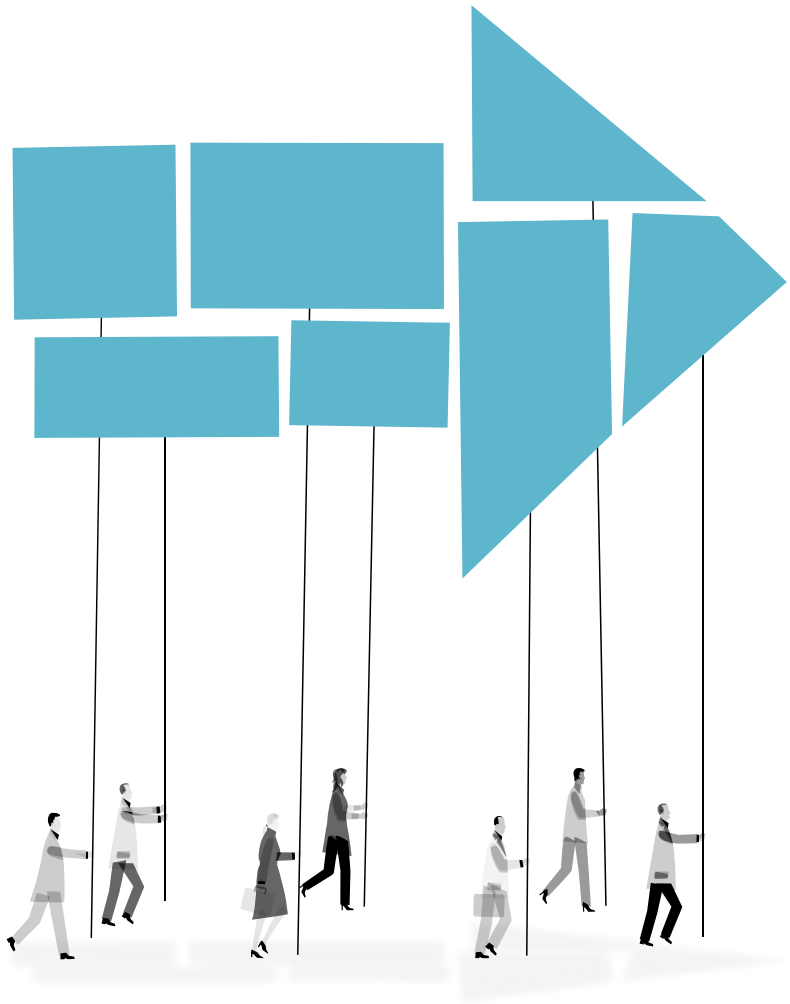
APPENDIX



Workshop Papers

for the DTES Second Generation Health System Strategy

Workshop Paper 1

MENTAL HEALTH AND ADDICTIONS SERVICES

Produced by the Participants of Service Segment Workshop #1
Held on January 30th, March 4th, and March 11th, 2013

Introduction

This Directions Paper was produced by participants in the first of five workshops hosted by Vancouver Coastal Health (VCH) aimed at improving how services are provided to residents of Vancouver's Downtown Eastside (DTES). It offers important guidance on how to fill service gaps, make more effective use of resources, improve relationships and increase collaboration amongst service partners, support frontline staff, gather evidence, and ultimately improve the quality of life for residents of one of Canada's most distressed neighbourhoods.

The workshop focused on mental health and addiction services, and involved twenty service managers and directors (both contracted and VCH) who met three times in January and March 2013. The paper they produced identifies nine major issues facing mental health and addiction-focused providers in the DTES, and proposes short- and long-term steps that VCH and its partners can take to address them.

Their suggestions sketch out many components of a far-reaching program to improve quality of life in the DTES. They are preliminary ideas, developed in small working groups labouring under considerable time pressure, and should be treated as starting points for further discussion. They cover a number of themes, including:

- Service gaps in the system of care
- Suggested improvements to VCH's internal practices
- Roles that VCH can take on to improve collective impact, including:
  - Collecting and disseminating information about 'big picture' issues in the DTES
  - Providing forums for DTES service providers to share information, raise issues, and develop solutions
  - Encouraging best practices, learning and training
  - Advocating to and coordinating with other funders and government actors
- Two-way accountability mechanisms, including evaluation metrics and potential contract modifications, that align with the goals described above.

The work that was accomplished by participants during a short time together shows a deep commitment to the residents of the DTES, expressed in both hope for improvements and a healthy skepticism for unproven approaches.

The results suggest that there is an appetite for more collaboration and coordination on the challenges facing the DTES. Participants also believe that data collection, evaluation, and contracts can better support these efforts if adjusted with care.

Workshop participants caution VCH that long-term care improvements and cost efficiencies often cannot be achieved without making least some short-term, time-limited investments upfront.

Workshop participants also expressed uncertainty about how to work across different philosophies of care — differences that can be both barriers to collaboration and a source of strength for a system that serves a diverse clientele. But as readers can see, participants found considerable ground for agreement, and have laid important foundations for the work ahead.

Workshop Paper 1

How to Read this Report

Each section of this report covers one of the nine priority issues identified collectively by participants during the workshop. These issues (listed in the order they are presented) are:

- Improving Care for People with Acquired Brain Injury and Psychosis
- Overcoming Stigma and Reducing Barriers for Individuals Who Can Be Hard-To-Serve
- Making the Cost Efficiency Case for Large Investment in Certain Individuals
- How Best to Serve Youth who are in the DTES
- Setting the Stage for Working Collaboratively
- Improving the Continuum of Care
- Bridging the '&' in Mental Health & Addictions
- Strengthening the Role of Providers and Managers in Program Design and Evaluation
- Training and Supporting Staff

Since the nine priority issues cover a range of concerns, the sections of the report complement and overlap with each other.

Each section identifies goals that participants believe would lead to significant progress on that given issue. The report also describes how participants believe these goals should be achieved. It lays out the steps required, the planning and contract implications that each goal entails, and a deadline participants believe is reasonable for accomplishing each goal. In order to meet many of these timelines, many steps will have to be taken well beforehand.

These sections were drafted in point form by participants during the workshop, edited by facilitators and then sent out to participants for further edits and final approval. In this way, it has been vetted and authorized by participants as an accurate account of their intentions and recommendations.

A list of participants is included at the end of the paper.

Improving Care for People with Acquired Brain Injury and Psychosis

Goal A: Survey the size of this population in the DTES

Goal To Be Completed Within:

- 1 year

Steps Required:

We are seeing front-line evidence that many hard-to-serve individuals in the DTES have Acquired Brain Injury (ABI).

In order to verify this, the steps required are:

1. VCH and partners draw on the ABI and Psychosis teams that currently exist in VCH to develop a screening tool.
2. Service providers screen in the community and collect data at the front line that provides demographic information about this population. VCH compiles data.

Contract and Planning Implications:

- Minimal direct implications. Data would be used to determine if subsequent steps (described below) are required or should be adjusted.

Goal B: Explore new and under-used methods of serving this population effectively

Goal to be Completed Within:

- 1 to 2 years

Steps Required:

1. The strategy to support this population should be informed by recent literature on what is effective.
2. Those involved should explore ways to use peer navigation to help improve client care for these individuals. They should also explore methods that empower individuals in this population to use self-management tools effectively (similar to strategies in HIV/AIDS care) to improve their quality of life.
3. VCH should ensure that methods are developed and delivered in a way that is gender-sensitive, including identifying where and how specialized services might be required for women, men, and trans people.

Contract and Planning Implications:

- Methods identified and developed here would inform roll out of subsequent efforts to improve services for this population.
- We believe some of these individuals cost the health, housing, social services, and justice systems large amounts of money. More and better-coordinated services for these individuals could lead to large savings along with better care.
- Funding could potentially be re-allocated to services that incorporate methods that are shown to be more effective in the DTES. Funding could also be sourced from non-VCH funders in the health, housing, social services, and justice systems.

Goal C: Establish a central consulting service that supports providers in the DTES when they encounter individuals who may have acquired brain injuries and psychosis

Goal To Be Completed Within:

- 3 years

Steps Required:

1. We currently conceive this central service (which could be housed out of a current service provider or created as a new stand-alone service) as a support for front-line staff across the DTES. Front-line staff who have had an interaction with someone who they suspect to have an acquired brain injury will be able to contact this consulting service over the phone. This service would provide expert, over-the-phone consultation and advice on next steps for service providers. This would help improve the effectiveness of frontline services and referrals provided to individuals.

Contract and Planning Implications:

- Funding for this central support service would be required. Funding could potentially be sourced from multiple funders in health, housing, social services, and justice.

Goal D: Train frontline and other initial points of contact for this population (shelters, jail, outreach workers, etc.) to identify individuals with ABI and psychosis and act accordingly

Goal To Be Completed Within:

- 3 years

Steps Required:

1. VCH works with central consulting service, internal ABI and psychosis teams, and other non-profit partners to develop and deliver this training. Training includes:
   a. User-friendly screening tool to identify ABI and psychosis in individuals.
   b. Simple protocol that describes what to do when an individual is identified as potentially having ABI and psychosis.
   c. Information about the full range of treatment responses that can support these individuals, stressing that responses go far beyond mental health and addiction services to include primary care, housing, HIV/AIDS services, etc.

Contract and Planning Implications:

- Requires the creation of a partnership agreement with any service providers involved in developing and providing training.
- Appropriate service providers (VCH and contracted) should be encouraged to participate in training.

Overcoming Stigma and Reducing Barriers for Individuals Who Can Be Hard-To-Serve

Goal A: A high-profile public announcement/ acknowledgement by VCH and other provincial officials that there is a serious mental health and addictions challenge in the DTES, one that calls for public resources to be prioritized for this population.

Goal To Be Completed Within:

- 1 Year

Steps Required:

1. There should be renewed public focus on the challenges faced in the DTES. This focus should acknowledge that the challenges facing the DTES have changed since the declaration of the public health emergency in 1997, and that they are now more explicitly about mental health and addictions issues.
2. This announcement should be built collaboratively with service providers who are serving these populations.
3. One reason why hard-to-serve individuals end up in the DTES is that services outside the DTES stigmatize and discriminate them. This public announcement should be geared towards engaging service providers in various fields about how to provide this population with the services they deserve.

Contract and Planning Implications:

- The official prioritization of services for those with serious mental health issues in the DTES could bring new resources from other parts of the public system.

Goal B: Ensure protection of existing resources for this hard-to-serve population

Goal To Be Completed Within:

- 1 year

Steps:

1. VCH should make a commitment that this population will be protected from any funding cuts in any ongoing funding adjustments or reductions.

Contract and Planning Implications:

- Funding for this population can be redistributed amongst current providers if evidence can be shown conclusively that it will lead to better outcomes for this population, but it should not be reduced.
- Funding from other service areas in the DTES can potentially be redirected to this population.

Goal C: Gather and disseminate evidence about effective services for this population

Goal To Be Completed Within:
- 2 years

Steps Required:
1. We believe many DTES service providers are very effective at serving this population at a low cost. VCH and contracted agencies should engage in a collaborative process to show evidence that demonstrates how effectively both VCH providers and non-profit agencies are serving the most marginalized and hard-to-serve.
2. Effective practices should be learned from and shared amongst providers.

Contract and Planning Implications:
- New resources that become available should be directed to those who are serving these populations most effectively.

Goal D: VCH and partners should develop and deliver targeted training to DTES staff on improved practices that help overcome stigma and reduce barriers for individuals who can be hard-to-serve

Goal To Be Completed Within:
- 3 years

Steps Required:
1. This training should focus on helping staff better understand the needs of this hard-to-serve population, explaining why they have more complicated needs and why certain types of practice are more effective. Findings from the evidence-gathering efforts under Goal C could be included in this training.
2. We believe training should include:
   a. Understanding trauma-informed care and the notion that 'all behavior makes sense'.
   b. The importance of relationship-building with the hard-to serve.
   c. The benefits of responding to functionality and symptoms, not diagnosis.

Contract and Planning Implications:
- Receiving training could be required of VCH and contract providers.
- Services that are believed to be stigmatizing this group may require more intensive assistance to adjust their practices.

Goal E: Set up a no barrier, 24-hour space in the DTES that is open to those who may be stigmatized by other service providers

Goal To Be Completed Within:
- 3 years

Steps Required:
1. If evidence gathered in Goal C confirms that more no-barrier services are required, VCH and partners should identify an appropriate site and some basic core services that will be in the "path" of these stigmatized and hard-to-serve individuals in order to meet them where they are and address the clients' goals and priorities.
2. VCH should identify partners who can work together in true partnership to offer these services in a client-centered, no-barrier way that addresses some client needs as soon as they walk in the door.
3. Other participants suggest that resources might best be applied further up the continuum of care. They suggest that it may be more effective to create a centralized point of responsibility for particular hard-to-serve individuals and then to help each individual transition into more stable arrangements. More discussion may be required.

Contract and Planning Implications:
- Such a site would require resources. The Buddhist Temple is one possible site. Alternatively, it could be used as a source of revenue.

Making the Cost Efficiency Case for Large Investment in Certain Individuals

Goal A: Establish a baseline understanding of VCH funded service use by clients in DTES services

Goal To Be Completed Within:
- 1 year

Steps Required:
1. VCH and partners should unpack anecdotes of 'Frequent Flyers' and 'Million Dollar Murrays' in terms of Emergency Department usage, involvement with the criminal justice system, housing services, and mental health and addictions services.
2. Potential data sources include *The At Home Project* and *VCH PARIS* database. Previous efforts in Nanaimo might also be looked at as a model to build from. This research would identify opportunities to 'group' clients who require more intensive care.

Contract and Planning Implications:

- This requires more case conference management in order to understand and learn about the needs of individuals using high levels of services.

Goal B: Match high-cost clients with services that lead to greatest cost savings and best client outcomes

Goal To Be Completed Within:

- 2 years

Steps Required:

1. VCH and partners should review existing research on cost-effectiveness of different mental health and addiction services for different client populations identified in Goal A.
2. Justice system costs should be included in cost-effectiveness assessment.
3. VCH and partners work together to determine which existing services lead to cost-savings for other parts of the system and how significant these savings are.
4. VCH and partners work together to develop a standard needs assessment/risk assessment scale that VCH and contract providers use to prioritize high-needs clients for more intensive services.
5. Using well-established clinical criteria, service providers would encourage more 'stable' clients in intensive services to transition to an alternative level of care, while assuring them that this does not lead to negative results for clients. This would require providing bridging support to ensure a smooth transition for clients who rely on the stability offered by consistent services.

