have input about reason for admission, goals, and discharging. I think we often don't have that collateral from people who have daily contact with clients.

**Crisis Support with Transitions**

- There are people who are so independent that need some controls in place for their protection and those around them. They want to do things in their own way. They need that relational supports to control the door and help them get through the day.
- We need a 7 Oaks that are at the mercy of their addictions. This is a loss of some independence but to be safe for them and the people around them. This is a 24/7 residential care. This often needs to happen quickly and doesn't always.
- Managed alcohol program people. Cycle through shelters and housing. Either the place doesn't tolerate drinking or the behaviour due to their high level of drinking. This is a group that falls well into the managed alcohol program. Do detox/treatment repeatedly. Their main harm reduction support would be managed alcohol.
- There are other times when it is not safe for the resident or people around them, they need a short term (Burnaby) or longer term (Oaks) that

helps to stabilize them with consistent mental health supports

- In order to access these residences, there needs to be a transition plan and assessment from emergency care. Right now this is a gap and there is no support for housing staff and clinical team.
- Emergency psychiatry in supportive housing for the residence and to assist the staff

**Continuum of Support**

- Respite and crisis admissions as a continuum for degree and timing of the support. With the goal of getting people back to independent, supported housing. With robust supports. So they don't end up in the acute cycle repeatedly or as often.
- People need to know that they will not be evicted. The housing situation MUST have practitioners and supports that simply 'get it', that understand this continuum and that it is going to go back and forth sometimes. Those who in the housing locations, providing service, must understand the social determinants of health and that in order to improve health inequities, we have to be on the same page, we have to see longitudinally, even if it means that those same providers will be disappointed with backwards steps sometimes. Same page, better care, back and forth … health and housing.
- This is also about trust and relationship building.
- Opportunities for community development, community led governance, cultural supports should all still be there....the principles that we think run across all housing
- The important services that are needed to support housing teams, it is often that there isn't mental health wrap around supports. They have a high level of need for these supports.
- If we have ACT team that can support the housing staff to keep people in housing.
- Longer /shorter term spaces for those needing more acute care
- Harm reduction and trauma informed care to meet needs
- Some of these clients need ACT but also needs a critical health team. They don't fit into the standards for an ACT team. There is a place for early engagement team with intensive support can see people multiple times a day and have a dual diagnostic lens. Small case loads and take time to meet people. Build goals with people depending on where they are at.
- Therapeutic intervention: this is the point of high needs, Group D.

**Mental Health Supports**

- When people haven't been captured by the mental health system, due to lack of a diagnosis and concurrent with substance use. If they aren't attached to an ACT Team it makes it challenging. They often need a higher level of psychiatric engagement. ICM teams do different things. Might need both at different times.
- Is it possible to boost the psychiatric support for ICM teams?
- The foundation is relational care. The same people who have the right background to support: mental health or substance use or both.
- When they are connected to the teams, it falls onto the housing staff who aren't equipped in the same way to manage this.
- With substance/alcohol use, there is often a high level of distrust for services and people in the healthcare or housing services. People don't want a diagnosis and assessment or a label. The research shows that trust-building is fundamental. We need to prioritize building trust and relationships for all groups but especially this group.
- Canadian Association of Chiefs of Police. Just recommended decriminalization for personal possession.

**Community Connection**

- Our system is driven by individualism and not as much as community. Especially for people who are vulnerable.
- What level of relationship do they have in their current space, even outside, do they want to stay in that community and are safe together, friends together. Our system deals with the person and not their community. Where will they feel connected and disjointed.
- This is part of the social/emotional health

## Appendix A.2: Location of Services

- Do the services have to be linked to housing: It would be good to be able to decouple services from housing, so they can take services with them as they move through housing or stay in the housing even if they don't need the supports to the same degree. It is a model that centres around the person, not the space where they live. The services are of all the levels and needs and that you can pull in the services as needed.
- This is especially valid for group A because they go in and out of services as they stabilize, potentially destabilize, and stabilize again. As an example, what if a youth is stabilized but they get to a point where they need services again. What if they have a closed file or don't have a social worker (due to aging out of care). It can take time to reconnect to access services and they lose more ground than if they got help sooner.
- This will be a challenge because this isn't a typical model of care so it requires different methods of funding and organization.

