DOWNTOWN EASTSIDE COMMUNITY CONSULTATION ON NEEDS AND GAPS IN SERVICES

Building Community Society

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Part One: Environmental Scan

Building Community Society (BCS) has engaged CitySpaces Consulting to complete a Needs Assessment to inform the development of a new approach for delivering services in the Downtown Eastside (DTES). This draft approach, known as Project Lifeline, is focused on supporting the area's approximately 300 residents experiencing chronic or recurrent homelessness and have complex and acute health needs. Project Lifeline is envisioned to be a one-to-three-year pilot program focused on addressing gaps, barriers, and systems failures. BCS is committed to securing funding and resources, building partnerships, and better integrating health and housing services to offer long-term solutions for stability and wellness.

The Environmental Scan outlines the current context including systemic factors that create and perpetuate inequities experienced by people living with complex needs in the DTES. The Scan also provides a summary of relevant existing programs, services, and initiatives as well as a review of best practices from comparable jurisdictions. The purpose of the Environmental Scan is to understand how the draft service delivery model proposed by BCS fits within the current landscape and identify opportunities to address existing gaps and barriers, as well as potential areas of duplication or conflict. Given the current network of services and programs in the DTES is intricate, complex, and evolving, this Scan provides a strategic, high-level summary of certain initiatives relevant to the BCS draft service delivery model.

Population Group

BCS estimates there are approximately 300 people living in the DTES experiencing chronic and recurring homelessness and living with complex, concurrent health needs including mental health diagnoses and active substance use. For the purposes of this Scan, this population group will be described as *people with complex needs*.

It is challenging to know the precise number of people with complex needs in the DTES, given the limited availability of data as well as an understanding that this population group likely changes over time. During engagement with service providers, feedback received indicated there are likely more than 300 people in this population group, and there are more people experiencing chronic or recurrent homelessness, who may not be considered as having complex needs.

Although this research focuses on a specific population group in the DTES, populations with complex needs are not limited to large urban centres. A study in 2016 found that the highest

per capita rate of people with complex needs exists in small, remote, rural communities where there are limited mental health and substance use services available.[i]

While service providers feel there are more than 300 people living with complex needs, relevant reports and publications demonstrate the 300-person estimate may be an appropriate starting place as a minimum number of people to support with this proposal.

- In the 2020 Vancouver Homeless Count, just over 2,000 people identified as being without a home, including 547 people without a shelter and 1,548 people who were sheltered. It is important to note that these numbers are considered to be an undercount[1]. Over half of these people (>1,000) were surveyed in the DTES, and 70% of all respondents (>1,400) were experiencing chronic homelessness, meaning they have not had access to housing for more than six months within the past year. Approximately 15% of all respondents (300 people) stated they had been experiencing homelessness for five years or more, while 7% (140 people) indicated they had been experiencing homelessness for over 10 years. Over time, Vancouver and Metro Vancouver homeless counts have consistently shown links between experiences of homelessness and health issues such as a mental health diagnosis and substance use. In 2020, 60% of respondents (>1,200) reported two or more health conditions.

- Published in 2014, the At Home/Chez Soi Project[ii] identified 2,400 people experiencing chronic homelessness and complex mental health and substance use challenges across Canada. Of this group, 497 were selected to participate in the Vancouver At Home (VAH) study, which included a moderate needs group with 200 people and a high needs group with 297 people. These groups were determined based on criteria relating to type of mental health diagnoses, functional impairment, criminal justice system involvement, history of psychiatric hospitalization, and substance use.[2]

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[1] Point-in-Time (PiT) counts only represent people that are both approached and consent to be interviewed during a 24-hour period, meaning total numbers of people experiencing homelessness are recognized to be an undercount (by as much as 20%). Despite this limitation, PiT counts represent a recognized methodology for collecting data on homelessness at a single point in time.

[2] This study provides empirical evidence in support of housing-first approaches; however, the study uses deficiency-based categorizations which can feel dehumanizing and may not sufficiently recognize the systemic and compounding impacts of poverty and oppression on the health, housing, and criminal justice outcomes measured.

- More recently in 2021, the Simon Fraser University Call to Action study[iii] targeted a similar population group with 1,500 participants across the province, 25% (225) from the DTES.[3]

BCS will need to determine a method for identifying and selecting individuals to participate as recipients of the proposed service delivery model. Once this criterion is clarified, a more robust analysis of existing data can be completed. Multiple data sources could be analyzed to determine a more precise estimate, including BC Housing's Homeless Individuals and Families Information System (HIFIS), as well as data from Vancouver Coastal Health and Providence Health Information systems.

COMMUNITY CONTEXT

Many DTES residents disproportionately experience systemic social, economic, and health inequities such as the lack of adequate, safe, or affordable housing, unemployment, extreme poverty, food insecurity, and limited access to education and health opportunities. These social determinants of health[4] impact a person's health more than individual choices and are amplified by systemic marginalisation such as colonisation, racism, discrimination, homophobia, transphobia, and classism. Although many low-income residents of the DTES experience multi-faceted marginalization, community members and leaders are active in advocating for and making change to alleviate some of the challenges and barriers to wellness. Volunteerism, activism, and collective action are long standing community strengths.[iv]

The purpose of this section is to outline the systemic and structural contexts that underpin and perpetuate current inequities.

Poverty as a Social Determinant of Health

According to the World Health Organization, experiences of poverty is the single largest determinant of health[v]. When impoverished, people are often unable to pay for necessities such as housing, food, childcare, health care, and education. Low incomes increase risk and prevalence of homelessness, experiencing a mental health challenge, developing a

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[3] The Homelessness, Addiction & Mental Illness: A Call to Action for British Columbia study recommends the immediate implementation (between 2021 to 2024) of an approach developed by Simon Fraser University researchers to improve housing and health outcomes for at least 1,500 people experiencing chronic homelessness and mental health and addiction challenges. This initiative is profiled in more detail later in the report (see page 25).