Contract and Planning Implications:

- VCH and contract service providers would become responsible for serving the right client, at the right place, at the right time. Further conversation is required to develop specific contract and planning changes that would ensure this occurs.

How Best to Serve Youth who are in the DTES

Goal A: Have VCH lead a table that informs planning and collaboration for youth in DTES

Goal To Be Completed Within:

- 1 year

Steps Required:

1. VCH identifies funders and service providers to participate in this table. Together, members define and identify the table's terms of reference. Priorities for this table would include:
   a. Defining what collaborative practice should entail, including the philosophy that should motivate collaborative practices.
   b. Addressing training and support needs to enable more collaborative practices.
   c. Encouraging greater collaboration between youth mental health outreach workers and other service providers in the DTES.
   d. Improving mental health services for youth experiencing acute crises.
   e. Expanding harm reduction strategies for youth city-wide.
   f. Ensuring that methods and initiatives that are developed and delivered are done so in a way that is gender-sensitive, including identifying where and how specialized services might be required for women, men, and trans people.

Contract and Planning Implications:

- Based on the work of the table, VCH would begin working with other ministries and funders to explore contract reallocations that support more collaborative practices.

Goal B: "Nothing About Us, Without Us": Launch a youth engagement strategy, including a youth survey and youth advisory board, so that funders and service providers hear from youth about what they want and need

Goal To Be Completed Within:

- 1 year

Steps Required:

1. VCH and service providers should work together to create and deploy a survey of youth in DTES.
2. Results of survey would be shared with all stakeholders.
3. VCH and partners should create a Youth Advisory Board with marginalized youth after the survey is complete.
4. Survey should be repeated on a regular basis in order to analyze whether youth needs are being met and outcomes are being achieved.

Contract and Planning Implications:

- The Youth Advisory Board would require ongoing funding.

Goal C: Enhance training on youth (and family) issues for all service providers in DTES

Goal To Be Completed Within:

- 1 year

Steps Required:

1. VCH and agencies that provide services in DTES should co-lead a process that enhances the training of service provider staff in all DTES service segments.
2. This would require identifying training needs of DTES staff in all service segments.
3. The training should inform staff about how to use trauma-informed practices, client-centered practices, strengths-based practices, and harm reduction strategies when working with youth. Training should also include information about youth mental health and development/ attachment theory.
4. Partners should design and deliver annual refreshers.

Contract and Planning Implications:

- The cost of organizing this training is relatively small.
- Contract agencies should be funded to attend.
- VCH providers should be required to attend.
- Contracts should include core expectations that staff attend these trainings.

Goal D: Protect and expand culturally appropriate health, mental health, and addictions programs for Native youth, their families, and their communities

Goal To Be Completed Within:

- 1 year

Steps Required:

1. VCH and partners should help expand *Native Health Evenings for Youth*. This involves:
   a. Assessing whether this is desirable and achievable by talking to Vancouver Native Health Society; UBC; Dr. Ada Satbir; VCH Medical Director (to determine funding availability); UBC Mental Health Team Leader; and McCreary Centre Society.
   b. Bringing service providers and the youth advisory committee together to determine the mix of services to be offered.
   c. Finding/allocating necessary funding.
   d. Implementing a data collection system in order to assess outcomes of *Native Health Evenings for Youth.*
2. VCH and partners should explore other ways for VCH to protect and provide greater support to programs that use Cultural Healing modalities for Native youth, their families, and their communities.

Contract and Planning Implications:

- Expanded *Native Health Evenings for Youth* likely requires a formal agreement with Vancouver Native Health Society for the provision of services and for funding.
- Culturally-appropriate data systems and assessment criteria should be developed and used in partnership.
- We believe this can be accomplished at minimal expense.

Goal E: Create a Youth Wet Shelter

Goal To Be Completed Within:

- 2 years

Steps Required:

1. VCH should take a lead role bringing together partners. VCH should be a potential funder and also an advocate to other funding partners. Partners could include MCFD, City and BC Housing, non-profits, Youth Funders Table, and others.
2. VCH should work with potential partners to gather data on the need for a youth wet shelter. This involves:
   a. Talking to shelters to determine more clearly what the youth issues are and how many youth get turned away for using drugs and alcohol.
   b. Talking to VPD to get the youth SIPP/Jail statistics.
   c. Getting youth detox statistics.
3. Partners should create a Youth Oversight Committee for the shelter.
4. Partners and Youth Oversight Committee should assess appropriate sites for youth wet shelter and whether it should be in the DTES or in another neighbourhood.
5. VCH should explore how to overcome regulatory, licensing, and other barriers to creating low barrier shelter options for all youth.

Contract and Planning Implications:

- Funding should be found from across ministerial partners. Funders may need to reallocate money from existing services to create a youth wet shelter.

Goal F: Create a Multidisciplinary Youth Support Centre

Goal To Be Completed Within:

- 5 years

Steps Required:

1. VCH should take guidance from the Youth Advisory Board and survey results (Goal A) in order to identify the core needs of youth and assess whether such a centre can meet their needs in a cost-effective manner.
2. VCH and service providers should approach other funders and ministries.
3. Funders and partners work together to find philosophical common ground so that the different services offered at site complement each other.
4. This philosophy should be embedded in the formal relationships between the organizations involved.
5. VCH, providers, and the Advisory Board would identify a safe space in an appropriate area so that youth will use the centre.
6. VCH and partners would then find resources to create the centre.
7. VCH and partners should ensure that the centre is a safe, supportive place for youth that prevents them from 'disappearing' into high-risk environments.

Contract and Planning Implications:

- Funders may need to reallocate funds from existing services to create this centre. Data should be used to assess what youth services are not achieving outcomes effectively.
- VCH will need to work with other ministries and funders to find funding.
- Data should be collected in order to assess the effectiveness of the centre's services.

Setting the Stage for Working Collaboratively

Goal A: Lay groundwork for service collaboration among both VCH providers and non-profit providers

Goal To Be Completed Within:

- 1 year

Steps Required:

1. VCH and partners should define service clusters in which collaboration is expected.
2. VCH and partners should outline the expectations for service collaboration done through well-structured partnerships.
3. VCH and partners should establish structured mechanisms for collaboration which could include:
   a. A shared, client-centred case management structure that is accessible to and used by all organizations (internal and external to VCH) within each service cluster.
   b. 'Service roadshows' to learn about what others are doing and their organizational cultures.
   c. Structured 'clinical rounds' and regular meetings to enhance collaboration concerning high need individuals.
4. VCH should establish any required support infrastructure that helps internal and external services collaborate and hold each other mutually accountable.
5. VCH and partners should evaluate steps taken and adjust their actions according to the lessons they learn.
6. VCH should encourage the creation of similar collaboration mechanisms across all internal and external organizations and in different service segments.

Contract and Planning Implications:

- With time, service contracts and service plans could be connected to these mechanisms in order to encourage more systematic collaboration.

Goal B: Establish a shared philosophy of care for each individual service cluster

Goal To Be Completed Within:

- 1-3 years

Steps Required:

1. VCH and partners would begin by identifying shared outcomes for each cluster.
2. VCH and partners should then develop measures of success related to these outcomes.
3. Agreements and disagreements about philosophies of care can be identified, explored, understood, and potentially bridged through these processes.
4. Outcomes and measures should take into account the continuum of care, so that service providers are encouraged to be responsible for those 'waiting to come through the door', not just those that have already 'made it through their doors'.

Contract and Planning Implications:

- Shared outcomes and measures of success for service clusters can, going forward, be used in service contracts and service plans.

Goal C: Establish a requirement that all internal and external service partners act in the best interest of clients across the broader continuum of care

Goal To Be Completed Within:

- 5 years

Steps Required:

1. As work under Goal A and Goal B progresses, VCH and partners are being oriented towards finding greater agreement on what it means to act in the best interest of clients across the whole continuum of care.
2. As agreement grows, VCH and partners develop mechanisms for evaluating and ensuring that all service partners (internal and external) are acting in this manner.

Contract and Planning Implications:

- Contracts and arrangements amongst service providers are strengthened by shared understandings of improved client care.

Improving the Continuum of Care

Goal A: Put the 'continue' in the continuum of care: creating a seamless process for people along their care journey

Goal To Be Completed Within:

- 1 year

Steps Required:

1. VCH and contracted service providers should work together to map client care and establish a well-understood role for each service provider across the system.
2. They should build from ongoing work around information sharing. This work involves service providers gathering to determine challenges with information sharing provisions in FOIPPA and then organizing training with experts to facilitate better information-sharing practices.
3. VCH should provide practice support around collaborative models of care.
4. VCH and partners should explore how to share physical space.

Contract and Planning Implications:

- VCH and contracted service providers should create and implement information sharing agreements and protocols for service providers.
- VCH and contracted service providers should work together to establish expectations through explicit service plans about what it means to serve the ***right*** client, at the ***right*** place, at the ***right*** time.
- VCH has to be more explicit about the requirement to work as part of the continuum.

Goal B: Develop organizational trust across the system of care by increasing knowledge and understanding

Goal To Be Completed Within:

- 3 years

Steps Required:

1. VCH and partners should create a mechanism so that service providers know what services others are providing.
2. VCH and partners should implement 'comprehensive care planning' that involves routine meetings between different service providers. These providers would work together to develop a system for better matching clients to services so that the full spectrum of needs across the social determinants of health are met.
    a. Hospitals need to be involved in this care planning work.

Contract and Planning Implications:

- Service providers, including VCH services, should be required to provide VCH with explicit evidence about how they are working collaboratively with other service agencies and VCH, including how they are using the mechanisms described in the steps above.

Goal C: Ensure there are no 'handoffs' of clients by focusing on shared care, well-managed transitions, and collaborative funding

Goal To Be Completed Within:

- 5 years

Steps Required:

1. VCH should bring together the full spectrum of actors working on given issues to build shared responsibility and heighten accountability amongst actors. Actors include:
    a. Government providers (city, province, parks)
    b. Non-profit providers (including faith-based providers)
    c. Funders (across government)
    d. Businesses
    e. Residents

Contract and Planning Implications:

- VCH should work with other funders to develop shared service agreements where multiple funders provide funding for a single comprehensive service package for each provider.

Bridging the '&' in Mental Health & Addictions

Goal A: Encourage integration of the two disciplines by helping providers understand the overlap and interconnection of mental health and addiction issues

Goal To Be Completed Within:

- 1 Year

Steps Required:

1. VCH should create a forum for VCH managers to work on this issue internally.
2. VCH in particular should work to broaden what 'mental health' means to their staff so that mental health is seen as one contributing factor in most addictions, and addictions are seen as one type of mental health challenge.
3. VCH and others should avoid trying to have one field be the primary, overarching field.
4. VCH and partners should educate in both fields about best practices and promising practices that bridge the two fields. One such practice, for example, is the shift from pure personality disorder-based practices to trauma-informed practices.
5. VCH should identify potential care pathways and treatment planning protocols that would help bridge mental health and addiction fields.
6. VCH should encourage creation and adoption of shared assessment tools and shared language across the disciplines.

Contract and Planning Implications:

- Mandatory cross-training for VCH management.
- Mandated changes to VCH service practices.

Goal B: Have mental health and addiction disciplines work in a truly integrated way

Goal To Be Completed Within:

- 3 years

Steps Required:

1. Disciplines should move towards forming multi-disciplinary teams that work in the same space, with shared caseloads, co-created treatment plans, and shared clinical rounds.
2. VCH should coordinate this work with provincial efforts that are underway

Contract and Planning Implications:

- This should involve the co-location of VCH Primary Care, Mental Health, and Addiction teams. Resource allocation should be adjusted to reflect this co-location.

Strengthening the Role of Providers and Managers in Program Design and Evaluation

Goal A: Strengthen regular consultation with VCH decision makers

Goal To Be Completed Within:

- 1 year

Steps Required:

1. VCH should encourage the creation of a regular forum driven by service providers and user groups where managers, providers, and user groups can sit together to assess trends and needs, create solutions, design programs and services, and design evaluations that can be provided to senior VCH decision-makers.
2. Senior, director-level VCH decision makers should value and act on the advice that is provided from this forum. These VCH staff should seriously consider the advice and offer a fulsome response in a timely manner. This response should include:
   a. Engaging with the content of the forum's advice.
   b. Posing clarifying questions about the forum's reasoning.
   c. Providing reasoning for VCH decisions that take a different approach than those advocated by this forum.
3. VCH should also acknowledge that it takes courage for contracted service providers to speak out about issues, since they may be risking their funding by doing so. This is especially true when senior VCH directors are perceived to have insufficient contextual and philosophical understanding of the work of front-line DTES staff and of the user groups they face. Providers will worry that these senior VCH staff are less likely understand and appreciate the feedback being provided by this forum because of this lack of understanding.

Contract and Planning Implications:

- This forum requires resources in order to support the time and energy required to create and maintain this forum.

Goal B: Improve Evaluation Design

Goal To Be Completed Within:

- 1 to 2 years

Steps:

1. VCH should ask contracted providers what they are doing already in terms of data collection and evaluation.
2. VCH and contracted providers should identify common quality-of-life goals across different services on DTES.

3. VCH and contracted providers should ensure that different measurement systems being used are capturing information on common outcomes. VCH should not mandate that the same evaluation tools be used by all service providers.
4. VCH and contracted providers should ensure that measurement systems take into account the relationship amongst individual programs in the service clusters and along the continuum of care.
5. Findings of evaluations should be collected and shared for the benefit of all service providers.

Contract and Planning Implications:

- VCH should provide resources to service providers to improve their evaluation systems. In particular, VCH must ensure that requirements to conduct evaluations be accompanied by adequate resources to establish necessary infrastructure and support evaluation work where these resources are required.

Training and Supporting Staff

Goal A: Define core competency requirements for DTES staff and develop basic training to meet these requirements

Goal To Be Completed Within:

- 2 years

Steps Required:

1. VCH should ask both staff and organizational levels what they feel they need in terms of basic competency training.
2. The training should Include DTES history, indigenous cultural competency, and other anti-oppressive competencies.
3. VCH and partners should investigate what trainings are already available to adapt and borrow, should engage with colleges/universities, and leverage cross-ministry support.
4. The training should include both face-to-face and online components.
5. As part of their orientation, new staff in the DTES should learn about key programs in the DTES and visit program sites around the DTES.
6. VCH should consider the development of an online listing of training resources so that staff have easy access to materials.