### Table 2A: On-Site Services

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| | **Medical**<br>• We don't need clinics in all spaces. Location of the buildings matters. If they are close to other services vs. if they are not close to the services may need more embedded services.<br>• Flexibility of services and not locked into on type of model based on preference and needs.<br>• Supportive housing needs to be paired with health services that are welcoming.<br>• Coordinated services plan and case management. The advocate or coordinator should stay with them even if they are moving to a new place. | **Medical**<br>• Care coordination (either on-site or in-reach) for health, culture, spiritual, etc.<br>• Larger building may better support the onsite services like primary care.<br>• Clinical care and primary care, wrap around for 7 days a week nursing support<br>• Integrated medication care<br>• Integrated mental health care for a continuum of care<br>• Pharmacy<br>• Nurses/doctors 24/7 |
| | **Peer Supports**<br>• on site' *and* 'in reach' led peer initiatives | **Peer Supports**<br>• Peer to peer supports<br>• Systems Navigator role (bridging to other services as a peer. This can work for health, finances, and many other kinds of services. They work with residents, and staff. )<br>• Tenant Advisory Committee |
| | **Security**<br>• food security on site. | **Security**<br>• Secure entryway<br>• Balance of security and low barrier access/welcoming |
| **Resident/Tenancy Advisory Board.**<br>• A body that can set up and manage social events | **Safe place and space.** | **Other Services**<br>• Laundry 24/7 |

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| or learning sessions.<br>• Advocate for residents and try to resolve challenges.<br>• Cool Aid does this at their sites and a Client Engagement working Group. Representatives come together to work with leadership and staff at CoolAid.<br>• There are also lots of examples of self organizing groups in housing through a variety of methods.<br>• CRD have different tenant's groups that form in different ways and reasons. Both formal and informal, From organization and from the residents.<br>• The east coast orgs: Have peer organizers, paid and do some maintenance and connecting with the residents. How to manage conflict | The supports are needed for the staff that are there most of the time. So they have the tools and are aware of who to access when/where. This is a lot of information to know. They would have the ability to provide a safe place for a crisis that they could then call the expert/ medical to come in an emergency. Not all buildings have this space. | • Transportation services (vehicles available)<br>• Office space<br>• Community Integration Specialist to help with income assistance |
| | **Employment opportunities**<br>• An integrated social enterprise opportunities on site (i.e. like PHS clean team, etc.). Important to have these embedded programs where possible for income generation and opportunities for work experience/development of references, etc.<br>• that is access to supports for employment. from paid peer resident work opportunities to links to other outside employment opportunities.<br>• resident based leadership/employment and training opportunities | |
| | **Mental Health**<br>• Psychological/social supports on site<br>• Harm reduction for mental health and interpersonal violence as well as Substance abuse<br>• Emergency responses should be a last resort. It should be preventative and supportive before. | **Mental Health**<br>• Mental Crisis response from medical or trained staff<br>• Psychiatrists for care and coordination of medications |
| **Harm Reduction**<br>On-site or in-reach with space on-site. | **Substance Use & Harm Reduction**<br>• Active OPS or capacity to have that on site in a space. To gather officially or as a peer led<br>• Inhalation needs to have a safe space.<br>• Harm reductions/OPS and inhalation | **Substance Use & Harm Reduction**<br>• Harm reduction support<br>• Overdose Prevention & Supervised Consumption Sites (OPS) |

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| | • Emergency responses should be a last resort. It should be preventative and supportive before. | |
| **Social**<br>• Coffee mornings, other group gatherings for social, need space for that to happen, on site or in community.<br>• Can visit with having people/service in the home if they are invited and welcomed.<br>• Multi purpose space and then supports could be laid out in terms of minimum supports, medium support or maximum which would mean the model is more flexible. | **Social**<br>Community building relational effectiveness, conflict resolution. | **Social**<br>• Group Gathering Spaces for residents and the community (also relates to cultural and spiritual)<br>• Animal friendly locations<br>• Library shelves<br>• Library with computer and internet access.<br>• Art, Gardening supplies and space<br>• Shared Kitchen |
| | **Cultural**<br>Trauma informed and culturally accessible care. | **Cultural**<br>Artwork displayed in common spaces |
| | | **Spiritual**<br>• Natural spaces<br>• Colourful spaces and access to natural light. |