[4] Defined by the World Health Organization, as the non-medical factors that influence health, including conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life that influence health outcomes more than individual choices.

substance dependence, and being involved with the criminal justice system. Nearly one in five children in British Columbia live in poverty and this rate has not changed since 2018. Many speculate that the COVID-19 pandemic worsens the situation further.[vi] There is some action at both the provincial[vii] and federal levels,[viii] with recently published poverty reduction strategies and accompanying legislation.

Many DTES residents are experiencing poverty, with a median household income approximately $23,359 according to 2016 Census data. This has increased by 6% since 2011 but continues to be much lower than the city-wide median income of $65,423. People earning $20,000 or less generally receive provincial income or disability assistance, and/or are underemployed. New Census data will be published in early 2022 and provide more up-to-date income information. Although provincial assistance rates increased by $175 per month in 2020[ix], these rates remain far below what is needed to afford rent, food, and other basic necessities. From 2011 to 2016, the DTES population grew from 18,500 to 19,950 residents – a faster pace (8%) than the city-at-large.[x] The number of people earning less than $20,000 per annum has decreased in number between 2011 and 2016, suggesting that many low-income residents are being displaced.

ONGOING LEGACIES OF COLONIALISM

The DTES is located on the traditional and unceded lands of the Coast Salish peoples and has been the home of many Indigenous, Metis, and Inuit people since time immemorial. Today, the DTES has a high proportion of residents who identify as Indigenous, making up nearly 10% of the population,[5] compared to 2% city-wide and 6% provincially. The DTES has a rich cultural heritage, being home to many diverse cultural and racial groups, including the Chinatown and Japantown areas. Today, nearly 40% of DTES residents are members of a racialized group, including a proportionally large Black population, and 39% of residents born outside of Canada, with many arriving as refugees[xi].

Indigenous homelessness is not defined as lacking housing but rather is it more fully understood through a composite lens of Indigenous worldviews and is defined as:

- A human condition that describes First Nations, Métis, and Inuit individuals, families, or communities lacking stable, permanent, appropriate housing, or the immediate prospect, means, or ability to acquire such housing. Unlike the common colonialist definition of homelessness, Indigenous homelessness is not defined as lacking a structure of habitation; rather, it is more fully described and understood through a composite lens of

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[5] Indigenous populations are undercounted in the Census program.

Indigenous worldviews. These include: individuals, families and communities isolated from their relationships to land, water, place, family, kin, each other, animals, cultures, languages, and identities. Importantly, Indigenous people experiencing these kinds of homelessness cannot culturally, spiritually, emotionally, or physically reconnect with their Indigeneity or lost relationships.[xii]

The legacies of colonialism are felt by Indigenous communities across Canada, resulting from the Canadian government's policies and acts of cultural and physical genocide, including residential schools. Ongoing impacts felt by Indigenous peoples in Canada include intergenerational trauma and experiences of racism, discrimination, barriers to employment and education, family separation, criminalization, and displacement. Gendered and colonial violence are particularly prevalent in the DTES and are experienced to a higher degree by Indigenous women, girls, 2SLGBTQQIA, and gender diverse residents.[xiii]

First Nations perspectives on health and wellness[xiv] is a holistic perspective that focuses on achieving wellness through balance and inter-relationships of the physical, mental, emotional, and spiritual aspects of a being. Increasing the availability of culturally safe and relevant housing and health care services in the DTES is integral to the process of reconciliation. Culturally relevant and Indigenous led case studies and promising practices are explored in the Promising Practices section of this Scan, page 27.

Canada's Truth and Reconciliation Commission calls for urgent and tangible actions to start to reconcile, heal, and address existing oppression. The province of BC adopted the Declaration on the Rights of Indigenous Peoples Act (DRIPA, 2019) into legislation in 2020 and has been increasing funding allocations to advance reconciliation including health, education, employment, and training investments in 2021.[xv] Continued investment and partnership with First Nations communities and urban Indigenous organizations is needed to address the current systematic inequities felt by Indigenous peoples, particularly for DTES residents.

COVID-19 PUBLIC HEALTH EMERGENCY

In March 2020, a provincial health emergency was declared due to the COVID-19 pandemic. Since then, the impacts of the pandemic have disproportionately impacted vulnerable groups, including DTES residents with low and very low incomes, racialized groups such as Black, Indigenous, People of Colour (BIPOC), people with pre-existing mental and physical health conditions, children and youth, people who are underhoused or do not have homes, as well as those who use illicit drugs.[xvi]

The need for more subsidized, supportive, and low barrier housing for people experiencing homelessness has intensified and become even more urgent. BC Housing, regional health authorities, the City of Vancouver, and non-profit shelter and housing providers are responding to the COVID-19 outbreak, which has included the rapid creation of new locations for people experiencing homelessness to self-isolate and recover. Across Vancouver five sites have recently opened, with 281 beds at undisclosed locations.[xvii]

OVERDOSE AND TOXIC DRUG SUPPLY PUBLIC HEALTH EMERGENCY

A public health emergency was declared in British Colombia in April 2016, following significant increases in opioid-related overdose deaths from drug poisoning. Since 2016, there have been 1,351 overdose deaths in Vancouver. Over 45% of all deaths were in supportive housing and single room occupancies (SROs) in the Vancouver Coastal Health region.