Contract and Planning Implications:

- In order to initially get all staff up to core competency requirements, extra funding will be required.
- Funding should be made available where necessary so that casual staff are available to backfill for frontline staff, enabling them to attend such training without compromising client care.
- Going forward, training would be required (and budgeted for) for new employees in VCH service contracts.

Goal B: Create mechanism(s) for routine knowledge exchange amongst providers (including VCH)

Goal To Be Completed Within:

- 2 years

Steps Required:

1. This could take various forms, including:
   a. A team of DTES providers that works together to educate 'out' to others in the city (including hospitals) about how to work with hard-to-serve clientele. Funding could be found in other ministries to support these trainings.
   b. The formation of communities of practice.
   c. Brown Bag Lunches where staff from different agencies offer seminars and exchange knowledge.
   d. Inter-agency staff exchanges and shadowing.

Contract and Planning Implications:

- Funding would be required for some of these activities.

Goal C: Improve recruitment and retention of qualified, talented, enthusiastic, and healthy staff

Goal To Be Completed Within:

- 3 years

Steps Required:

1. VCH should acknowledge that a lack of staff wellness is a drain on effectiveness. VCH should also acknowledge that staff (both internal and contracted service staff) are at risk of mental health strain and vicarious trauma due to the nature of their work. Staff are asked on a daily basis to try to remedy the consequences of deep systemic failures.
2. VCH should consider evidence that shows how investment in clinical supervision and other staff support leads to better services as well as savings for the system, since it reduces turnover and worker compensation claims.
3. VCH should develop internal and external HR policies that are specific to the circumstances of the DTES. These HR policies should foster a culture of supportive interventions rather than punitive actions against staff.
4. VCH should play a more assertive role in assessing and supporting contracted agencies staff-wellness practices. This role needs to include providing necessary administrative resources and/or budgetary flexibility so that contracted agencies can implement effective staff-wellness practices.
5. VCH should also be held responsible for showing evidence of the effectiveness of its own staff wellness efforts for DTES staff.

Contract and Planning Implications:

- VCH should begin asking contracted organizations to provide evidence about how well staff are being cared for, as well as barriers they face in caring for their staff.
- VCH should provide evidence that its staff wellness efforts are effective for its own DTES staff.
- VCH should invest in staff support as a way to reduce long-term costs and improve effectiveness.

Participants

Gail Boivin
Gail is the Manager of Primary Outreach Services and Sheway at Vancouver Coastal Health.

Gerry Bradley
Gerry is the manager of the Strathcona Mental Health Team and the Vancouver Intensive Supervision Unit (VISU), as well as the West End Mental Health Team at Vancouver Coastal Health.

Miranda Compton
Miranda is a Manager of HIV/AIDS Services at Vancouver Coastal Health.

Reg Daggitt
Reg is a Manager of Adult Addiction Services and Contracted Adult Residential Treatment Programs at VCH. Previously, Reg worked as a Vancouver Coastal Health DTES project manager during the opening of The Downtown Community Health Centre (DCHC), The Pender Community Health Centre, The Health Contact Centre, and The Life Skills Centre. He was also Manager at DCHC from 2003-2006.

Michelle Fortin
Michelle is the Executive Director of Watari Research Association.

Lorraine Grieves
Lorraine is a Manager of HIV/AIDS & Harm Reduction Programs and Youth Addictions & Prevention Programs for Vancouver Coastal Health.

Deborah Hines
Deborah is the Corrections Manager responsible for operations at Vancouver Intensive Supervision Unit, Drug Treatment Court of Vancouver, and the integrated programs at Downtown Community Court including both the Case Management Team and the Mental Health Program. All of these programs integrate Corrections and Vancouver Coastal Health programs to provide services to mental health clients who are involved with the criminal justice system in the DTES.

Bob Manning
Bob is Clinical and Program Coordinator at Urban Native Youth Association.

Richard Marquez
Richard is the Case Management Supervisor for Off-Site Programs at AIDS Vancouver.

Russ Maynard
Russ is the Coordinator at Onsite Detox for PHS Community Services Society.

Scott McDonald
Scott is the Physician Lead at the Crosstown Clinic with Providence Health Care.

Sri Pendakur
Sri is the Manager of Withdrawal Management Services at Vancouver Coastal Health.

Greg Richmond
Greg is an Associate Director at RainCity Housing and Support Society in Vancouver, and their ACT Project Team Lead. Greg has a particular interest in homelessness and has developed and implemented specialized outreach and supportive housing programs for homeless people with complex health concerns. He has also worked with municipal, provincial, and federal authorities to develop and evaluate responses to homelessness, and holds a Bachelor of Arts degree from Simon Fraser University.

Amy Salmon
Amy is the Coordinator of Sheway at Vancouver Coastal Health.

George Scotton
George has been a psychiatric nurse for 25 years, and has worked in the DTES at the Strathcona Community Mental Health Team as a case manager for 16 years. He left the Strathcona Team to work on the project team for the Burnaby Center for Mental Health and Addiction, and returned to Vancouver Community Mental Health Services in a leadership position. George is the manager of Venture (a short-stay crisis stabilization home), Mental Health Emergency Services, the Vancouver Assertive Community Treatment (ACT) Team and a newly implemented second ACT (IPCC) Team.

Emmy Sevilla
Emmy is the Detox Manager at Harbour Light Detox, a part of The Salvation Army.

Sonja Sinclair
Sonja is a Manager of Regional Mental Health and Addictions at Vancouver Coastal Health.

Workshop Paper 1

Kathy Snowden
Kathy is the Director of Counseling Services for the Boys & Girls Club of South Coast BC. Kathy has been working with at risk youth for 30 years. She started working as a house parent in a group home specifically designed to serve street involved youth. Kathy worked for 3 years as a youth counselor in an alcohol and drug residential treatment program. She then worked for 13 years as a Substance Abuse Counselor and Program Coordinator with the Boys & Girls Club of South Coast BC Odyssey II program which provides services to youth and their families who are affected by substance abuse.

Monika Stein
Monika is Manager of Aboriginal Health Services and HIV AIDS & Harm Reduction Programs for Vancouver Coastal Health, involving InSite, OnSite, CTCT, PSS, and the Rainier Hotel.

Howard Tran
Howard is a Sergeant with the Vancouver Police Department.

Jennifer Vornbrock
Jennifer is Director of Strategic Deployment at Vancouver Coastal Health.

Workshop Paper 2

PRIMARY CARE AND ADDICTIONS MEDICINE

Produced by the Participants of Service Segment Workshop #2
Held on May 6th and May 13th, 2013

Introduction

This Directions Paper was produced by the participants of the 'Primary Care and Addictions Medicine Service Segment Workshop' — the second of five workshops hosted by Vancouver Coastal Health (VCH) aimed at improving how services are provided to residents of Vancouver's Downtown Eastside (DTES). This workshop involved eighteen managers, clinical supervisors, and medical directors from VCH-provided and VCH-contracted services operating in the DTES, as well as providers from PHSA who serve residents of the DTES.

This paper summarizes the key recommendations they provided during their deliberations over the course of two full days in May 2013. It offers important guidance on new primary care models, priority investments, improved information sharing and care coordination, and outcome measurement systems.

The paper identifies five major issues facing providers of primary care and addictions medicine in the DTES, and puts forward twelve recommendations that VCH and its partners should take to address them. These are 'first drafts' suggested by the group while labouring under considerable time pressure and should be treated as starting points for further discussion.

The five major issues identified by participants are:

1. Barriers to accessing effective primary health care;
2. Information-sharing and coordination of service delivery concerning complex clients;
3. Access to effective opioid replacement therapies;
4. Provision of care to individuals with mental health challenges which are outside of current mandates; and
5. The coherence of data collection, measurement, and goal-setting.

The twelve recommendations put forward by participants are:

1. Alter primary care models so that providers have broader mandates, provide more mobile and embedded care, and include more robust outreach efforts;
2. Ensure providers have access to basic information about who is providing clinical care to complex clients;
3. Develop a care coordination system that ensures every care provider has the necessary (but not superfluous) access to information;
4. Equip providers to case conference concerning complex clients in an effective and hassle-free way;
5. Improve opioid replacement therapy by expanding methadone slots, providing alternative treatment options, coordinating amongst methadone providers and pharmacists, preventing interruption of treatment, and integrating methadone with primary care and mental health;
6. Build capacity to provide trauma-specific treatment and counseling, embed trauma-informed practices into all DTES services, and provide tertiary mental health services to those beyond Axis 1 diagnoses;
7. Form a working group of experts to develop a measurement system for the DTES;
8. Create a dashboard of five overarching neighbourhood-level indicators that track health needs and health care effectiveness in the DTES;
9. Link patient-level data to system-level data;
10. Implement client-centred care planning and track patient satisfaction data;
11. Develop program-level quality assessment indicators; and
12. Improve capacity for efficient data-collection.

Participants were confident that effective primary care and addictions medicine for residents of the DTES would lead to considerable long-term savings for the health system overall. Having succeeded to a significant degree in providing effective crisis medicine, preventing deaths from HIV and overdoses, and creating basic stability for clients with deep mental health needs, health

care providers in the DTES now face new challenges: the growing number of individuals seeking multiple services, the ageing of the DTES population and the onset of new health needs because of it, and a growing interest in more intensive addictions and mental health treatments. Providers believe the health system was never designed to meet the needs of this unique population, and that improved care requires more flexible, accessible, and coordinated service models that meet clients where they are at. They want to develop evidence to show how effective services are and how they can be improved, but they know they cannot achieve effective coordination and evaluation off the sides of their desks, and that systems need to be designed to facilitate and reward these important efforts.

The results produced by participants during a short time together show that there is considerable agreement about steps that can be taken to improve the effectiveness of the resources dedicated to primary care and addictions medicine. Their work deserves careful study.

How to Read this Report

The content from this report is drawn from discussions held by participants over the course of two days. It was drafted by independent facilitators and sent out to participants for further edits and final approval. In this way, it has been vetted and authorized by participants as an accurate account of their intentions and recommendations.

The body of the report is divided into two sections: *Issues* and *Recommendations*. During Day One of the workshop, participants were guided by facilitators through a series of discussions about the current state of primary care and addictions medicine in the DTES. Participants concluded Day One by identifying priority issues that they would like to focus attention on during Day Two. The *Issues* sections are drawn primarily from the discussions on Day One.

During their second day together, participants broke into working groups to develop recommendations for how to address the priority issues identified during Day One. These recommendations were drafted out in point form by participants, and have been edited to form the *Recommendations* section of this report.

Over the course of the two days, many topics and suggestions were touched on in passing and are not included in the body of the report below. They included:

- The need for more focused attention on creating accessible primary care for families and children living in the DTES, and mental health treatment for children;
- The need for better housing;
- The large and rising number of individuals with untreated Hepatitis C, the predicted health effects if these individuals remain untreated, and the consequences for the healthcare system;
- The lack of effective youth services funded by other government ministries;
- Disability, COPD and chronic disease management;
- The challenge of identifying who is not connected to primary care;
- The unacknowledged barriers that prevent access to specialist care for DTES residents;
- Opportunities to share and celebrate innovative ideas and initiatives;
- The need for 24-hour respite; and
- The need for long-term sanctuary for people with very high needs.

A list of participants is included at the end of the paper.

Issues

We believe that there are five priority issues that must be addressed in order to better meet the primary care and addictions medicine needs of residents in the DTES. They are:

1. Barriers to accessing effective primary health care

Some residents of the DTES who have serious health care needs are not being reached by the health care system as it currently operates. Residents may come into contact with some portion of the primary care system, but they do not always receive the necessary package of services. Health care providers are not sufficiently integrated, nor are they sufficiently mobile and responsive. The lack of integration and flexibility has, at times, led to inefficient and ineffective care provided by multiple clinicians operating independently, each with a focus on a specific aspect of the client's care. This creates a system where those who most need care are also most likely to fall through the cracks.

2. Information-sharing and coordination of service delivery concerning complex clients

Residents of the DTES who have complex needs and require multiple clinical services sometimes receive inadequate care because care providers struggle to effectively share information and coordinate their actions. More information sharing and coordination between clinical care providers around individual clients is required to ensure clients get appropriate and effective care.

Several barriers stand in the way of better coordination. First, service providers often do not know who else is involved in providing care to a given individual. The lack of a shared patient records accessible to both non-profit and VCH providers means

basic care information is stored in a variety of locations. We believe that a unified patient record system for non-profit and VCH clinicians is likely out of reach at this point, but that it is possible to use PARIS as a database that shares basic information about what clinical providers are involved in an individual's care. Once this information is available, case conferencing and shared care planning would be easier to organize and execute, leading to more effective service and improved health outcomes for clients.

3. Access to effective opioid replacement therapies
The DTES lacks enough effective opioid replacement therapy to meet the needs of people who want to stabilize, manage, and treat their opioid addiction.

There are not enough methadone treatment slots available in the DTES — currently, there are physicians working in the DTES that do not prescribe methadone, and among those that do, physicians are generally operating at capacity. Providing effective opioid replacement therapy in the DTES is also difficult because methadone treatment is often not coordinated or integrated with primary care and/or mental health care. Other opioid replacement options are not widely available, which further undermines the ability of physicians to provide the most effective care for each individual client.

Missed methadone doses can interrupt treatment and often have serious consequences for clients struggling with opioid addictions. The current environment makes missed doses more likely. Entry and/or exit from correctional facilities often leads to missed methadone doses because physicians in remand have sometimes failed to determine that someone requires continued methadone treatment and/or refused to provide said treatment when requested. Further, pharmacies that fill methadone prescriptions in the DTES are not open 24 hours. Someone may be released from a correctional facility and require a dose of methadone before pharmacies open in the morning, thus leading to an interruption of treatment and a likely relapse. For any client, a lack of 24 hour, 7 day access to methadone-prescribing physicians and pharmacies is a significant barrier for those struggling to find order in chaotic lives, as client crises do not happen at optimal times for providers.

4. Provision of care to individuals with mental health challenges which are outside of current mandates
Many of the most complex clients in the DTES suffer from serious mental health challenges that are not covered by currently mandated mental health services. These mental health challenges are frequently related to trauma (including personality disorders, PTSD, general trauma, attachment disorders, and co-occuring disorders), but also include acquired brain injuries, fetal alcohol spectrum disorder, and cognitive impairments. Stabilizing and improving the overall health of these individuals is extremely difficult when appropriate mental health support is absent.