## Table 2B: In-Reach Services

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| **Support Services**<br>• Support workers who can visit on site if it is okay with the tenant. It may be good to be able to meet away from the home unit but close to home<br>• Space on site to bring in services or readily accessible. A building need to still have community and common spaces for a health needs and not just apartments. | **Medical**<br>• A combination of community and In-reach. There is an opportunity to do more in-reach services.<br>• Health care, clinic space that is open for specific hours in a day or week.<br>• Capacity for in reach to be broadened and not all on the housing support staff.<br>• Dual diagnosis treatment and assessment.<br>• Her way home for pregnant women.<br>• The in-reach services would be well paired with a space that can be a clinic for scheduled times for a week. Not necessarily a dedicated clinic but would work for a variety of services for in-reach support.<br>• Pharmacy delivery to people as an option.<br>• Routine of in reach services so people know when to expect that they are there and what is available. | **Medical**<br>• Care coordination (either on-site or in-reach) for health, culture, spiritual, etc.<br>• Specialized services and primary care coming in for smaller buildings.<br>• Specialist medicine on site coming in periodically to address specific medical needs:<br>• Social Work<br>• Financial supports<br>• Physical Therapy<br>• Occupational Therapy<br>• Home care services<br>• Pharmacy can be in-reach for a time of day<br>• Physical Care |
| | **Peer Supports**<br>on site' *and* 'in reach' led peer initiatives | **Peer Supports**<br>Peer to Peer supports<br>System Navigator can be in-reach or on-site |
| | **Mental Health**<br>• Mental health supports, internal collaborative space<br>• Drop in facilitated groups, for harm reduction/mental health/substances and facilitated (co) by people with lived experience.<br>• help with harm reduction with regard to collecting/ hoarding...before it gets to the point of eviction/ biohazard/ extreme fire risk | **Mental Health**<br>Psychiatrists for care and coordination of medications |
| | **Substance Use & Harm Reduction**<br>• substance use supports.<br>• Drop in facilitated groups, for harm reduction/mental health/substances and facilitated (co) by people with lived experience. | **Substance Use & Harm Reduction**<br>Harm reduction support |
| **Educational** | | **Other Services**<br>• Life skills programs |

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| Comfortable multipurpose space that can be used to meet and access with projector or computer for training, learning, sharing. But also for providers and services that could come and meet with people there. | | • Laundry delivery<br>• Veterinary services<br>• Supports for trauma and hoarding |
| | | **Social**<br>• Bringing community events onsite (also relates to cultural and spiritual)<br>• Art, Gardening, Cooking Group activities lead by tenants and peer support<br>• Space for physical activity, like a gym or classes |
| | | **Cultural**<br>• Cultural supports<br>• Cultural events/ groups |
| | | **Spiritual**<br>Spiritual events/ groups |

## Table 2C: Community Services

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| | **Medical**<br>• Drop-in centres and clinics for counselling, supports, and social networks.<br>• Ability to access services that enable people to be in a safe space.<br>• Access to virtual technology esp. right now. Community meeting or physicians. Etc.<br>• Give people the option to go out into Community as well. To develop routine and accessible support. | **Medical**<br>• Care coordination (either on-site or in-reach) for health, culture, spiritual, etc.<br>• Low barriers to housing and community services (like home care)<br>• Complimentary supports in the areas outside of Victoria where the services are not available as readily. |
| | **Mental Health**<br>• Drop-in centres and clinics for counselling, supports, and social networks.<br>• Mental health access points and how they move in and out of the services from their housing.<br>• Interactions with emergency services: need focused care with emergency psychiatry support. How to get to them in a crisis and return to their community. | |
| | **Substance Use & Harm Reduction**<br>• Substance use access points and how they move in and out of the services from their housing.<br>• A place for people with concurrent disorders to get diagnostic answers that are harder to diagnosis with concurrent substance abuse. A safe and knowledgeable space that this can be accessed. | **Substance Use & Harm Reduction**<br>• Harm reduction support<br>• OPS |
| **Social**<br>• Coffee mornings, other group gatherings for social, need space for that to happen.<br>• Community garden. | | **Social**<br>• Going to social and community events (also relates to cultural and spiritual)<br>• Appropriate outings where the residents can go safely and comfortably for fun or for education and social integration.<br>Skills and classes that are in the community<br>Access the gyms/libraries in community |
| | | **Cultural** |