In July 2021, there were 184 suspected illicit drug toxicity deaths in the province, which equates to 5.9 deaths per day.[xviii] The per annum death rate is also increasing, with 69 deaths in Vancouver in 2011 compared to 286 as of July 2021. City of Vancouver staff estimate that approximately half of Vancouver's overdoses in 2020 were in the DTES.[xix] Due in part to physical distancing measures to prevent the spread of COVID-19, such as guest bans in SRO hotels, in tandem with increasing toxicity of illicit drugs, overdose deaths have spiked across the country and the province, particularly in the DTES.

The B.C. Coroner found that more than half of those who died in the crisis had accessed some form of mental health or primary care service but had not been able to access effective or timely addiction care. The death toll from the toxic drug supply in the province is far greater than that of COVID-19, yet there continues to be lack of implementation of effective interventions, such as the provision of safe supply and improved substance use and addictions services. By August 2020, there were more overdose deaths due to illicit drugs than all of 2019. In the summer of 2020, emergency services responded to nearly 7,500 overdose calls, which is the highest number of calls in a three-month period.[xx]

Figure 1: Overdose and COVID-19 deaths, 2020[xxi]
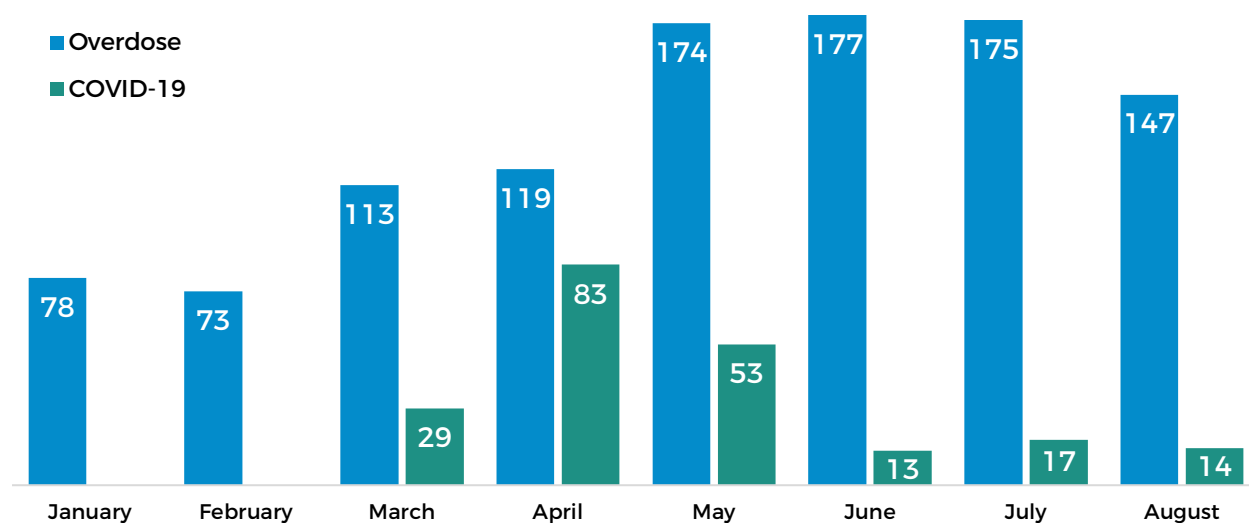
Downtown Eastside Services Snapshot

The following snapshot highlights the existing health and housing services currently in-place in the DTES. Given the extent of services provided in the DTES, this snapshot is not a comprehensive scan but rather focuses on the strengths and challenges of existing services that support people with complex needs. Health and housing services are discussed in distinct sections for clarity, but a strong emphasis is placed on intersections and integration of these sectors.

HOUSING AND HOMELESSNESS SERVICES

Like many cities across Canada, Vancouver is experiencing a housing crisis, with a loss of affordable housing units and increasing rental prices, resulting in housing insecurity and greater risk of homelessness for residents. This current housing emergency is due to a confluence of factors; however, the lack of affordable housing for people with very low incomes is in large part a result of inconsistent funding from senior governments to build new social housing since the 1990s.[xxii]

The impacts of this crisis are felt acutely in the DTES, which has the highest proportion of residents experiencing homelessness in Vancouver, with a minimum of 1,000 people identified in the 2020 homeless count.[xxiii] Causes of homelessness reflect a cumulative combination of structural and systemic failures and individual circumstances rather than a single cause, such as lack of affordable housing and health support, low or no incomes, and experiences of marginalization and discrimination.[xxiv]

Over the past decade, people living outdoors and in 'tent cities' are becoming a more frequent occurrence in the DTES, from bi-annually to monthly. Several high-profile encampments and occupations have taken place in recent years, including a tent city at Oppenheimer Park in 2014 and a tent city at 58 West Hastings in 2010 and 2016. Between 2018 and 2020, Oppenheimer Park was home to recurring encampments, resulting in the park's closure in 2020. There has been a recent encampment at Strathcona Park (2020 to 2021) and an active encampment in CRAB Park in the fall and winter of 2021.

HOUSING SERVICES & PLANS

There are several housing programs available for people experiencing homelessness in Vancouver, including emergency shelters, outreach teams, SROs, private market rentals with supplements, and supportive housing. A high concentration of these services is available in the DTES; in fact, there has been an increase in the supply and diversity of supportive housing options in the DTES over the past decade due to investments from senior and local governments. However, there remains a critical shortfall in the availability of supportive housing for people experiencing chronic homelessness and require integrated health supports to treat complex health needs.