5. The coherence of data collection, measurement, and goal-setting
Though plenty of data is collected in the DTES through programs and studies, this data is not always comparable or available for wider use. This makes it more difficult to form a clear picture of what needs exist, what progress is being made, and what adjustments would improve the collective impact of services provided in the DTES.

The availability of DTES-specific indicators would provide clearer direction and assist providers to focus their efforts on collective goals and benchmarks.

Further, service providers and VCH management do not have an agreed-upon method of evaluating the quality of services provided — data reported to VCH management is generally focused on determining what has been done (be it patient-visits, treatments provided, or needles exchanged) but not on how well that service has been provided or on how effective those services have been.

This leads to a sense that VCH and non-profit decision-makers are sometimes 'flying blind' — or at least with limited visibility — when it comes to allocating resources, setting priorities, and evaluating progress.

Recommendations

We have twelve recommendations that, if implemented, would improve the effectiveness of primary care and addictions medicine for residents of the DTES. Taken together, our recommendations create a basis for lowering barriers to primary care, improving the coordination of care; increasing access to opioid replacement therapy; addressing mental health needs; and effectively measuring community needs and system effectiveness.

1. Alter primary care models so that providers have broader mandates, provide more mobile and embedded care, and include more robust outreach efforts
VCH should work towards altering its primary care service model by:

- Supporting more robust and coordinated outreach services that focus on reaching people who are not receiving regular care and connecting them into primary care services, whether provided through fixed clinic locations or through mobile care. Outreach services would need to be given broader program, service, and scope mandates in order to be able to fulfill this function;
- Improving the physical environments of stationary clinics and extending hours of operation to meet the needs of clients;

- Encouraging the development of mobile primary care services and embedded primary care services that reach clients in their homes. This could include after-hours, 'on-call' services to address urgent primary care needs that do not require an ambulance visit or an emergency department visit;
- Creating more flexible, patient-centered program mandates that encourage providers to take responsibility for a wider spectrum of health needs of each individual; and
- Facilitating rotating specialist visits to locations (clinics and embedded services) where primary care is provided in order to address the lack of access to specialist services.

2. Ensure providers have access to basic information about who is providing clinical care to complex clients

To ensure access to basic information, VCH should provide all clinical care providers with at least minimal read/write access to PARIS. All clinical care providers should agree on 'minimal charting requirements' on PARIS that cover the basic details about who is providing care to individuals, and VCH should support the clinical care providers to put this into practice. This requires training in PARIS and resources for data entry. VCH should consider extending this to clinical care providers in corrections facilities, Fraser Health Authority, PHSA, and Providence Health Care.

3. Develop a care coordination system that ensures every care provider has the necessary (but not superfluous) access to information

To facilitate effective information sharing and care coordination, VCH should develop a 'care coordination system' for complex clients (clients with complex needs who should be receiving multiple clinical services). When a client is believed to require more systematic care coordination, a provider should organize a case conference with the clinical care providers listed on PARIS (and any non-clinical providers that are known to be involved in this individuals care). At the case conference, one clinician would be designated the 'Most Responsible Care Person' (MRCP).

The MRCP would be responsible for maintaining an updated version of the client's care plan (developed through information-sharing and case conferencing with other involved care providers). A standard care plan template should be offered for use by the MCRP and all other programs, services, and associated providers. The MRCP would be marked on PARIS, and any provider who begins offering services to an individual with an MRCP would contact the MRCP for information about the care plan. This role should be designed so that it does not become an onerous administrative role for the MRCP.

VCH should also work with clinical care providers and other key partners (including representatives of service clients in the DTES) to establish agreed-upon confidentiality practices amongst clinical and other support services so that said care coordination system is effective.

Often times non-clinical, support workers are those who know the most about the clients' situation and needs. VCH should support information sharing and collaboration between clinical and non-clinical workers; multidisciplinary teams are important to effectively improve the health of these clients.

Lessons from the DTES Integrated Primary and Community Care (IPCC) Pilot, which aimed to reduce unnecessary Emergency Department Use, should inform the development of this care coordination system.

4. Equip providers to case conference concerning complex clients in an effective and hassle-free way

VCH should establish a simple conference call system that allows case conferencing to occur between providers in different locations. Best practices and standards of care for case conferences should be defined in consultation with providers — guidelines to be developed include:

- How to identify the need for case conferencing
- Which issues to cover in initial conference
- Frequency of follow-up conferences/review processes
- What providers should be involved and when (clinical, other support services)
- Access for those not on PARIS (other support services)
- How to encourage full and appropriate client input, participation, and choice in the case conferencing process

5. Improve opioid replacement therapy by expanding methadone slots, providing alternative treatment options, coordinating amongst methadone providers and pharmacists, preventing interruption of treatment, and integrating methadone with primary care and mental health.

VCH should work to expand methadone treatment in the DTES by increasing the number of methadone slots and requiring each physician practicing in DTES to provide both methadone treatment and primary care. As a stop-gap measure, VCH should support the coordination of methadone-prescribing physicians in the DTES. Providers would work towards the goal of having everyone seeking methadone treatment in the DTES able to access it somewhere — physicians would each agree to take on more methadone patients than they have slots. Coordinating between physicians would ensure that each physician and service is shouldering its fair share of the added burden, and that all available slots are being used.

VCH should work to prevent interruptions of methadone treatment. VCH should bring together physicians to create an 'Inter-Clinic Registered Retention Plan' that coordinates services to provide emergency access to methadone treatment 24 hours a day, 7 days a week. The plan could include an outreach component for complex clients and be coordinated with mental health supports (when necessary). Lessons from the 'Stop HIV' program may be beneficial to learn from.

Entry and exit from correctional facilitates can cause interrupted treatment. VCH should discuss how to maintain treatment for people entering and exiting correctional facilitates with appropriate decision makers, which include the College of Physicians and Surgeons, the College of Pharmacists, and the City of Vancouver. VCH should work with the city and with the College of Pharmacists to broaden the number of pharmacies dispensing methadone in the DTES and to ensure that at least one methadone-dispensing pharmacy is open 24 hours, 7 days in the DTES.

6. Build capacity to provide trauma-specific treatment and counseling, embed trauma-informed practices into all DTES services, and provide tertiary mental health services to those beyond Axis 1 diagnoses

VCH should acknowledge that addressing these mental health challenges is central to improving the health and quality of life in the DTES. VCH should build capacity to provide trauma specific treatment and counseling, while working to embed trauma-informed practices into all DTES services (clinical and other support). For those suffering from serious trauma-related mental health challenges, mental health and primary care should be consistent and coordinated with psychiatry to offer well-trained, specialized care.

An intensive, tertiary mental health environment is required to effectively serve some of the most in need individuals struggling with mental health challenges that fall outside Axis 1 — many of these individuals now reside in emergency shelters and do not receive consistent mental health or primary care. VCH should provide tertiary mental health service for these individuals.

7. Form a working group of experts to develop a measurement system for the DTES

We believe the DTES needs a more robust measurement and evaluation system, and we propose a number of elements for this system (below). But in order for such a system to be effective, its development requires guidance from individuals with deeper expertise than us. VCH should convene a working group of experts that would involve some or all of the following organizations and individuals: Evan Wood, and Thomas Kerr from the Urban Health Research Institute, PHSA, VCH Decision Support, Catharine Hume from the Mental Health Commission of Canada, the BC Centre for Excellence in HIV/AIDS, and researchers from SFU.

8. Create a dashboard of five overarching neighbourhood-level indicators that track health needs and health care effectiveness in the DTES

VCH, under the guidance of the expert working group and with the input of service providers, should select, track, and publicize five overarching neighbourhood-level indicators. These indicators should provide basic information about and/or act as effective proxies for:

- The health of the DTES population - who is here and what are their needs?
- The state of priority disease populations in the DTES
- Health service coverage: Are individuals receiving care for each of their health needs? Who is being served and who is not being served?

These indicators would orient service providers towards strategic goals for the healthcare system in the DTES, providing a sense of what the system is aiming to achieve and what progress is being made. As these indicators are tracked over time, they provide evidence about where success is occurring and where current efforts are falling short. Indicators should be chosen so as not to hide the differences amongst population sub-groups in the DTES with overall averages.

The data for these indicators may already be available — efforts should begin with an inventory of available data and an assessment of the viability of candidate indicators from among these data sources. Indicators could potentially be aligned with measures from the Canadian Institute for Health Information. Potential indicators might include some of the following:

- Life expectancy
- Participation in opiate and alcohol replacement
- Housing status
- Drug-use related illness
- Police calls and/or emergency visits
- Hospitalization rates
- All cause mortality rates
- STIs, HIV, Hepatitis C, COPD
- Quality of life indicators

9. Link patient-level data to system-level data

VCH, in partnership with other DTES health care providers, should consider adopting a system that analyzes existing patient data to create population profiles of those receiving care. One such system, the Adjusted Clinical Groups (ACG) system developed at Johns Hopkins University, can analyze data from PHNs, Primary Care EMRs, and other patient records in order to build disease-burden profiles for the population receiving care and also for specific population subgroups. These profiles can then be used to better understand the health service needs of the current population, to predict future health care needs, to examine health utilization data and to track group health status over time.

10. Implement client-centred care planning and track patient satisfaction data
VCH and DTES health care providers should develop shared protocols for client-centred care plans that include goals defined by the clients themselves. Data from these 'shared care' models on whether clients are successfully achieving their own goals should be collected and reported to VCH management, and should be aggregated for the DTES as a whole.

11. Develop program-level quality assessment indicators
Service providers and VCH managers should work together to develop an agreed-upon method of evaluating the quality and effectiveness of services being provided by VCH and by contracted providers.

It may be possible to implement similar quality indicators across different programs, but variation will be required in order to properly measure the effectiveness of each program. Individual managers will have to be equipped to play a part in designing and monitoring the quality assessment indicators. Once quality indicators are set, they can be used to set goals in contracts and service plans.

12. Improve capacity for efficient data-collection
Programs currently have different data collection processes. In order to ensure that data is useful at the patient-level, the program-level, and the neighbourhood-level, data-collection systems will need to be modified. Necessary I.T. infrastructure will need to be put into place to allow data collection and aggregation to occur at low costs, and widespread training will be required. For the sake of feasibility, there should not be considerable increases in the time required from frontline clinicians to input data. Ideally there should be minimal changes to the current methods of inputting data, and new data-collection tools would draw data from the existing electronic systems to create necessary program- and neighbourhood-level information.

Participants

Andrew Larcombe
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Workshop Paper 3

PRIMARY SUPPORTED HOUSING

Produced by the Participants of Service Segment Workshop #3
Held on May 7th and May 14th, 2013

Introduction

This Directions Paper was produced by the participants of the 'Supported Housing Service Segment Workshop' — the third of five workshops hosted by Vancouver Coastal Health (VCH) aimed at improving how services are provided to residents of Vancouver's Downtown Eastside (DTES). This workshop involved seven directors and executive directors representing housing providers and funders (including VCH) operating in the DTES.

This paper summarizes the key recommendations they provided during their deliberations over the course of two full days in May 2013. It offers important guidance on how to gather and share better data, identify priority investments, make more effective use of current resources, and improve planning and collaboration amongst providers and partners in supported housing.

The paper lists six principles for supported housing partners, identifies three major issues facing supported housing providers in the DTES, and proposes six actions that VCH and its partners can take to begin addressing them. These are 'first drafts' suggested by the group while labouring under considerable time pressure and should be treated as starting points for further discussion with a wider range of partners.

The six principles for supported housing partners are:

1. Create appropriate mixed-needs housing;
2. Respect resident preferences;
3. Bring in and/or embed flexible health services;
4. Give residents and housing seekers options to move within and outside the DTES;
5. Use vacancies to address the most critical gaps in the DTES's supported housing system, while balancing for a good 'fit' for the individual and the housing program; and
6. Be consistent and predictable.

The three major issues identified by participants are:

1. The need for better planning, coordination, and cooperation amongst housing providers, health service providers, and funders;
2. The need for system-level information about housing needs and housing programs; and
3. The need for an improved system of housing access and referrals.

The five recommendations put forward by participants are:

1. Embed or provide mobile clinical services in all supported housing sites in the DTES;
2. Form a permanent planning and coordinating table for major partners in housing;
3. Create a housing directory for the DTES that is accessible to all;
4. Create and adopt a shared client vulnerability assessment tool;
5. Create a shared registration list and application form; and
6. Set and share targets for how vacancies are filled.

Participants were unanimous that supported housing is an essential platform for providing health care to individuals struggling with serious mental health and addiction challenges; supported housing provides a foundation of stability for these individuals, without which health services can have only modest health impacts. Participants believe VCH should play a substantial role in making sure vulnerable residents in the DTES have access to appropriate housing with sufficient care and supports, and would like to see greater clarity, consistency, and coherence concerning the roles of BC Housing, the City of Vancouver, and VCH in the provision of housing and the necessary housing supports.

They believe it is possible to create a more effective supported housing system for people in the DTES with the resources currently at the disposal of providers and funders. Participants believe partners and funders should strive for mutual learning and mutual adaptation, and have focused their recommendations on actions that allow better planning, coordination and cooperation to take place amongst all involved.

Yet participants fear that these actions, if approached carelessly, will create bureaucratic procedures that impede, rather than improve, the ability of providers to serve members of the DTES community. Front-line workers and service providers have applied real ingenuity to navigating the current system effectively. Participants caution that the improvements they are suggesting require consistent commitment on the part of all partners to come to the table as equals, find common ground, acknowledge differences in priorities, and make the necessary concessions to keep everyone involved.

The results produced by participants during a short time together signify a clear desire on their part for VCH to play a substantial role in creating a better-coordinated housing system. It shows considerable agreement about how to get there and a willingness to get started. Their work deserves careful study.

How to Read this Report

The content from this report is drawn from discussions held by participants over the course of two days. It has been drafted by independent facilitators and sent out to participants for further edits and final approval. In this way, it has been vetted and authorized by participants as an accurate account of their intentions and recommendations.

The body of the report is divided into three sections: *Principles, Issues, and Recommendations*. During Day One of the workshop, participants were guided by facilitators through a series of discussions about the current state of supported housing in the DTES. Participants concluded Day One by identifying priority issues that they would like to focus attention on during Day Two. The *Principles* and *Issues* sections are drawn primarily from the discussions on Day One.

