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.

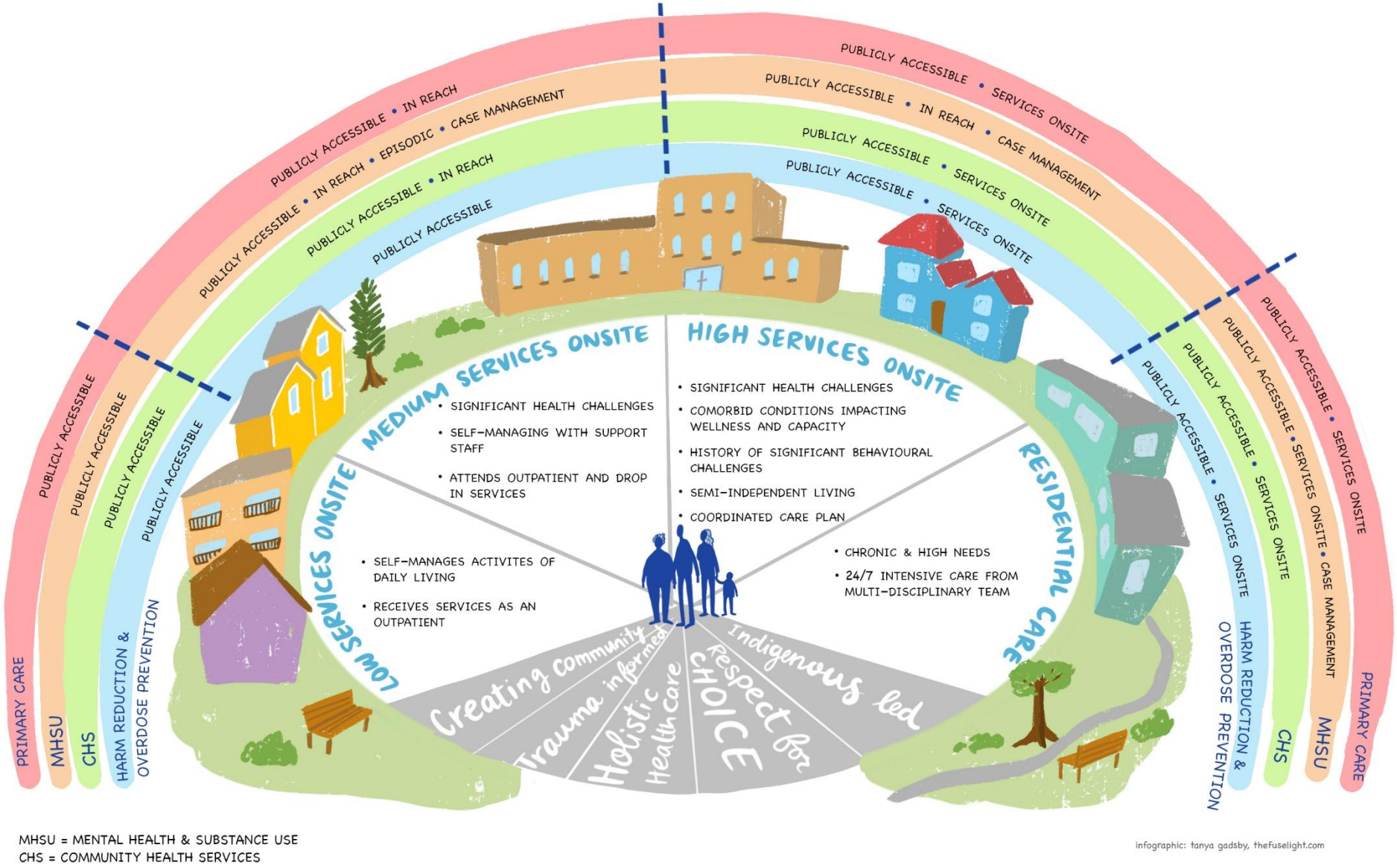
Spaces and services should be trauma informed.

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



MHSU = MENTAL HEALTH & SUBSTANCE USE
CHS = COMMUNITY HEALTH SERVICES

infographic: tanya gadsby, thefuselight.com

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
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Ashley Heaslip, PHS
Avery Taylor, PHS
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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
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Mary Morrison, VIHA
Sean Hand VPD
Monique Huber, ACEH
Rachel Phillips, Peers
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Victoria Inner City Medical Leaders Group Members

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

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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