The Housing Vancouver Strategy (2017) responds to the housing crisis by targeting the creation of 72,000 new homes between 2018 and 2027, including 12,000 units of social and supportive housing.[xxv] The strategy seeks to enable the 'right supply' of housing for people who live and work in Vancouver, which includes housing options that are affordable to local incomes and a shift to more social, supportive, and rental housing. Included in the 12,000 social and supportive housing units target is approximately 5,200 homes intended for people who are homeless and SRO tenants currently living in inadequate housing and requiring supports. Housing Vancouver also includes actions to advance commitments as a City of Reconciliation[xxvi] to address short- and long-term housing and wellness needs of urban Indigenous residents.

The Downtown Eastside Plan[xxvii] was approved in 2014 and provides a vision, policies, and strategies to improve the lives of low-income community members. The plan was developed in partnership with the DTES Neighbourhood Council (DNC), BCS, and the City Planning Committee. Through its implementation, the Plan's policies maintain low density permissions in order to incentivize mixed income rental developments that include a high proportion of social housing onsite (60 per cent social housing and 40 per cent secured market rental). This plan is outlined in greater detail in the Government Policies and Practices section of this report, on page 21.

There is a high concentration of single room occupancy hotels (SRO's) in the DTES, which are managed by private or non-profit operators, often with supports provided onsite. These rooms are often the last resort for very low-income residents at risk of homelessness and may often be the only form of housing accessible to those experiencing racism and discrimination. Increasing prices and poor conditions of the area's existing stock of below-market rentals, primarily Single Room Occupancy Hotels (SRO Hotels), increase risks of homelessness. A 2017 study[xxviii] found that the average monthly rent for a room in an SRO Hotel rose to $897 per month, which leaves only $23 for food and other necessities for people receiving income assistance.

The SRO Renewal Initiative (SRI) [xxix] was completed in 2017 and involved the renovation of 13 SRO hotels in the DTES, Chinatown, and Gastown areas to provide safe and affordable accommodations for approximately 900 individuals at risk of homelessness. The Province invested $147 million in this initiative, under a public-private partnership, including $29.1 million from the Government of Canada through the P3 Canada Fund.

Single Room Accommodation (SRA) Bylaw[xxx] prevents the loss of low-income housing and the displacement of tenants in Vancouver's Downtown core. SRA includes single room occupancy hotels, rooming houses, and non-market housing with rooms less than 320 square feet. The bylaw prevents tenant displacement and the loss of this housing stock by regulating its alteration, conversion, and demolition. Most SRAs[xxxi] are privately-owned and operated and provide minimal quality of housing: a room typically 100 square feet in area with a basic cooking setup (such as a hot plate) and a shared bathroom accessible. Tenants are covered by the Residential Tenancy Act.

The City's policy is to replace SRA housing over time with safe, secure, and self-contained dwelling units (i.e., sleeping area, living area, private kitchen, and bathroom) that are affordable to low-income single people. The City recently adopted a new bylaw using Business Licensing powers to enact vacancy controls within SRO buildings, which enacts rent control between tenant occupancy of a unit.[xxxii]

Supportive Housing is operated by various non-profit housing providers, including Atira Resources Society, Bloom Group, Community Builders, MPA Society, Lookout Housing Society, PHS Community Services Society, RainCity Housing and Support Society and more. Supports are provided 24 hours, 7 days a week and include a broad range of on-site non-clinical services such as meal programs, laundry, life skills training, and health care referrals and connections. Buildings vary in size and style; new supportive housing developments provide tenants with self-contained units including kitchenettes and private bathrooms, as

well as access to communal spaces and, in some buildings, culturally appropriate spaces. There are very few supportive housing buildings in the DTES that have in-house health services, with only one identified through research.

A wide variety of services and programs are offered by the many non-profit housing providers operating in the DTES. Each organization has their own definitions of 'low-barrier' or 'supportive housing' as well as their own individual mandates and tolerances for supporting tenants with complex and high needs. This diversity of services provides suitable options for many different unique housing and health needs, but it also creates inconsistency in the way that supportive housing is offered; there is a critical shortfall in providers that can successfully keep people with complex health needs housed over the long-term.

BC Housing's Coordinated Access System and Supportive Housing Registry oversees the placement of tenants within the Supportive Housing Registry, which currently includes approximately 3,000 units (1,841 SROs and 1,072 self-contained units).[xxxiii] Since 2018, BC Housing has opened more than 1,000 supportive housing units in Vancouver and plans for an additional 1,700 spaces by 2023.[xxxiv]

The purpose of the Coordinated Access System is to assess the eligibility, vulnerability, and support needs of applicants through a standardized Vulnerability Assessment Tool. The intention of both the tool and system is to create a fair and transparent process that triages people with the most complex needs. This process considers appropriate placements for tenants, referrals to various non-profit housing providers that offer a diversity of programs, as well as the level of needs of existing tenants in distinct buildings. The number of tenants with complex needs that can be housed in a single building varies depending on the policies, experience, training, and tolerance of each particular housing provider.

Overtime, the tenanting process has been enhanced and refinements continue to improve equity and transparency. In practice, this process can be challenging given the limited supply of supportive housing and the volume of people waiting for supportive housing. The backlog makes it nearly impossible for tenants to be able to move between supportive housing depending on their needs. Appropriate tenanting can be particularly challenging for people with disabilities and older adults, whose support needs are unique and may change overtime. Non-profit housing providers often feel limited in their ability to manage the social environments in their buildings when they do not oversee the tenanting process.

The City of Vancouver's Homelessness Services Outreach Team connects with individuals throughout Vancouver and particularly in the DTES who are in need of housing, income, and other support services. In 2019, the Outreach Team supported 5,469 individual clients access

a range of services and housing, including 2,548 new clients.[xxxv] Over the course of 2019, the Outreach Team housed 938 people[xxxvi]. It is important to note the Outreach Team also assists people currently receiving housing to assess the supports they need to remain housed. The Outreach Team has played an important role in helping people from tent encampments transition to housing, particularly the people living in Oppenheimer Park who were supported with housing and shelter transitions in early 2020.