During their second day together, participants developed recommendations for how to address the priority issues identified during Day One. These recommendations were drafted out in point form by participants, and have been edited to form the *Recommendations* section of this report.

Over the course of the two days, many topics and suggestions were touched on in passing and are not included in the body of the report below. They included:

- The need to prevent hospitals from discharging individuals into shelters;
- The need to find a better way to 'pilot' innovations without problematic repercussions when the pilot phase is completed;
- An interest in exploring minimum standards in the housing sector;
- The importance of addressing the housing needs of underserved population groups, in particular youth leaving care and homeless Aboriginal individuals;
- The need for improved tertiary mental health facilities and long term care facilities for those with mental health and addictions challenges;
- The growing need for services geared at helping individuals age in place in DTES' supported housing.
- The need to divert high-needs individuals from prolonged incarceration; and
- Suggestions about how to improve contrasting practices by releasing calls for proposals at appropriate times of the year, providing sufficient time for organizations to respond, and placing all applicants on a level-playing field by standardizing and simplifying the application process.

A list of participants is included at the end of the paper.

Principles

Supported housing provides an essential foundation for providing health services to marginalized people in the DTES. Without effective housing, health services will have only modest impacts on the health outcomes of these individuals. We believe it is essential for VCH, in cooperation with other partners, to play a substantial, clear, and consistent role in making sure vulnerable residents in the DTES have access to appropriate housing with sufficient care and supports.

We believe that it is possible to create a more effective supported housing system for people in the DTES with current resources. We believe partners can create a more effective housing system if they work to:

1. Create appropriate mixed-needs buildings
Buildings should have a mix of residents who require a range of supports. Mixed housing environments generally make for healthier communities. Providing catered environments for specific populations and highly complex, acute populations may be necessary to ensure these individuals receive the services they require, but funders and providers should strive to expand the range of needs that can be effectively served within each building in order to create healthy mixed communities.

2. Respect resident preference
The support needs of individual residents typically change over time and their wishes about whether to stay or move can also change. To support resident independence and self-determination, housing and support systems need to prioritize the housing preferences of residents as this is critical to improving health outcomes.

3. Bring in and/or embed flexible health services
Life expectancy for residents of the DTES has risen, pushing supported housing providers to adapt as resident needs change over time. When the needs of residents change, the system should work to alter the supports around the individual and bring appropriate supports to them (including primary care, addictions, and mental health services). Clinical services in the DTES should be mobile and/or embedded within supported housing programs as much as possible, and housing providers should be given broader mandates from funders in order to more flexibly deploy the resources at their disposal to support changing client needs. In this way, the individual truly has the option to stay if they wish to do so. Housing should not be linked to receiving particular services and there should not be strict time limits on how long an individual can stay in a particular housing arrangement.

4. Give residents and housing seekers options to move within and outside the DTES
Housing is more than just a unit — it is embedded in a community and that community can help or hinder care. For some, the DTES is the welcoming and accepting community that they have been unable to find anywhere else. For others, it is a chaotic and triggering environment that makes it difficult to address mental health and addiction challenges. Yet options outside of the DTES are few because, in many service settings, individuals facing serious mental health and addictions challenges are not welcome. Supported housing must be suited to the needs of the resident, and providers should work to find a well-suited setting either inside or outside of the DTES. Flexible clinical services should, when possible, move with the individual. In order to create more viable housing options outside of the DTES, VCH must use the tools at its disposal to ensure that services outside the DTES take individuals from the DTES with complex and challenging needs, and work to eliminate the stigma experienced by vulnerable populations.

5. Use vacancies to address the most critical gaps in the DTES's supported housing system, while balancing for a good 'fit' for the individual and the housing program
Vacancies in supported housing should be filled by individuals who have need-profiles that are most underserved by the current housing system, so that over time the housing system adjusts to meet the most critical supported housing gaps for people in the DTES. This should be balanced with the need for good 'fit'; Individual vacancies should also be filled so that new residents are well-suited to the supports available and the culture of the housing program, and also so that new residents help maintain a healthy resident population mix in each building.

6. Be consistent and predictable
When funders and providers set shared goals and priorities, these partners should find ways to keep each other mutually accountable to these long-term commitments while allowing for necessary responsiveness to changing conditions. Contracts should be for extended periods of time and partners should make public commitments in order to create more predictability in the housing system. Roles and responsibilities of different funders should be clear and coherent in order to ensure clients with similar needs receive similar (and satisfactory) levels of service irrespective of the funders involved. Unexpected vacillation and lack of clarity from partners and funders undermines long-term coordination and strong partnerships.

Issues

We believe that three major issues need to be addressed by VCH and partners in order to begin creating a housing system for the DTES that meets the principles outlined above. They are:

1. Better planning, coordination and cooperation amongst housing providers, health service providers, and funders
More coordination and cooperation amongst housing providers, funders, and other service providers is required. VCH must work with providers to create and expand flexible, mobile, and embedded service models. Housing providers and funders must improve the system of intake (so that critical housing gaps for people in the DTES are being addressed) and the system of referral (so that individuals are able, when they desire, to move to another housing environment that better suits their needs). Funders must work with providers to allocate resources and services to meet the changing needs of the resident population as effectively as possible. Funders must also work together to clarify and rationalize their respective roles and responsibilities so that clients with similar needs are receiving sufficient supports irrespective of the building's primary funder.

Yet coordinated planning and cooperation amongst major players in supported housing (BC Housing, VCH, non-profits, and the City of Vancouver) is not happening as much as it should. By acting in an uncoordinated fashion, partners fail to focus their efforts on achieving specific goals over given time periods. Partners end up working at cross-purposes, spreading resources too thinly across multiple priorities to achieve sustained progress, and creating uneven and inconsistent levels of resident support.

2. System-level information about housing needs and housing programs
Day-to-day coordination is made difficult because data is lacking (at the level of the whole DTES) about what populations require supportive housing in the DTES, which populations are well-housed and which are under-housed, what housing is collectively provided, and what types of services are being offered at different locations.

3. Housing access and referrals
Accessing housing in the DTES is opaque, often high-barrier, frustrating, and potentially unfair for many housing seekers. It also requires support workers to expend large amounts of time as they work to understand how vacancies are filled, build relationships with housing providers, and broker spots for their clients.

Recommendations

We have five recommendations that, if implemented, would improve coordination amongst funders and providers of supported housing, create necessary system-level information, and improve housing access and referrals. Taken together, our recommendations create a basis for more informed planning, improved coordination, and shared commitment by all those involved in providing supported housing. They are:

1. Embed or provide mobile clinical services in all supported housing sites in the DTES
VCH should work with all housing providers to ensure basic clinical services are available through either embedded or mobile models at all supported housing sites in the DTES. Housing providers and other funders should commit to creating housing environments that are conducive to effective and cost-efficient health care delivery.

2. Form a permanent planning and coordinating table for major partners
VCH should work to have all major players in supported housing for the DTES (BC Housing, VCH, non-profits, and the City of Vancouver) commit to attending a permanent planning and coordinating table where participants clarify roles and responsibilities, identify housing gaps, coordinate funding, and ensure necessary supports are in place. An effective table will require the consistent participation and commitment of all providers and funders, clear structure and goals, and potentially ongoing neutral 'backbone' facilitation to help overcome roadblocks and maintain momentum. Mechanisms for client input such as client surveys and client representatives should be developed.

3. Create a housing directory for the DTES that is accessible to all
VCH should work with providers and funders to create a simple, transparent, rough-and-ready guide that describes what supported housing programs are available for individuals in the DTES that are seeking housing and what services are being provided in each of these programs. This should be accessible on a website and in print. The directory should be designed in order to be useful for front-line workers making referrals. It should also provide funders and housing providers with a clear and current picture of the full scope of supported housing programs offered in the DTES — a useful tool for planning services and allocating resources.

This guide would organize housing programs into a small number of broad, agreed-upon categories based on those listed on the housing continuum. These categories would be defined with reference to target clientele and ratios of staffing levels to residents.

Each building or housing program would have a standardized description that includes:

- Basic statistics: # of residents, # of 24-hour FTEs, etc.;
- A short description written by the provider that covers the ethos, culture, intent and resident population of the housing program; and
- A list of services, supports, and characteristics for that housing program. Services and supports listed would cover those provided by the housing provider themselves and those provided by other service providers. A standard list would be created — each provider would use the list to select those services provided at their building, and at what intensity. This list could include the following:
  - Home support and cleaning
  - Food
  - Medication management
  - Money management
  - Case management with dedicated case managers

- Case management (liaison, referrals, case planning, waitlist management) without dedicated case mangers
- Women-only/gender specific housing
- 24-hour care
- Embedded primary care
- Outreach primary care
- Crisis response
- Needle exchange
- Managed alcohol
- Peer programs
- Social activities for tenants
- Conflict management
- Family re-connection services
- Life skills training
- Extra maintenance workers to address resident-inflicted damages
- Counseling
- Spiritual support
- Aboriginal cultural support
- Bedbug management
- Hoarding management

4. Create and adopt a shared client vulnerability assessment tool

VCH, other funders, and providers should all adopt an agreed-upon client vulnerability assessment tool. This tool would help providers communicate with each other and with funders about the broad class of housing supports required for individual residents and applicants. In combination with Recommendations 5 and 6, it would help increase transparency and accountability concerning how vacancies are filled. And it would help funders and VCH allocate resources more effectively and arrange necessary embedded services. The tool that is adopted should be simple and strengths-based to the greatest extent possible. Seattle's adoption of the D.E.S.C. deserves study as a model that could be modified for use in the DTES.

5. Create a shared registration list and application form

VCH should work with providers and funders to create a shared, online DTES housing registration list for individuals in the DTES that are seeking residence in supported housing (excluding shelters). Such a registration list would require a shared, web-based, minimum-barrier application form that includes the vulnerability assessment tool described above. The form would be completed with a staff member at multiple existing service locations across the DTES — whether VCH service locations, supported housing buildings, BCH's Orange Hall office, local hospitals, or shelters — and would gather the minimum amount of information required by providers to identify the type and intensity of supports needed by the applicant.

Applicants would be able to work with a service provider to modify their application as their needs change. The registration list should not be cross-referenced with any other database (e.g. PARIS) and privacy concerns should be addressed.

In order to simplify the housing application process for vulnerable individuals and reduce the amount of time front-line workers must expend navigating the housing system for clients, the shared registration list should be used by all housing providers to fill as many of their vacancies as possible. Some housing providers could continue to fill a certain number of vacancies through referrals from specific service providers, institutional sources (prisons, hospitals, youth-care), or from walk-ins, as appropriate. Providers seeking to fill a vacancy from the registration list would be able to pull up a list of those on the registration list who meet particular criteria and select an individual best suited for the vacancy.

The registration list should also be used by providers and funders to collectively identify problems with access to housing in the DTES. VCH, other funders, and major partners should use the registration list to identify groups of high-priority individuals whose housing needs are not being met and/or have been on the registration list for extended periods of time. Funders and providers should develop collective solutions to ensure improved access for these individuals by adjusting targets (see below), funding levels, and housing supports. VCH and other funders should also create and share regular summaries about the housing needs of the DTES that combines summaries of the population on the registration list with other demographic data about the DTES.

6. Set and share targets for how vacancies are filled

VCH should work with other funders and with providers to set targets for how each provider fills vacancies in their housing program. Each program would have a target for referrals from specific services, from institutional sources (prisons, hospitals, and youth leaving care — important sources of homelessness), for walk-ins, and for individuals selected through the central registration list. In order to better align resource allocation with resident population, these targets would be reviewed and modified through discussion with funders when contracts are renegotiated. All service providers
should agree to house some of the 'hardest to serve', as identified through the vulnerability assessment tool and the registration list, and funders should allocate necessary resources and provide sufficient contract flexibility so that housing providers are able to offer appropriate services to these individuals.

All housing providers should agree to release information about their targets and their progress towards them in order to create greater clarity amongst DTES services about how individuals can access each housing program.

Workshop Paper 3

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Workshop Paper 4

COMMUNICABLE DISEASE PREVENTION, SPECIALIZED HARM REDUCTION, HIV TREATMENT SUPPORTS

Produced by the Participants of Service Segment Workshop #4
Held on May 9th and May 16th, 2013

Introduction

This Directions Paper was produced by the participants of the fourth of five Service Segment Workshops hosted by Vancouver Coastal Health (VCH) aimed at improving how services are provided to residents of Vancouver's Downtown Eastside (DTES). This workshop focused on Communicable Disease Prevention, Specialized Harm Reduction, HIV Treatment Supports and involved thirteen managers, directors, and coordinators from VCH-provided and VCH-contracted services.

This paper summarizes the key recommendations they provided during their deliberations over the course of two full days in May 2013. It identifies the weak-points that the DTES' most vulnerable residents fall through as they navigate the patchwork of harm reduction, addiction treatment, and mental health services available, and offers important guidance on how to create a more coherent system of care where investments in one area are not squandered by gaps somewhere else.

The paper identifies seven major issues faced by providers of Communicable Disease Prevention, Specialized Harm Reduction, HIV Treatment Supports in the DTES, and puts forward seven recommendations that VCH and its partners should take to address them. These are 'first drafts' suggested by the group while labouring under considerable time pressure and should be treated as starting points for further discussion.

The seven major issues identified by participants are:

1. Gaps in distribution of basic harm reduction supplies and services across the DTES;
2. Lack of consistent and effective harm reduction practices in VCH, inside and outside of the DTES;
3. Inadequate intensive harm reduction services for the diversity of drug users in DTES, including cultural communities, LGTBQ2S people, youth, polyusers, crystal meth users, crack cocaine users, heroin users, and illicit drinkers;
4. Undersupply of effective, affordable and dignified opioid, stimulant, and non-beverage alcohol replacement therapies;
5. Unaddressed trauma-related mental health illnesses;
6. Interruptions in care for those with communicable diseases and other health challenges that need consistent contact with the health system; and
7. Regulations and rules that impede client capacity to improve their health and prevent frontline services from providing the best care.