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| | | Cultural events/ groups |
| | | **Spiritual**<br>Spiritual events/ groups |

# Appendix A.3: Bricks & Mortar Needs

## Table 3: Bricks & Mortar Needs

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| | **Welcoming Space**<br>• Attractive outdoor space at the entrance so the street facing is a well cared for and integrates with the community.<br>• Like Arbutus shelter with a private entrance but also a nice public outside facing space.<br>• Community is more open to a more attractive building.<br>• sight lines with privacy; use trees as privacy<br>• Colour | **Welcoming Space**<br>• Entry way that exemplifies the community you are trying to create (welcoming, safety, easy to find the supports that are available)<br>• They should be attractive and well maintained.<br>• Outdoor space, natural space<br>• Light!<br>• Artwork displayed in common spaces, (not just signs).<br>• Colourful spaces and access to natural light. |
| | **Secure Building**<br>• Balance of engaging with community but also have a private space.<br>• Safety may need some control around the entrances. Balance welcoming with safety.<br>• The entrance and control of guests is a pivotal issue for sex workers.<br>• at a minimum you want to have an entrance area that has some supervision but not so much that people feel that cant bring guests in or the guests feel surveilled | **Secure Building**<br>• Secure access to protect them, safe space<br>• Space for storage safely<br>• Safety for people on building (staff, supports, tenants). Fire, floods, violence etc.<br>• Balancing security and low barrier access<br>• Allow people we want to come in and keep people out who are causing violence (safe working and living space) to make sure that services are willing to come into locations. (Work Safe) |
| **Social & Communal Spaces**<br>• Ideally there would be a full-service kitchen and break bread together.<br>• Community posting board in the lobbies of the building: social, looking for babysitting, etc.<br>• Mixed tenancy: They want to connect with peer group but also with all the tenants of the building.<br>• Space also allows for families and children safe space or extended family coming to visit.<br>• Visitor parking<br>• A suite onsite for out of town family/friends to stay in the building. | **Social & Communal Spaces**<br>• Multipurpose indoor spaces Flexible for cultural, medical and social spaces.<br>• Common space indoors and outdoors.<br>• A big and beautiful kitchen and dining area....it is the centre piece of a lot of things if the programming is organized around it | **Social & Communal Spaces**<br>• Spaces for people to entertain guests or larger groups<br>• Space for non-custodial parents to visit children with a family room for visits.<br>• Family visiting and gathering space.<br>• Social space with all buildings<br>• Opportunities for recreational activities (i.e.: job related; exercise; hobbies, games, gardening, outdoor activities etc.<br>• Food vending machines<br>• Shared kitchen |
| **Private, Outdoor Spaces**<br>• Playground | **Private, Outdoor Spaces**<br>• Garden space and outdoor area. Being able to be | **Community Building Spaces**<br>• Communication whiteboards for people on the |

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| • Smoking spaces outside esp for non-smoking apartments.<br>• Green spaces: lawns or community gardens. | outdoors and socialize with community is a nice space for livability. Trees and nature is good for mental health.<br>• We need gardens, area for outdoor exercise, grass;<br>• Nice to have indoor exercise area.<br>• An inner court yard has been a good space for socializing and have some privacy and contained space for community. | outside of their doors, and in main hallways and common spaces.<br>• Community room that can be used by the community to enable building those bridges or participation to bring people together.<br>• Cozy, quiet, spaces/rooms for meeting with Peer Support, counsellors, decompress, and have some alone time.<br>• Space for tenants and for people who aren't tenants to socialize together to weave people into the community.<br>• Multipurpose room for training, education, etc.<br>• Large space for hosting large community social events (indoor & outdoor).<br>• Large enough space where people can be offered all the group activities for creative, physical activities. |
| | **Creative & Leisure Spaces**<br>• multipurpose rooms with computers;<br>• TV room or social room. | **Creative & Leisure Spaces**<br>• Space for physical activity, like a gym (or do you encourage people to access the gyms/libraries in community? This could be a site-specific question)<br>• Art/Music room<br>• On-site bike shop for tenants to work on/build/repair bikes and bike trailers and carts.<br>• Library with computer and internet access.<br>• 24/7 access to arts and crafts supplies.<br>• Common space where people have gardening/landscaping<br>• outdoor space, gardening options, social space |
| | **Pet Friendly**<br>Outdoors space. Esp. for pets. Grass outside | **Pet Friendly**<br>• Accommodation for pets<br>• Space for Animals and pets. |
| **Comfortable, Livable Rooms**<br>Sound proofing from the neighbours. | **Comfortable, Livable Rooms**<br>Nice sized rooms with private bathrooms. | **Comfortable, Livable Rooms**<br>• Units aren't too big but large enough to socialize and it is not just a room.<br>• Large enough rooms to live well within,<br>• Wheelchair accessibility |