Temporary Modular Supportive Housing (TMH)[xxxvii] follows a Housing First[6] approach, providing safe, affordable, self-contained supportive housing options across Vancouver for people experiencing homelessness and significant barriers to accessing housing and supports. This housing form is effective in responding to homelessness rapidly because it can be constructed more quickly than permanent housing. Since 2017, the City has partnered with BC Housing to build over 650 new TMH homes. A BC Housing survey of tenants six months after many of the TMH buildings opened in Vancouver found that most (80%) were experiencing improved overall well-being, had experienced positive interactions with neighbours in the surrounding community, and nearly all (94%) remained housed six months after move-in.

HEALTH SERVICES

This section provides a high-level overview of the extensive network of health services in the DTES administered by Vancouver Coastal Health (VCH), including community health clinics, mental health clinics, substance dependence services like safe supply, harm reduction, withdrawal management, and outreach teams.

Despite the plethora of services, there continues to be barriers for accessing health care by the people in the DTES with complex needs. People living outside and in shelters are not able to visit a clinic for physician care because they are occupied by accessing basic necessities for survival such as food, shelter, and substances. Some people with complex needs are followed by an interdisciplinary outreach care team. However, many needing these supports are not able to receive them due to barriers and limited resources and therefore cannot access the treatment they need to stay healthy and housed.

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[6] Housing First is an approach for addressing homelessness, by transitioning people experiencing homelessness – particularly chronic homelessness – rapidly into stable, long-term housing with supports and does not require sobriety or stability to be eligible for housing. This approach is profiled in detail in the Promising Practices section on page 27.

A notable gap in the DTES services network is a team that responds when a person is experiencing a mental health crisis. Car 87 and 88[xxxviii] dispatch a registered nurse and police officer team to respond to calls across Vancouver. This service is often oversubscribed resulting in many calls not being responded to, or being delayed, as well as limited response rates in the DTES specifically.

These barriers to accessing health care for people with complex needs impacts their ability to achieve and maintain stability, including health and wellness, social connections, employment, and housing.

Second Generation Strategy

The health services in the DTES are outlined in the Second Generation Strategy, which came into effect in 2018.[xxxix] The strategy focuses on integrated care teams in new and existing community health centres, including a one-stop-shop for primary care, mental health and substance use services, harm reduction, and specialized care. A key outcome of the Strategy was to consolidate health services into one-stop-shop hubs; however, community engagement has identified that this approach has increased barriers to access for some, with more diverse service options and responsive models needed.

Integrated Care Teams & Community Health Clinics

- Six Integrated Care Teams include social workers, counsellors, community liaison workers, physicians, nurse practitioners, nurses, and health care workers as well as peers. These teams offer clinic and outreach services at the Heatley, Pender, and Downtown Community Health Centres.

- Mental Health Clinics include the Strathcona Mental Health, STEPS services – Psychosocial Rehab, and Vancouver Intensive Supervision Unit (VISU), providing intensive supervision and services to clients with mental illnesses serving adult provincial sentences in the community.

Outreach Teams

It is unreasonable to expect people with complex needs, who are often experiencing health and housing crises, to go to a clinic to access health services. The role of outreach services is critical for people with complex needs to receive regular health care. Currently, there are several outreach health teams operating in the DTES.

- STOP HIV Outreach Team is an interdisciplinary team of nurses, nurse educators, outreach workers, social workers, administrative support workers and peers all working with the support of a physician. The team's mandate is to expand low-barrier HIV testing services and to improve engagement in HIV treatment, care, and support for some of the most marginalized people in Vancouver.

- DTES Intensive Case Management (ICM) Teams are multidisciplinary outreach teams that offer support and health services to DTES residents with complex care needs, experiencing homelessness and/or barriers to accessing health clinics or services. The teams comprise social workers, nurses, nurse practitioners, and health care workers with access to other clinical resources as required. There is one team focused on serving marginalized women and a new team under development focused on youth.

- Integrated Housing and Outreach Teams (IHOT) are a new specialized team focusing on supporting people transitioning from homelessness into housing (modular, hotels, and other supported housing), connecting them to primary care, mental health, and addiction services as well as opiate replacement therapy.

- Assertive Community Treatment (ACT) provides 24/7 health and life skills supports, community treatment, and rehabilitation for clients living with mental illness who may also have severe substance use disorders.

Harm Reduction & Safe Supply

Harm reduction services are well integrated in the DTES and include innovative and effective community-led approaches.

- Overdose Prevention Society (OPS), which operates a harm reduction and overdose prevention site staffed by volunteers, located at 58 and 62 East Hastings St.

- Tenant Overdose Response Organizers (TORO) help prevent overdose deaths in 14 private SROs in the DTES by employing residents to provide overdose response and prevention services.

- Overdose Outreach Team includes outreach, social workers, and peer support specialists to connect people who have recently experienced an opioid overdose and/or are at high risk for an opioid overdose with substance use care and support such as primary care, prevention education, detox, treatment, and Opioid Agonist Therapy (OAT)[7].

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[7] The therapy involves taking the opioid agonists methadone or buprenorphine, medications that work to prevent withdrawal and reduce cravings for opioid drugs. People addicted to opioid drugs can take OAT to help stabilize their lives and to reduce the harms related to their drug use.