The seven recommendations for VCH put forward by participants are:

1. Expand coverage and coordination of the 24-hour provision of basic harm reduction supplies and services across the DTES, and harmonize harm reduction practices with other service mandates;
2. Improve VCH's harm reduction practices through an anti-stigma campaign and robust 'Standards of Practice' for harm reduction in community, primary, and acute care settings;
3. Create and expand harm reduction facilities and programs, including expanded supervised injection and new managed opiate, managed alcohol, supervised inhalation, peer, and addiction diversion programs;
4. Improve availability of low-cost, low-barrier methadone;
5. Embed trauma-informed practices and expand trauma-specific services in VCH and contracted providers in the DTES;
6. Avoid interruptions in care for those with communicable diseases and other health challenges that benefit from consistent contact with the health system; and
7. As part of VCH's 'ethic of care', champion regulatory changes that improve the health of clients and increase capacity of services to provide the best care.

Participants encourage VCH to build on the important victories that have been achieved so far in the DTES — victories that came about because policies and programs were designed to reduce the stigmatization of the Vancouver's most vulnerable residents. Participants are strong believers that providing drug users with a diversity of harm reduction and treatment options, and proactive attempts to address underlying mental health challenges are key components of a cost-effective strategy to improve DTES health outcomes. They agree that rebuilding momentum and closing the remaining gaps in these areas requires strengthened relationships and VCH leadership, and look forward to continued work in the areas described herein.

How to Read this Report

The content from this report is drawn from discussions held by participants over the course of two days. It was drafted by independent facilitators and sent out to participants for further edits and final approval. In this way, it has been vetted and authorized by participants as an accurate account of their intentions and recommendations.

The body of the report is divided into two sections: *Issues and Recommendations*. During Day One of the workshop, participants were guided by facilitators through a series of discussions about the current state of Communicable Disease Prevention, Specialized Harm Reduction, HIV Treatment Supports in the DTES. Participants concluded Day One by identifying priority issues that they would like to focus attention on during Day Two. The *Issues* section is drawn primarily from the discussions on Day One.

During their second day together, participants broke into working groups to develop recommendations for how to address the priority issues identified during Day One. These recommendations were drafted out in point form by participants, and have been edited to form the *Recommendations* section of this report.

Over the course of the two days, many topics and suggestions were touched on in passing and are not included in the body of the report below. They included:

- The need for expanded Hepatitis C treatment for vulnerable DTES residents;
- The need to prevent HIV + individuals from contracting multiple strains of HIV;
- The importance of complementing research with advocacy;
- The asynchronous disbursement of welfare payments in the DTES;
- Uneven access to methadone and harm reduction supplies such as needle exchanges in jail;
- The disconnect between mental health and addictions workers;
- The violence experienced by many vulnerable women in the DTES, and the lack of safe community spaces for women fleeing violence;
- The need for better planning around how to continue successful pilot programs;
- Expanding the use of medical marijuana;
- The importance of developing simple yet effective evaluation systems that are easy to implement;
- The potential impact of offering funding to organizations to complete RFP processes;
- The potential impact of focusing shared efforts on a limited number of goals for a limited time period; and
- The ageing of DTES residents.

A list of participants is included at the end of the paper.

Issues

We believe that there are seven priority issues that must be addressed in order to create a more coherent and effective system of care for the most vulnerable residents of the DTES. They are:

1. Uneven distribution of basic harm reduction supplies and services across the DTES

Harm reduction services are geographically centered in the DTES, especially along Hastings corridor. In consequence, there are many pockets in the DTES where people do not have quick access to harm reduction services. In addition, the services that do exist are often not open 24 hours a day, 7 days a week. This undermines the effectiveness of harm reduction services, which must be easy to access and available when needed.

Harm reductions services sometimes struggle to provide sufficient harm reduction supplies in the face of demand, which limits the reliability of services for clients. Part of this struggle may come from a lack of understanding about how to get approval from VCH to order free supplies through the BC Harm Reduction Strategies and Services Group, and about how to navigate the process of receiving those supplies through primary 'Ordering' sites and secondary 'Satellite' sites. The pulmonary health of many clients have benefited from the limited provision of crack pipes in the DTES. BC Harm Reduction Strategies and Services (BC HRSS) is not adequately funded to provide crack pipes, nor sterile filters for injection drug use. In health services across the DTES, best practices are not always met in terms of availability of all recommended safer injection, safer smoking, and safer sex supplies.

Current harm reduction programs do not always adequately serve all populations groups in the DTES. Individuals in certain population groups — women, LGBTQ2S people, MSM Aboriginal people, youth — are disproportionately underserved in the DTES; current harm reduction programs sometimes work at cross-purposes with attempts to create safe and welcoming spaces for these underserved, marginalized populations within the DTES.

2. Lack of consistent and effective harm reduction-informed practices in VCH, inside and outside of the DTES

Harm reduction is not practiced effectively by all VCH service providers (inside and outside of the DTES). Though standards of practices do exist for supply providers and addictions clinicians, there are not standards of practice for harm reduction across all VCH settings (e.g. mental health, acute care, etc.).

VCH services range from high-performing, internationally recognized harm reduction services to those who have yet to adopt effective harm reduction practices. There are significant bureaucratic and cultural barriers within parts of VCH that prevent effective harm reduction work from being done across the organization. For instance:

- There are internal cultures that discourage a commitment to harm reduction, including considerable stigma concerning harm reduction practice and the populations who benefit from harm reduction services. Some VCH staff and contracted service providers are dismissive of, or hesitant to adopt harm reduction. Not all clinical practitioners know how to appropriately treat and manage complex clients who have concurrent disorders; some feel uncomfortable dealing with this population, and lack the awareness and understanding needed to provide effective harm reduction.
- VCH and Ministry of Social Development compensation policies make it difficult for VCH programs to incorporate peer workers into VCH services despite the fact that it is cost-effective for VCH, and when employed appropriately in partnership with professionals, enhances effective harm reduction practices. Peer workers are important to effective harm reduction practices because they can sometimes be more accessible and effective educators and role models than professionals.
- Highly-medicalized and professionalized models of services do not make adequate space for paraprofessionals and peer support workers that are important for good harm reduction practices. A blended model that combines the strengths of professionals, paraprofessionals and peers is the most effective.
- Several DTES non-profit organizations are leaders in the field of harm reduction, however VCH does not do enough to harness the knowledge and experience of these non-profits in order to support internal changes at VCH.

3. Inadequate intensive harm reduction facilities for the diversity of drug users in DTES, including youth, LGTBQ2S people, women, polyusers, crystal meth users, crack cocaine users, heroin users, and illicit drinkers

The availability of intensive harm reduction facilities is inadequate in the DTES. Insite is running over capacity and only from 10:00 a.m. to 4:00 a.m., leaving a 6-hour gap each day during which injection drug users have an elevated risk of fatal overdoses. Similar services do not exist for crystal meth users, crack cocaine smokers, and illicit drinkers. Clinically consistent and affordable opiate medications are unavailable to most drug users, encouraging the consumption of low quality illicit drugs that have been mixed with dangerous substances. The poor quality of drugs available has diminished the resilience of long-time drug users and increased the chances of illness, injury and deaths from overdose. The impact of testing kits is unclear and requires further research. Testing kits do empower some drug users to make decisions about what to consume and how, while for others they have relatively little impact on adverse drug reactions because users do not have access to alternative substances that satisfy their addictions.

Increased access to harm reduction for minors is a contentious issue that requires further study and direction from VCH leadership. An increasing number of minors are looking to access harm reduction services in the DTES; these services have been designed for adult populations. Care providers offering harm reduction find it difficult to balance the dictates of harm reduction practices, which encourage the creation of welcoming environments for all who need and want these services, with the statutes and requirements of child protection when working with vulnerable, neglected, and/or abused minors. Some foundational work has been done in this area already; BC CDC created guidelines for harm reduction and mature minors, but no collective effort has been made by VCH and service providers to adapt and adopt similar guidelines for the DTES.

Some vulnerable women, especially those who have experienced (or are currently experiencing) violence, do not always feel safe when accessing mixed-gender intensive harm reduction facilities, and so are sometimes prevented from seeking their services.

4. Undersupply of effective, affordable and dignified opioid replacement therapies

Effective, affordable and dignified opioid replacement therapies allow individuals to stabilize, manage and treat their opioid addiction. Currently, VCH physicians and contracted physicians prescribe and dispense methadone in the DTES; private providers also dispense methadone. Residents of the DTES who want to begin methadone therapy are not always able to receive it because physicians who have methadone licenses are operating at capacity, and some VCH and contracted physicians do not have methadone licenses.

Though some VCH and contracted services also dispense methadone, some clients go to private providers to fill their methadone prescription because some private pharmacies purportedly provide incentives (including cash payments), are more conveniently located, have longer hours, or because VCH and contracted services are operating at capacity. These financial inducements by private pharmacies are ethically questionable (and an ongoing focus of the College of Pharmacists). These private operators also purportedly charge dispensing fees for methadone, placing serious costs on low-income, vulnerable individuals.

Some vulnerable women, especially those who have experienced (or are currently experiencing) violence, do not always feel safe when accessing mixed-gender methadone clinics, and so are sometimes prevented from seeking opioid replacement treatment.

5. Unaddressed trauma-related mental health illness

There is an extremely high prevalence of trauma-related mental health challenges among residents of the DTES. Many of the mental health illnesses faced by residents of the DTES are rooted in trauma, yet trauma has gone largely unaddressed in the provision of mental health services in the neighbourhood. There is a lack of trauma-informed care amongst those working in the DTES. We are beginning to work with second- and third-generations of DTES families — current programming has done little to explicitly prevent the intergenerational transmission of trauma from parents to children, and there are inadequate trauma-specific services for children.

Trauma often leads to personality-related disorders found in Axis II of the Diagnostic and Statistical Manual of Mental Disorders. Axis II clients are sometimes difficult for traditional service providers to serve, and can have challenging behaviour that traditional service providers sometimes struggle to manage effectively. In our experience, service providers who lack background and understanding regarding how to care for and manage these clients occasionally respond to these challenges by excluding them from services.

Effective trauma-informed care often includes providing basic social supports and low-barrier activities and programming that engage and stabilize the client enough to begin talk therapy. Yet the interventions that are given sufficient funding as part of mental health treatments in the DTES (and elsewhere) do not include these approaches.

6. Interruptions in care for those with communicable diseases and other health challenges that need consistent contact with the health system

Many clients who require consistent contact with the health system are 'lost to care' — i.e. they do not remain in consistent contact with their care providers. Those with communicable diseases and other health challenges need this consistent contact with the health system in order to stabilize and improve their health. Those who are at risk of being lost to care lack special support and outreach. Clinical care providers and existing outreach services lack effective coordination, which has lead to unnecessary and avoidable numbers of clients 'lost to care'. Those recently incarcerated within or released from a correctional facility appear to face barriers to maintaining contact with the health system. Large numbers of individuals in pre-trial jail sometimes do not have sufficient access to mental health care, needle exchanges, or methadone. There is still a gap in understanding exactly who is at risk of being lost to care, who may be better served by outreach, and what service barriers need to be addressed to reduce interruptions in care.

7. Regulations and rules that impede our clients' capacity to improve their health and prevent us from providing the best care to our clients

Certain regulations, high barrier systems and rules impede our clients' capacity to improve their own health and prevent us from providing them with the best care. Public services broadly were not set up to serve our clients; consumers of our services have been failed and marginalized by our public services — by schools, child protective services, residential schools, police and the justice system, and by health care providers. In order to serve people with needs that are often very different from the general population, we work at the margins of these different systems - health, housing, criminal justice, Ministry of Children and Family Development - often working to fit services to the needs of challenging populations rather that trying to force these populations to fit the needs of high barrier systems.

These systems overlap and each has limited resources. Thus, the regulatory and funding environment we face is complicated, difficult to navigate, haphazardly designed, and often it ends up preventing us from doing our work, which is serving vulnerable and disenfranchised people. The system wasn't designed for them, and by extension it wasn't designed to enable those who serve them.

Some examples include:

- The criminalization of HIV compounded with the lack of anonymous testing for HIV in BC has discouraged people from getting tested;
- Changes to Healthcare Benefit Trust (HBT) have left certain non-profits with unfunded employee benefit liabilities;

- Inflexible guidelines at regulatory authorities (e.g. College of Physicians and Surgeons) and Health Ministry directives around methadone have led physicians to arbitrarily cut down people's methadone prescriptions without notice despite the fact that many of these clients have been functioning at a particular dosage effectively for many years;
- The lack of consumer/client complaint system and lack of ombudsperson or advocate for marginalized clients means many do not feel safe coming forward to complain about poor services received from someone with immense power over them;
- Current drug policy, justice policies, and policy around HIV lack a public health lens, leading to systemic marginalization and worsening health of consumers of our services;
- The lack of Federal Section 56 exemption from the Controlled Drugs and Substances Act for supervised injection facilities, supervised inhalation facilities, and pharmaceutically assisted therapy including heroin assisted therapy in clinical practice)
- The creation of VCH and the disappearance of direct channels for non-profits to bring issues to the Ministry of Health has so far meant the loss of opportunities for non-profits to raise and discuss important provincial policy issues with appropriate decision makers. VCH is not currently structured to facilitate the communication of concerns between non-profit providers and the Ministry of Health —VCH managers are kept busy with their other responsibilities, and unclear lines of responsibility and hierarchical barriers that limit access further up the VCH and provincial chain of authority make it hard for issues to find their way past the managerial level within VCH.
- In some cases, VCH has not offered robust evidence-based harm reduction services due to staff or public resistance.

Such regulations, rules, and management practices stand in the way of our work. Trying to change these regulations eats up limited resources and energy, and the lack of change discourages frontline providers.

Recommendations

We have seven recommendations that, if implemented, would fill the service gaps that continue to undermine health care investments aimed at serving the DTES' most vulnerable residents. They are:

1. Expand coverage and coordinate 24-hour provision of basic harm reduction supplies and services across the DTES, and harmonize harm reduction practices with other service mandates

VCH should build on current work to create better coverage of basic harm reduction services in the DTES through the following actions:

- VCH should build on the work of the harm reduction service providers group to better coordinate services so that there are harm reduction options that cover the whole DTES geographically and are available 24 hours a day, 7 days a week.
- VCH should work with the Ministry of Health to ensure the BC HRSS is adequately funded to distribute all necessary harm reduction supplies, including crack pipes, meth pipes, and sterile filters for injection drug use. Until the Ministry of Health funds the BC HRSS to provide these supplies, VCH should expand current purchasing of supplies to ensure necessary coverage.
- VCH should work with the Ministry of Health, College of Pharmacists and pharmacies to increase the availability of basic harm reduction supplies, including safer injection, safer smoking and safer sex supplies.
- VCH should expand and coordinate the use of outreach vans. It should explore new, lower-barrier models of harm reduction such as harm reduction dispensing machines, and peer-administered naxolone — VCH should continue to partner with BC HRSS on the 'Toward the Heart' project to advocate for changes to provincial prescribing guidelines that will make peer-administered naloxone possible.
- VCH should work with all service providers to ensure they are able to meet guidelines for stocking and providing basic harm reduction supplies. VCH should encourage the adoption of these guidelines while acknowledging the need for flexibility amongst different services based on their goals and the population they served.