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| | | • Accessible showers<br>• Private washrooms and showers<br>• Privacy in housing provided.<br>• Range of experience and needs<br>• Phone access.<br>• Units that are "hardened" to protect the suites from damage as much as possible. |
| | **Clean & Hygienic Spaces**<br>Laundry options on site. | **Clean and Hygienic Spaces**<br>• 24/7 access to cleaning supplies/toiletries/linens, etc. On each floor of the building for tenants to meet their own needs in these areas. (Not all of these things should be locked up.)<br>• 24/7 On-site laundry facilities.<br>• Clothing room |
| **Medical & In-Reach Services**<br>When services come to people in a space that is useable and comfortable and safe it created capacity for services to reach more people. Can serve more people and have more staff than can fit in the space so that increases the capacity of the service providers. (ie Cool Aid. ) | **Medical & In-Reach Services**<br>• Multipurpose indoor spaces to allow visiting professionals and allow the clinics to come in.<br>• adequate accessible parking for in-reach services and deliveries; | **Medical and In-Reach Services**<br>• A space for clinical/medical visits if a clinic is not embedded in the building on a permanent basis.<br>• Inhalation<br>• Sheltered outdoor space for smoking tobacco.<br>• Room that has nursing set up to leverage on site or services coming in<br>• Onsite overdose response/prevention services<br>• Overdose prevention units on-site<br>• On-site medical supports/services<br>• On-site Ministry Workers (Ministry of Poverty Reduction and Social Development; Ministry of Children & Families, etc.).<br>• On-site employment services access.<br>• Youth supports and services.<br>• 24/7 on-site safe supply/pharmacy/Opioid Agonist Therapy Services (OATS)<br>• Integrated into CAA - reduced duplication of process |
| **Accessible building and Rooms**<br>Wheelchair/mobility device accessible building and rooms. | **Accessible building and Rooms**<br>• Wheelchair accessible.<br>• Accessible rooms | |

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| | **Focused Areas, Suites, Buildings For Indigenous, Gender Sensitive, And LGBTQ, Youth**<br>Housing for women/ non-binary/ trans women with some flexibility for those who do sex work form their homes or to have visitors but also help to remove visitors, place where kids can visit | **Focused Areas, Suites, Buildings For Indigenous, Gender Sensitive, And LGBTQ, Youth**<br>• Ensure needs of LGBTQ2+ folks are also considered in the delivery of services and built environment<br>• Tailored supports like Indigenous, gender sensitive, and LGBTQ, youth populations<br>• We need youth housing, and also housing for pregnant women where they can stay for at least two years. |
| | **Space for Working**<br>• Also, it is probably a radical concept but having a place to work that is not your home is also important.<br>• Commercial kitchen could support social enterprise.<br>• yes! cooking, maybe house repairs with supervision, etc. | |

## Bricks & Mortar Needs for Group D

**Types of spaces/housing**

- There are different spaces available: acute, short, long term.

**Trauma Informed Healing Spaces**

- Spaces when possible, promote healing. Even in the acute space.
- Security guards and how they are trained for approach: relational not criminal.
- Patients had so many encounters with the system and that in itself is trauma inducing
- Dignity, harm reduction, trauma informed, positive space that supports the overall process of healing.
- I think we may need more cleaning/hoarding support than we have....in our experience, we are not able to get timely support or proactive support.
- HWS don't typically see themselves as appropriate resource for more complex cleaning needs and market-business based services are often discriminatory. More intensive cleaning support can be, though not always, part of the varied support needs of this group. HWS was supposed to be HSW - housing support workers
- The trauma people have experienced in hospital system and institutional non voluntary spaces...there was a reason we moved away from institutionalization. peer based supports can be helpful... anything we can do to not have the institutional approach.
- No guests: policing is not good and it is stigmatizing, and undermining of safety policy

**Community Building**

- Peer based services to call into question the bureaucratic and institutional sides of these space.
- Link to the foundational/universal aspects of space that we discussed in the other discussions.
- Stigma and negative media about these high needs spaces. They aren't a positive space before someone even sets foot into the space.
- What can we do as providers, to think creatively about bringing the community alongside. So when people move in they aren't stigmatized from the get go.
- There needs to be structures outside of the housing where people can build community and come together.