- Safe Consumption Sites include Insite, which opened in 2003 as North America's first legal supervised consumption site, and Powell Street Getaway, which opened in 2017. Both sites operate under Health Canada exemptions from prosecution under Federal drug laws:

- Rapid Access Addiction Clinic (RAAC)[xl] is a short-term outpatient addiction clinic at St. Paul's Hospital, offering consultation and stabilization supports by referral, including immediate access to a physician, nurse, or social worker and same-day Opioid Substitution Therapy (OST), another term for OAT.

Many advocates, including people who use drugs, health care professionals, researchers, policy makers, and politicians are advocating for the introduction of more effective and evidence-based safe supply options, such as hydromorphone to prevent more deaths from the toxic drug supply.[xli] Providing a legal and regulated supply of drugs has the potential to support people who use drugs to stay alive and live safe and healthy lives. Existing substitution programs such as methadone are not as effective in curbing the use of poisoned, illicit drug supplies.

- The North American Opiate Medication Initiative (NAOMI)[xlii] piloted a program in Vancouver between 2005 and 2008 where patients were provided with injectable heroin and their likelihood of staying in treatment was improved.

- The Study to Assess Longer-term Opioid Medication Effectiveness (SALOME)[xliii] followed NAOMI and concluded in 2015.

- DTES Connections[xliv] is a low-barrier on-demand addictions treatment site opened in 2017 that offers rapid access to oral opioid agonist treatments, connections to services and housing, and mental and primary health care.

- Providence Crosstown Clinic[xlv] is the first and only clinic in North America to offer medical-grade heroin (diacetylmorphine) and the legal analgesic hydromorphone within a supervised clinical setting to chronic substance users. This approach follows evidence-based treatment models for substance use disorders that have found supervised prescription heroin is feasible, more effective and likely as safe as methadone, and reduces the many physical, mental, and social problems associated with illicit street drugs.[xlvi] Although the new pilot program is an important first step, it is still difficult for people to access this program with limited availability and complex eligibility requirements.

As part of the 2021 budget, the B.C. government is phasing in a new policy to expand access to prescribed safer supply, providing up to $22 million to heath authorities over the next

three years to monitor and expand safe supply prescriptions. Critics have noted that a prescription-based model has too many access barriers limiting its potential to address the current toxic drug supply.

Health Services for Vulnerable Groups

- DTES Women's Health and Safety Strategy[xlvii] is under development and initial services identified include a women's only Intensive Case Management Team (ICMT); 38 addiction recovery beds provided by Atira, SisterSpace – a women's only OPS, and plans for a mobile health van to be used by the women's ICMT.

- Health Supports for Indigenous peoples include an Elders in Residence program at each community health clinic, as well as the integration of Indigenous design concepts into renovation/new build plans; new Indigenous-specific Naloxone distribution sites and training; and Indigenous cultural safety training.

- Kilala Lelum is an Indigenous health centre that seeks to address holistic health and wellness through Elder-led services. Services and programs are culturally informed and targeted to serve Indigenous residents of the DTES, including primary care clinic and cultural field trips.

Currently, there are limited programs in the DTES that support people with complex needs as they age, including palliative care, home care, and assisted living. The COVID-19 pandemic has highlighted a need to reconsider and improve the current care models for older adults and there may be an opportunity to improve access and support for older adults with complex needs.

SERVICES FOR PEOPLE WITH COMPLEX NEEDS IN THE PROVINCE

- Riverview Lands Master Planning Process[xlviii] is currently underway, led by BC Housing and in partnership with the kʷikʷəƛ̓əm, Kwikwetlem First Nation. The land has been given the traditional name of səmiqʷəʔelə "the Place of the Great Blue Heron". Project principles include partnering with the kʷikʷəƛ̓əm First Nation and creating an integrated community of mental health excellence as well as opportunities for affordable, safe, and functional housing.

  Riverview is a historic mental health institution that was decommissioned in the 1990s and 2000s. At the time, its closure was proposed to be replaced with a community care approach that would move away from institutionalization and support community integration. However, this approach was never implemented and there remains a lack of mental health services available for people in need of care.

- Red Fish Health Centre for Mental Health and Addictions[xlix] is a new centre for mental health and addiction treatment and research in Coquitlam on the former Riverview Lands and replaces the Burnaby Centre for Mental Health and Addiction[l]. The new facility provides 150 beds to treat people across the province living with the most complex and acute substance use and mental health issues. The centre implements an evidence-based, trauma-informed model of care to promote dignity, offer therapeutic programs, build physical wellness, and support the transition to care in patients' home communities.

MAJOR HEALTH AND HOUSING DEVELOPMENTS UNDERWAY

There are several new social housing developments that will offer supportive homes and improved health supports to the DTES, including:

- 58 West Hastings is one of the largest social housing projects in the DTES currently being developed and will provide 231 new homes for people experiencing homelessness and low-income families in the upper seven floors, including 120 supportive housing units. There will also be a 50,000 square foot integrated health centre serving the entire community. The project will be located half a block east of Woodwards, across from the former Army & Navy department store complex and immediately west of the Portland Hotel. Over the first two floors, the building will have a new 48,500 sq ft integrated health centre developed and operated by VCH. It will offer health services and provide easy access to the unique needs of neighbourhood residents, including those in need of specialized mental health and addictions treatment. This project is led by the Vancouver Chinatown Foundation, with support from multiple funders including the Province and the Government of Canada.

- First United Church, at 320 Hastings Street, is being re-developed and will include expanded programming accessible to the public, as well as a mix of supportive and low-income housing.[li]

There have been renewed investments from the Province of B.C. that have funded the development of new addictions services, including three near the DTES:

- New St. Paul's Hospital and Health Campus is anticipated to be completed by 2026. The new facility is located near the DTES in the False Creek Flats and will include research, office, hotel, and workforce housing. This will bring acute care and integrated health services closer to residents as well as opportunities for increased investment and spending in the local economy. However, there are concerns that this development will increase gentrification and development pressures in the DTES[lii].