In order to improve the accessibility of harm reduction programs for all population groups in the DTES, VCH should convene dialogues with service providers and clients in order to develop harm reduction materials and guidelines that are suited to specific underserved populations, including Aboriginal people, MSM, LGBTQ2S people, Chinese residents, and women. These dialogues would explore how to modify and adapt harm reduction practices so that these populations feel 'culturally safe' when seeking services while still benefitting from harm reduction principles. Lessons from these dialogues could inform current harm reduction services, help expand harm reduction services on offer, and improve coordination between harm reduction and other services.

Access to harm reduction for minors is a contentious issue that must be addressed due to increasing demand by minors for these services. VCH should enlist an ethicist as well as VCH Risk Management, and convene an expert working group to develop further practice guidelines that clarify the relationship between good harm reduction practice and mature minor guidelines. This should build on the work already done by BC CDC on mature minors and harm reduction in order to develop DTES/VCH specific guidelines that will be relevant, appropriate and practical to their services.

Orientation training for these specific guidelines should be provided after they are developed to ensure frontline workers are empowered and comfortable putting them into practice. This would help front-line providers navigate the sometimes morally complex and conflicting requirements of good harm reduction practices and responsible child protection. Guidelines would then assist professionals in navigating this moral borderland in order to provide harm reduction and child protection practices ethically and effectively.

2. Improve VCH's harm reduction practices through an anti-stigma campaign and a robust 'Standard of Practice' for harm reduction in community, primary, and acute care settings.
VCH leadership should build on its past successes (such as its leadership in supporting supervised injection) and endeavor to 'catch up' to field-leading non-profits in their ability to offer effective harm reduction services. This effort should go beyond VCH's DTES services to include all of VCH's mainstream services. This will help prevent people from having to come to the DTES to receive effective harm reduction services. While some work is already underway in this area, it should be ramped up significantly.

VCH leadership should make harm reduction a standard, not a choice, in VCH services across the organization. VCH should build on current harm reduction Standards of Practice that already exist in certain service areas to create service-specific harm reduction 'Standards of Practice' for all VCH service areas. These could include requirements for providing appropriate supervised injection and supervised consumption services. These standards would be applied and enforced throughout VCH in community, primary, and acute care settings. Key partners in this effort may include VCH Employee Engagement, the College of Nurses, College of Physicians and Surgeons, College of Social Workers, and the College of Pharmacists.

VCH should also work with other, non-VCH public service providers such as law enforcement officials, firefighters and the provincial ambulance service to establish standards for harm reduction practices in those public services.

Improving harm reduction practices within VCH requires changing bureaucratic processes that makes delivery of harm reduction services difficult — risk management approaches and compensation policies need to be altered in order to make it easier to engage peer workers and advisors into VCH services. Greater adherence to the harm reduction guiding principle of 'drug user involvement' in creating and delivering services is needed in VCH. Appreciation in VCH for the existing contributions of peer workers to effective harm reduction is required — VCH should create guidelines and practice standards which ensure more meaningful, low-barrier, peer involvement in harm reduction services, as well as opportunities for peer advisory within the health authority.

VCH should engage in training and an anti-stigma campaign in order to encourage changes to clinical practices in VCH services across the organization. Awareness-raising and training would help shift culture around harm reduction activities and build greater comfort with the population who often need harm reduction support. Training may involve hiring non-profit providers who are leaders in harm reduction as teachers. These trainings could include online components and be made available to contracted organizations.

3. Create and expand harm reduction facilities and programs, including expanded supervised injection and new managed opiate, managed alcohol, supervised inhalation, peer, women-only, and addiction diversion programs and facilities
VCH should create and expand intensive harm reduction facilities and programs available to drug users in the DTES. Greater use of peers in the operations of these facilities may improve the effectiveness and reduce the cost of these harm reduction programs.

VCH should build on its previous leadership concerning supervised injection programs by expanding access to supervised injection. VCH can do so by developing a business case for keeping InSite open 24-hours a day. Currently, supervised injection services are only available from 10:00 a.m. to 4:00 a.m. each day, leaving a perilous 6-hour gap between 4:00 a.m. and 10:00 a.m. when vulnerable injection users are unable to inject under supervision and face serious threat of fatal overdose. VCH should also work towards opening a second safe injection site in the DTES to increase the geographic coverage and accessibility of these services. Utilizing the Ministry of Health's *Guidance Document — Supervised Injection Services,* VCH should identify opportunities to build supervised injection services into existing services, such as housing sites and community health centres.

In order to more appropriately serve the diversity of drug users in the DTES, VCH should take a leadership position in establishing supervised inhalation services for the population of seriously addicted individuals in the DTES. These individuals are often using the same illicit drugs as at InSite, but are using them through a different mode of administration (smoking or snorting). In establishing this site, VCH should look to established best practices in other jurisdictions, such as Switzerland, that have offered both supervised injection and inhalation of illicit substances.

VCH should also build on the existing evidence base regarding the effectiveness of managed alcohol facilities and expand them accordingly, in residential facilities and elsewhere.

VCH should advocate for prescribing changes which would permit the development of a peer-to-peer naloxone program. Overdose prevention and intervention education should be improved for peers and service providers, as should the overdose alert/ 'bad

dope' system. VCH should seriously explore the development of an intranasal naloxone research collaboration and first responder (e.g. VPD) naloxone administration (as occurs in other police jurisdictions such as New Mexico). VCH should also explore the development of an addiction diversion unit that provides cost-effective and appropriate care to vulnerable drug users who are at risk of frequent emergency department visits (San Francisco's model of a home-like, community based addiction diversion unit is worth examining).

VCH should work with partners towards the creation of a medicalized managed opiate program that is a standard part of clinical care rather than a research study. VCH needs to build on the extensive research and evidence base already available concerning medicalized managed opiate programs, and take a leadership role in advocating for managed opiate and other substitution therapies as part of standard clinical care.

VCH should work with service providers to create women-only hours where women who have experienced or are fearing violence are able to safely access harm reduction facilities and programs. VCH should also study whether there is sufficient demand to create specific women-only harm reduction facilities.

4. Improve availability of low-barrier methadone

VCH should work with physicians, nurse practitioners, and pharmacists to improve the availability of low-barrier methadone. VCH and contracted services should be supported in scaling up methadone prescription and dispensing programs. All VCH and VCH contracted physicians in the DTES should have a methadone license within three months of arrival in the DTES, and VCH should work to allow nurse practitioners to prescribe methadone.

VCH should work with methadone providers and dispensers to make low-cost, low-barrier methadone available 24 hours a day by re-organizing the operations of current programs. VCH should work with service providers to create women-only hours at certain methadone providers, so that women who have experienced or are fearing violence are able to safely access methadone. VCH should also consider creating specific women-only methadone facilities.

5. Embed trauma-informed practices and expand trauma-specific services in VCH and contracted providers in the DTES

All health care providers in the DTES — VCH and contracted — should be encouraged by VCH to adopt a trauma-informed ethos and adjust their care practices accordingly. The foundation of strong trauma-informed care practices exist in the DTES — harm reduction, one of the DTES' strengths, complements trauma-informed care because both focus on making sure clients are treated with dignity and meet their immediate needs at the first point of contact with the health care system.

Mental health services in the DTES should be modified to place greater focus on trauma-informed and trauma specific services that serve clients with Axis II personality-related disorders, since many Axis II mental health disorders are rooted in traumatic experiences. Talk therapy, consistent social support, and more low-barrier activities and programming can be important components of an effective mental health intervention for Axis II clients. In order to better serve Axis II clients, community mental health services should be reorganized so that mental health teams seek out those most in need by embedding themselves in housing and in low-barrier service environments, and/or engage in more systematic outreach activities. Mental health teams should be designed to provide talk therapy and counseling to clients in need (rather than primarily focusing on medication administration), and to coordinate with low-barrier services and programs that provide a therapeutic environment for individuals. Mental Health teams and services should be resourced with salaried counselors that can provide talk therapy to supplement mental health interventions for the most challenging and vulnerable (including those with Axis II diagnoses).

Care for families in the DTES should include a greater focus on preventing the intergenerational transmission of trauma from parents to children. VCH should work with Public Health to develop an early years (0-5 years) strategy that increases the availability of trauma-informed support to parents and facilitates access to trauma-specific services for children.

6. Avoid interruptions in care for those with communicable diseases and other health challenges that benefit from consistent contact with the health system

Health care savings and improved client outcomes can be achieved by avoiding interruptions in care for certain clients. Models developed through the STOP HIV/AIDS program provide useful models for effective partnerships between clinical care providers and outreach workers in order to prevent interruptions in treatment. To avoid interruptions in care for other patient groups, VCH should attach existing outreach services to clinical care providers, including clinics and mental health teams. Clinical care providers would proactively identify individuals who are at risk of being lost to care and request support from their designated outreach partners. The clinic would recommend clients to be added to the outreach caseload based on their health needs, their consistency making it to appointments, and the need for follow up concerning self-managed care. Each day, the clinic could notify their affiliated outreach team about upcoming clinic appointments for outreach clients, and/or about general health issues that the outreach worker should follow up about with the individual. Care providers located in clinics would also be encouraged to accompany outreach workers into housing settings in order to bring health services to particularly hard to reach clients.

VCH should work with service providers involved in the 'lost to care' initiative to analyze professional, paraprofessional and client experiences, as well as records and data from outreach/clinical partnerships to better understand who is at risk of being lost to care, who is being well-served by outreach partnerships, and what other systemic and/or professional barriers have inadvertently lead to disconnection from care and still need to be addressed. This research could be a basis for system improvements and changes in professional culture that reduce barriers faced by certain groups in accessing and returning to care.

People released from hospitals and correctional facilities are at especially high risk of being lost to care. VCH should create a central DTES outreach liaison worker whose job is to keep record of individuals being released from correctional facilities and hospitals who may require outreach services in the DTES, and then to link the individual to community care via outreach teams. This will require VCH to seek the commitment of hospitals and prisons to contact the DTES outreach liaison worker. Conversely, VCH needs to ensure adequate healthcare services follow people into the criminal justice system so that they are not, inadvertently, lost to care when they enter the criminal justice system (e.g. jail) where they have limited or no access to basic standards of care including needle exchange or methadone, and mental health care.

7. As part of its 'ethic of care', champion regulatory changes that improve the health of our clients and our capacity to provide the best care to consumers of our services.
VCH should stand beside its front line workers concerning important system issues they face while operating on the DTES. VCH should champion certain regulatory changes that will improve care and improve health for DTES residents.

Any regulatory changes that are achieved need to be concurrently followed up with professional colleges (such as the College of Physicians and Surgeons of BC) in order to ensure that changes in the research and regulatory coincide with clinical practice.

VCH should act as a conduit for front-line concerns with regulatory issues that impede effective health care and service delivery. VCH should create venues for service providers and managers to come together and identify, explore, address and advocate with respect to regulatory issues. Meetings should occur on an issue-by-issue basis, and recommendations that flow from these meetings need to be examined by VCH's policy analysts and taken up with the appropriate decision-makers by VCH leadership.

VCH should also create partnerships with other ministries and funders to share resources and co-fund programs that serve the residents of the DTES. In particular, VCH should work to develop an inter-ministerial strategy on the next generation of harm reduction modeled after the Vancouver Agreement.

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Workshop Paper 5

LOW BARRIER GATEWAY, NAVIGATION, AND SOCIAL SUPPORT SERVICES

Produced by the Participants of Service Segment Workshop #5
Held on May 10th and May 17th, 2013

Introduction

This Directions Paper was produced by the participants of the last of five Service Segment Workshops hosted by Vancouver Coastal Health (VCH) aimed at improving how services are provided to residents of Vancouver's Downtown Eastside (DTES). This workshop focused on Low Barrier Gateway, Navigation, and Social Support Services and involved seventeen managers, directors, and coordinators from VCH-provided and VCH-contracted services.

This paper summarizes the key recommendations they provided during their deliberations over the course of two full days in May 2013. It offers important guidance on underserved populations, service coordination amongst diverse providers, and opportunities for system leadership on the part of VCH.

The paper identifies five major issues facing providers of Low Barrier Gateway, Navigation, and Social Support Services in the DTES, and puts forward six recommendations that VCH and its partners should take to address them. These are 'first drafts' suggested by the group while labouring under considerable time pressure and should be treated as starting points for further discussion.

The five major issues identified by participants are:

1. Accessibility and 'cultural safety' for specific populations;
2. Violence against women;
3. Understanding the importance of low-barrier services;
4. System leadership within government bureaucracies; and
5. Evidence in public discourse concerning the DTES.

The six recommendations for VCH put forward by participants are:

1. Support and enable low-barrier, client-centred health service models;
2. Address the needs of vulnerable women in the DTES and promote a culture of anti-violence;
3. Ensure all services are accessible to specific populations, while also supporting the growth of services tailored to specific underserved populations;
4. Commit to learning about the emerging and long-standing challenges that service providers face while caring for DTES clients, and the innovative responses that have been developed to address them;
5. Analyze policy barriers and initiate problem-solving with government partners; and
6. Become a public authority on health in the DTES, providing data and evidence for public consumption about what works when it comes to improving health for high-needs populations in the DTES.

Participants recognized that VCH is one of the most supportive and amenable public agencies operating in the DTES. Yet they worried that low-barrier services are still poorly understood by VCH decision-makers, and that changes to VCH's activities in the DTES could make it more difficult for them to meet the needs of their already-vulnerable clients. They believe there are many opportunities for VCH to help increase system effectiveness in the DTES, but in order to do so, all partners need to build on previous accomplishments in order to better bridge the professional cultures of mainstream health providers and frontline workers in the DTES.

The results produced by participants during a short time together show that there is considerable agreement about which populations are most underserved in the DTES and about what role VCH should aspire to play in the DTES. Their work deserves careful study.