**Context of Living with Homelessness**

- The universal is the determinants of health (the community, environment, food, physical and mental health). What is tailored on top of that for each of these groups.
- Not institutional, they are viewed as a "sickness."
- Thinking about context in which PWLE live: the stigma, the individualism (stigma, blame, fix yourself), criminalization (police, bylaw, enforcement, personal belonging), medicalization (people need medical support but we can't medicalize every problem).
- There is an invisible netting that keeps people in place because they can't access/barriers. And if you don't pull up your bootstraps then you are criminalized or medicalized

## Table 4: Optimal Occupancy

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| Mixed market so size can be variable | 40-50 is ideal. 80 max. | • Smaller than bigger for the type C groups.<br>• ~40-50 is good/ideal but 100 is too many. Can be a good size for community.<br>• 80 or less is important and having people with space<br>• Size is less important than what you do with it.<br>• Coordinated supports and on-site services may be easier to deliver to a larger group.<br>• Mixed services and diversity of needs can good for community (bringing in services that can be ramped up or down depending on the needs of the residents.)<br>• Tailored supports like Indigenous, gender sensitive, and LGBTQ, youth populations that may need to be 25-35 units....so in the end a combo is required.<br>• Can there be a mix of sizes because there are a diversity of needs even within this group?<br>• There is a recommendation for 48 people. |

## Table 5: Building Location

| Low Needs Type A | Moderate Needs Type B | High Needs Type C |
|---|---|---|
| • Lots of options in an ideal world. Choice of which community they want to live in. Downtown, outlying communities.<br>• On bus routes, as close as possible. | • Don't want to have too many sites within one community. Hubs or in different community not one area of town with all the buildings in close proximity. communities mixed neighbourhoods.<br>• Location of the buildings matters. If they are close to other services vs. if they are not close to the services may need more embedded services. | • Public consultation forces location into small spaces<br>• Putting locations into different neighbourhoods for better integration and provides choice/options. Will put less stress on the locations that are existing now<br>• This is a challenge due to community push back.<br>• Close to groceries, services so walkable<br>• There is a roll for shelters and transitional housing. A fix in the meantime and then placing people into the right location that suits them for needs physical/cultural/social<br>• When there is a clear agreement and supports, people who have moderate needs can be successful in the larger community. |

# Appendix B: Previous Research and Models

- *10 Point Plan for Harm Reduction Services in Residential and Hotel Settings,* prepared by Mark Willson, SOLID, Rachel Phillips, Peers Victoria, Katrina Jensen, Taylor Teal, Kim Toombs, AVI, Bernie Pauly, CISUR, Corey Ranger, RN.
- At Home/Chez Soi Study from the Mental Health Commission of Canada
- The Future of Healing: Shifting From Trauma Informed Care to Healing Centered Engagement, Shawn Ginwright
- *Housing and Harm Reduction: A Policy Framework for Greater Victoria,* by Bernie Pauly, Dan Reist, Chuck Schactman & Lynne Belle-Isle
- *Housing and harm reduction: What is the role of harm reduction in addressing homelessness?* by Bernadette (Bernie) Pauly, Dan Reist, Lynne Belle-Isle, Chuck Schactman in the International Journal of Drug Policy.
- *Housing and Supports for Adults with Severe Addictions and Mental Illness in BC*, by Michelle Patterson & Julian Somers.
- *Levels of Community Engagement*
- *Reaching Home Coordinated Access Guide*, Employment and Social Development Canada.
- *Vancouver Final Report at Home/Chez Soi Project*, Mental Health Commission Canada
- *Housing First Toolkit* section on planning
- *Where's the Housing and Income Outcomes of a Transitional Program to End Homelessness*, a research study Cool Aid about role of Transitional Housing, by Bruce Wallace, Bernie Pauly, Kathleen Perkin & Geoff Cross