- Clark Drive Facility: A new 51 bed in-patient treatment and addictions services facility and 90-unit social housing project is being developed at East First Avenue between Clark Drive and McLean Drive, on a site owned by the City of Vancouver and in partnership with Vancouver Coastal Health and BC Housing.

- The Salvation Army Harbour Light is under redevelopment with a nine-storey building to include 46 social housing units within 27,500 sq. ft., 120 supported residential beds, and 134 emergency shelter beds. The former site's detox beds will become available at the Clark Drive facility.[8]

- RayCam Cooperative Community Centre Renewal Project to redevelop the aging two-story community centre facility, which holds the potential of 6.0 Floor Space Ratio (FSR) and up to twelve stories. The current project is in the early visioning and community engagement stages of the rezoning and local area planning process. It is envisioned to become a neighbourhood centre with inclusive, multi-generational services and housing to serve to serve the current and future local population. There is potential for expanded recreational, childcare, seniors, local health and youth projects; as well as opportunities for partner organizations, including non-profit organizations, local start up enterprises and local services businesses to locate onsite as well as lease space.

Government Policy and Practice

The BCS proposal is being developed at a time where there is government action and funding to respond to homelessness and improve health care services for at-risk groups. The section below identifies the initiatives underway at the municipal, provincial, and federal government levels.

Any response to the current health and housing challenges felt in the DTES requires a multi-jurisdictional partnership, with enhanced funding and resource commitments from senior government, as well as collaboration with the DTES community and non-profit sector. It will be important for BCS to consider what is currently underway or forecasted, in order to leverage existing efforts and avoid duplication.

Numerous plans related to housing and health in the DTES have been published over the past two decades, the most relevant of which are outlined below. Many of the initiatives referenced make recommendations that mirror calls from advocates today. This summary illustrates that evidence and approaches for resolving the issues of chronic homelessness for

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[8] It is unclear whether there will be a net increase in the number of detox treatment beds available due to this consolidation.

people with complex needs have existed for at least a decade. Although progress has been made, key recommendations and evidence-based approaches have not been implemented effectively, fully, nor received sufficient political support.

CITY OF VANCOUVER

The City of Vancouver is not mandated to deliver health services; however, it offers several direct services to support inclusive and safe communities, including owning and operating non-market housing, community centres and libraries, and the 311 phone line. Emergency response does fall under the City's purview, and police and fire departments routinely provide first response services in the DTES. The City also provides financial or in-kind support to community groups that deliver services and advocacy.

The Four Pillars Strategy[liii] was implemented in Vancouver in 2005 as an approach to addressing substance use dependency using four principles: Harm Reduction, Prevention, Treatment, and Enforcement.

The Downtown Eastside Plan 2014[liv] is a 30-year plan developed in partnership with the DTES Neighbourhood Council (DNC), BCS, and the City Planning Committee. Several actions were identified, and implementation includes:

- Coordinated overdose response with participation from drug users and guidance from the Mayor's Overdose Emergency Task Force, recommendations of which are outlined on page 19 of this report.

- New social, supportive, and rental housing including Temporary Modular Supportive Housing as part of the B.C. Government's Rapid Response to Homelessness.

- Renovations/replacement of SRO hotels with senior government investment. Over 1,000 SRO replacement units (shelter-rate units for singles) were approved and are under development as of 2019. Recent purchases include the Ross/Aoki House and the expropriation of the Regent and Balmoral Hotels.

The Mayor's Task Force on Mental Health and Addictions[lv], 2014, recommended:

- Adding 300 long-term and secure mental health treatment beds;

- Increasing staffing in supportive housing to assist tenants with psychiatric issues; and

- Increase support through Assertive Community Treatment (ACT) teams for psychiatric patients living in the community.

In 2018, the Mayors Task Force on Overdose Crisis Report[lvi] recommended:

- Investments in Indigenous Healing and Wellness, relating to over-dose response and grief supports, including providing grant funding and advocacy for funding from senior governments to various Indigenous led and serving organizations including the Metro Vancouver Indigenous Services Society and the Pacific Association of First Nations Women;

- Enable a Peer-based Organization/Drug user Network;

- Supporting Peer First Responders to Save Lives: including an 18-month pilot to the DTES SRO Collaborative Society for the Tenant Overdose Response Organizers ("TORO");

- Expanding Harm Reduction in the DTES;

- Support Safe Supply;

- Expand Access to Treatment Supports;

- Outside the DTES: Harm Reduction, Treatment, and Supports; and

- Collective Action for Systemic Changes, recommendation to enter into an agreement with senior governments and First Nation partners about substance use.

PROVINCE OF BRITISH COLUMBIA

A Public Health Emergency was declared in April 2016 in response to the overdose crisis and increasing toxicity of the illicit drug supply, which has led to a spike in overdose deaths. The Ministry of Mental Health and Addictions was established, and in 2017, initiated an Overdose Emergency Response Centre (OERC), allocating $150 million for immediate overdose emergency funding across the province. Over three years, a total of $330 million was provided by the Province. In 2018, $1.5 million from the provincial overdose emergency response funding was dedicated to establishing Community Actions Teams (CATs) throughout the province to address the overdose response in the local community.

Pathway to Hope[lvii] is a 10-year plan with four sets of priority actions over the next three years to transform the Province's mental health and addictions care system. The plan sets out long- and short-term changes and is based on four principles:

1. Wellness promotion and prevention;

2. Seamless and integrated care;

3. Equitable access to culturally safe and effective care; and

4. Indigenous health and wellness.

The current services system is structured to provide crisis response, while the pathway to hope is seeking to shift the system to focus on wellness promotion, prevention, and early intervention. The goal is to connect people experiencing mental health and substance use challenges to low-barrier services and supports that are culturally relevant and informed by the perspectives of people with lived and living experiences.