Workshop Paper 5

How to Read this Report

The content from this report is drawn from discussions held by participants over the course of two days. It was drafted by independent facilitators and sent out to participants for further edits and final approval. In this way, it has been vetted and authorized by participants as an accurate account of their intentions and recommendations.

The body of the report is divided into two sections: *Issues and Recommendations*. During Day One of the workshop, participants were guided by facilitators through a series of discussions about the current state of Low Barrier Gateway, Navigation, and Social Support Services in the DTES. Participants concluded Day One by identifying priority issues that they would like to focus attention on during Day Two. The *Issues* section is drawn primarily from the discussions on Day One.

During their second day together, participants broke into working groups to develop recommendations for how to address the priority issues identified during Day One. These recommendations were drafted out in point form by participants, and have been edited to form the *Recommendations* section of this report.

Over the course of the two days, many topics and suggestions were touched on in passing and are not included in the body of the report below. They included:

- The large numbers of vulnerable DTES residents with untreated Hepatitis C;
- The importance of supported housing as a foundation for health care;
- Improving cooperation with the private sector in the DTES;
- The unresolved tension between providing effective harm reduction to those aged under 19 and the statutes and responsibilities that is child protection requires;
- The efficiency gains that can be achieved through peer-driven drug treatment programs;
- The need for supervised inhalation and managed alcohol programs;
- The benefits of legalizing drug use;
- Meeting the needs of the ageing population on the DTES; and
- Creating an annual organization forum to celebrate and learn from each other.

A list of participants is included at the end of the paper.

Issues

We believe that there are five priority issues that must be addressed in order to better meet the needs of the DTES' most vulnerable residents. They are:

1. Accessibility and 'cultural safety' for specific populations
A number of specific population groups face considerable barriers in accessing services in the DTES. These groups include women, Aboriginal people, families with children, seniors, youth, and members of the Chinese community. These barriers are especially concerning when some of these groups make up large percentages of the residents of the DTES and/or are proportionately over-represented in the DTES when compared to the general population. Individuals in these population groups often report feeling unwelcome, misunderstood, and/or poorly served in DTES health services.

2. Violence against women
Women are, tragically, the biggest commodity in the DTES. Their bodies are bought, sold, traded, fought over, and subjected to brutalizing violence.

Violence against women occurs everywhere in our society. Yet there is a particular culture of violence in the DTES that is accepted as a matter of course. Violence against women happens in shelters, in housing, and in the street, and few seem ever to be called to account for their role in allowing it to occur. The worst perpetrators — a handful of violent drug dealers — are widely known yet still go free. Some DTES men, who are victims of violence and abuse themselves, lash out at those even more powerless than they are. And men from outside the DTES, often inebriated, come into the neighbourhood to hurt vulnerable women. We have collectively failed at providing safe alternatives to women who are drawn to the DTES, and once they arrive, vulnerable women have so few viable options for leaving the DTES that they are essentially trapped. Most programs are mixed-gender and male dominated, making services inhospitable to women who are trying to escape violence.

Theirs is a story of poverty and survival, and we see far too little being done by VCH to address their needs.

3. Understanding the importance of low-barrier services
Too few health professionals and planners understand why low-barrier services are essential to meeting the health care needs of marginalized populations. Because low-barrier services seek to shrink the divide between 'provider' and 'client', providers of low barrier services are sometimes given less professional respect, and their concerns are given less attention than other health care professionals. Yet bridging the divide between providers and clients is what makes low-barrier services effective for marginalized people.

Our work is what brings people in the door, helps them trust service providers when they have lost all trust in those who are supposed to help them, and makes them comfortable enough to start getting help with the challenges they are facing. We provide basic, holistic care in an extremely affordable manner. The health system simply cannot serve these individuals without effective low-barrier services, and other providers can learn a great deal from low-barrier practices about how to serve marginalized populations.

Despite this, in our experience, the further one gets from the front line in the DTES, the harder it becomes to find decision-makers and health-care providers who understand our work and see the importance of addressing our challenges. The healthcare system is set up to make discrete interventions to fix discrete problems — an approach that fails to help people who face multiple, compounding, complicated health challenges. Low-barrier services are treated as peripheral when they should be treated as essential, which has lead to poor health outcomes and misallocation of resources in the health authority.

4. System leadership within government bureaucracies
Uncontroversial (though administratively complicated) changes to certain policies and practices of government ministries could improve the health of DTES residents and the health system in the DTES. Yet, in our estimation, VCH frequently does not make the most of the opportunity provided by its position to encourage and facilitate the administrative and managerial changes that would advance the health of residents of the DTES.

An incomplete list of examples includes:

- Social assistance is paid out on the same day for everyone, and in one lump sum. This creates negative social dynamics and poor health outcomes for people struggling with drug addictions in the DTES.
- Probation officers often structure probation in such a rigid way that people suffering from mental health and addictions challenges — people who live in chaotic environments, with cognitive impairments and/or dissociative tendencies — are unable to meet their probation requirements. This leads to probation breaches and unnecessary prison time. Evidence collected by the Native Courtworker and Counselling Association illustrates the extent of this problem. Consultation with community agencies knowledgeable about these individuals would help officers structure probation in a way that works both for the individual and meets legal requirements.
- Individuals who are held in pretrial jail are sometimes evicted from housing because no one knows where they are. Preventing such occurrences would prevent a housing crisis for these individuals and save housing workers the time required to re-house individuals who didn't need to lose their housing in the first place.
- First Nations courts that used circle sentencing and other modified justice procedures have been shown to be effective at addressing crimes committed by Aboriginal individuals in other parts of the province. While certain limited options are available for Aboriginal individuals involved in the criminal justice system (an Aboriginal case worker at Downtown Community Court, referral to the First Nations Court in North Vancouver, and the Vancouver Aboriginal Transformative Justice Services), there is a lack of robust culturally appropriate legal options for Aboriginal people on the DTES.
- The Ministry of Health sometimes sets priorities and outlines best practices that are not well-suited to the circumstances of residents and care providers in the DTES. Non-profit providers in the DTES struggle to communicate directly to the MoH about the special circumstances of their work.
- Other health authorities in BC often do not effectively serve the high-need population groups that are served in the DTES, driving individuals to the DTES in search of services that meet their needs and also preventing individuals who want to leave the DTES from doing so due to a lack of appropriate, non-stigmatizing services elsewhere.
- The Societies Act encourages the professionalization of non-profits, making it difficult to build and maintain organizations that are peer-based. Yet organizations with strong peer components are some of the most effective low-barrier service providers in the DTES.

5. Evidence in public discourse concerning the DTES
Public discourse concerning treatment and support for residents of the DTES is sometimes hampered by unfounded assumptions and a lack of evidence about what works and what does not. The lack of public understanding sometimes limits the ability of service providers, VCH, and other government ministries to serve DTES residents as effectively as possible.

Recommendations

We have six recommendations that, if implemented, would lead to more affordable and effective services for vulnerable populations in the DTES. Taken together, our recommendations improve service accessibility, increase coordination of care, and create a policy environment that promotes the health of all DTES residents.

1. Support and enable low-barrier, client-centred health service models

VCH should increase support to low-barrier service models on a number of fronts.

VCH should commission research to provide a framework for understanding the contributions of low-barrier services to long-term client outcomes and, by extension, acute care savings. Commissioned research should build on previous research efforts in this area. Measurement systems are generally not structured to capture and take into account increased stability, higher self-esteem, and reduced risk-taking of vulnerable individuals — some of the most important outcomes of effective low-barrier services. This research should suggest how VCH can improve and rationalize its current methods of funding low-barrier services in order to take these dimensions into account.

Funding for low-barrier services should be seen as preventative investments, and so should be tied to the disease burden of the client population, the intensity of service provided, and the risk level involved in serving these clients.

Peer programs are often implicitly encouraged to professionalize in order to make interactions with funders and health authority partners more straightforward. VCH should develop a strategy to protect and support peer programs in the DTES. Cost-savings can be achieved by supporting peer workers as an effective, low-cost workforce in the DTES. The strategy should aim to reduce the administrative burden placed on peer programs and facilitate greater cooperation with more professionalized services.

More needs to be done to connect low-barrier services with the broader continuum of care. Because low-barrier service providers operate in ways that are different from normal clinical care operations, we are often deprived of access to shared client and patient data and left out of case conferencing. Frequently this leads to failed care transitions for our clients — after spending time in low-barrier services, our clients are ready for higher-barrier, more intense services. But when we connect our clients with those services, information we have gathered about the clients needs are not taken into account, leading the client to stop seeking care, creating unnecessary upheaval in the client's life and bringing them back to our doors.

VCH should examine privacy and information-sharing policies concerning low-barrier services in order to facilitate greater data-sharing, cooperation and case conferencing for low-barrier services, while still protecting the privacy rights of our clients. VCH should also identify areas where 'medium barrier' services may be required in order to prevent failed care transitions for low-barrier clients, and encourage all services in the DTES to adopt a low-barrier ethos, with more flexible hours of operation, more empathetic and welcoming environments, and more choices for clients in the services that they receive.

2. Address the needs of vulnerable women in the DTES and promote a culture of anti-violence

VCH needs to direct equitable funding towards programs that serve women who are in the DTES. This means improving the services provided to women in the DTES, as well improving access for DTES women to services outside the neighbourhood.

In order to improve services provided to women in the DTES, VCH should require that organizations serve, at minimum, a set percentage of female clients. In order to retain funding, these services would have to attract and retain clients from these underserved groups. VCH should require that all DTES services have gender equity and gendered-violence policies. They should encourage gender-specific programs and gender-specific times within programs as simple ways to begin making services more accessible to women. Providers should also be made accountable for conditions that led to violence against women in their programs or in their housing.

For every dollar that goes to services for women in the DTES, VCH should commit a dollar to services outside the DTES that are accessible to women from the DTES. Women, especially women who have experienced violence, need viable options that help them exit from the neighbourhood. VCH should also work with MCFD and BC Housing to implement a special portable rent subsidy for women living with children in the DTES so that they are able to move out of the neighbourhood when they choose to.

There is a critical need for women-only addiction and drug treatment programs outside the DTES — current women-only detox and residency programs predominantly cater to middle-income women, and are not welcoming environments for low-income women from the DTES who may also be struggling with mental health challenges. In the absence of sufficient residency for DTES women, VCH should work to provide addiction and treatment day programs that are suitable for women in the DTES.

VCH should work with partners (such as MCFD) to intercept young women (especially those under the age of 19) who have recently arrived in the DTES and are becoming involved with drug use and potentially with prostitution. This should involve social workers complementing the efforts of health clinicians, since social workers are capable of addressing certain needs and challenges that clinicians cannot.

3. Ensure all services are accessible to specific populations, while also supporting the growth of services tailored to specific underserved populations

To improve accessibility and cultural safety for specific populations, VCH should both ensure that all services meet minimum standards of accessibility, while also supporting tailored programs that are targeted to under-served populations.

In order to improve the accessibility of all services, VCH should set out guidelines to encourage diversity in hiring practices for front-line staff in VCH and contracted services. VCH should also work to partner tailored services with those providers who serve the general population in the DTES, and should encourage and support the sharing of strategies that improve accessibility for underserved populations.

Greater funding is required from VCH in order to ensure that there are adequate tailored services available. Aboriginal services — especially services for Aboriginal children, youth and elders — are one particularly critical area of need. More programs are needed that reach out to the Chinese community in the DTES to help connect them to the services they need. Chinese seniors are especially in need, and simple low-barrier programs (beading workshops, movies with subtitles, paperwork support, etc.) help bring these individuals into contact with the health and social services systems.

Families with children live in the DTES, yet few services provide spaces that feel safe and welcoming for parents and their children. VCH should work with appropriate partners to make sure families with children have access to safe, welcoming care in the DTES.

Agencies in the DTES should work together to improve their connection and response to youth. VCH should modify its funding and guidelines for youth programs so that front-line providers have greater flexibility to respond to youth's individual needs. VCH should consider funding a drop-in space for youth, and should work with the justice system to prevent unnecessary apprehensions and incarceration that exacerbate health and social problems faced by youth.

4. Commit to learning about the emerging and long-standing challenges that service providers face while caring for DTES clients, and the innovative responses that have been developed to address them

VCH should work with low-barrier service providers to educate other providers in the health authority about the important role that low-barrier services play in the continuum of care.

VCH should give managers formal responsibility to learn about the impacts of government policies on the health of residents of the DTES, and to relay that information to appropriate actors within VCH. VCH should use this information as a basis for cooperation and problem solving with other health authorities and government partners (See recommendation #2).

In order for VCH board members and senior leadership to better understand the importance of low-barrier services, we believe they should commit to having a more in-depth orientation to the service environment in the DTES. This should involve more than short, scripted visits, but potentially day-long stays that allow board members and senior leaders to observe the regular operations of services and have informal interactions with DTES residents. These opportunities could also be extended to other influential decision-makers in government, business, and philanthropy.

5. Analyze policy barriers and initiate problem-solving with government partners

When VCH is informed by providers about policy barriers they face when providing care to residents of the DTES. VCH should gather evidence about how these policies affect the health of DTES residents, work up budget implications of policy changes, and present this evidence to ministries and other government partners as part of a collaborative problem solving effort.

We believe VCH is especially well positioned to help other health authorities improve the services they provide to high-needs populations like those found in the DTES. VCH and its service providers have expertise in these areas that others do not. Not only does this improve their health systems, it also reduces the flow of individuals into the DTES and creates opportunities for individuals to move out of the DTES.

6. Become a public authority on health in the DTES, providing data and evidence for public consumption about what works when it comes to improving health for high-needs populations in the DTES

We understand that there is not always widespread public support for programs that support our clientele and meet their needs. Drug users, sex trade workers, and the mentally ill do not always engender supportive, compassionate attitudes. We do not necessarily expect VCH to take a prominent role in public discourse, advocating for the sake of our clientele on every contentious public issue that affects their health, be it drug policy, sex trade policies, or new harm reduction policies. This is not part of VCH's role.

But we do believe that VCH, as an authority on health, has a responsibility to help ground public discourse in evidence — to use facts and data to debunk myths about the effectiveness of controversial programs, and to show the negative impacts of certain public policies on the health of DTES residents. Currently, medical health officers are champions for patients and for health across the province — we believe VCH should bring this same ethos to bear on its work, and in the process help the public understand why programs and policies work.

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