Vancouver Community Action Team (CAT)[lviii] is one of 35 teams across the province to respond to the overdose crisis at the local level.[lix] The Ministry of Mental Health and Addiction's Overdose Emergency Response Centre (OERC) and the Community Action Initiative (CAI) is funding these teams in communities hardest hit by the crisis. The Vancouver CAT is co-chaired by VCH and the City of Vancouver. About 15 organizations participate, including people who use drugs, parents with children who have died of overdose deaths, not-for-profit and advocacy groups, urban Indigenous organizations, housing providers, researchers, as well as VCH, BC Ambulance, Police, and Fire & Rescue Services. Their mandate is to create action plans and coordinate a multi-sectoral response, as well as escalate barriers to effective response to the provincial level as needed.

Oral Hydromorphone Pilot Program offered by the BC Centre for Disease Control (BCCDC), in partnership with Providence Health Care and Health Canada, provides low-barrier access to a safer, predictable supply for people at-risk of overdose.

Navigation Centres[lx] are currently being launched in Vancouver and Nanaimo. Together, these centres are funded through the provincial 2020 budget with investments of $1.5 million each for three years. These centres are being developed to help people experiencing chronic homelessness and who require supports to address complex and acute health needs.

The Vancouver Navigation Centre will provide 60 emergency shelter beds and be open to its residents 24/7. This centre differs from typical shelters in that it provides individualized case-planning and intensive wrap-around supports onsite, including integrated clinical health supports as well as culturally appropriate services for Indigenous peoples. Residents will be referred to the navigation centre and able to stay until they are offered long-term housing that meets their individual needs.

The Navigation Centre model is the first of its kind to be implemented in Canada and is modeled from other cities around the world, including San Francisco. Work is underway to identify an appropriate site for the Vancouver Navigation Centre and BC Housing has issued a request for proposals to select an experienced non-profit organization to operate the centre. Kilala Lelum is currently supporting the planning for specific health services for the facility.

Data Integration Project[lxi], led by the Ministry of the Attorney General and Responsible for Housing, in partnership with BC Housing and the Ministries of Social Development and Poverty Reduction (SDPR) and Citizens' Services, is an initiative to identify and track the cohort of individuals experiencing homelessness or are at risk of becoming homeless in B.C. By providing a comprehensive, robust, and reliable dataset, the project will help the Provincial Government better understand, respond to, and prevent homelessness.

FEDERAL

Reaching Home: Canada's Homelessness Strategy seeks to prevent and reduce homelessness across Canada and funds localized responses in urban, Indigenous, rural, and remote communities. The Strategy supports the goals of the National Housing Strategy to reduce chronic homelessness nationally by 50% by 2027-2028. The Strategy implements a Housing First approach, includes a Coordinated Access system to prioritize access, and uses the Homeless Individuals and Families Information System (HIFIS)[lxii] for data collection and case management. Additional funding through Reaching Home was provided in 2020 to help extend and expand emergency responses to the COVID-19 pandemic.

In October 2021, Carolyn Bennett was sworn in as the first Minister of Mental Health and Addictions in Canada.[lxiii] Previously there was no federal department or ministry responsible for specifically addressing mental health and substance use issues. The Federal Government is positioned to provide a coordinated vision and leadership to address the existing mental health and overdose crises, which have been exacerbated by the COVID-19 pandemic.

Mental health and substance use health needs are significant across Canada and both continue to be underfunded within health care systems when compared with physical health. The COVID-19 pandemic has exacerbated mental health issues, particularly for those with pre-existing conditions. There has been an increase in substance use, with higher rates of use for those with mental health and substance use issues. The Canadian Alliance on Mental Illness and Mental Health (CAMIMH) has called on the Federal Government to introduce the Mental Health and Substance Use Health Care For All Parity Act[lxiv] to ensure timely access to a range of inclusive and accessible mental health and substance use programs, services, and supports.

OTHER INITIATIVES IN THE DTES

Simon Fraser University's study Homelessness, Addiction & Mental Illness: A Call to Action for British Columbia[lxv] calls for support from the Provincial Government to implement an evidence-based approach to end homelessness in four regions of B.C. The effort is targeting

at least 1,500 people to receive supports between 2021-2024. The approach integrates health and housing, through a defined standard of care to reduce rates of chronic homelessness, crime, and incidents of acute psychological, social, and medical crises. It will be guided by Canada's Truth and Reconciliation Commission and British Columbia's Declaration on the Rights of Indigenous Peoples Act[lxvi].

Key elements of this initiative include:

- Implementing a new person-centered approach for supporting people experiencing chronic homelessness, including the implementation of evidence-based practices like Housing First and recovery-oriented housing;

- A focus on developing communities of practice by convening people with lived experience (PWLE), the non-profit sector, government, and community to implement and scale-up the new service delivery model at the local levels; and

- Regular and transparent reporting and measuring of outcomes using benchmarks to evaluable effectiveness and impact.

The first two years will focus on establishing Indigenous-led housing with supports and services for people of all ethnic backgrounds in Southern Vancouver Island, the Interior, and Lower Mainland, with Northern BC added in year three.

Promising Practices, Guiding Approaches, and Case Studies

There are numerous evidence-based approaches and case studies for solving chronic homelessness for people with complex and concurrent health needs, including mental health and substance dependence issues. This section outlines promising practices that are most relevant to the BCS model in the DTES context outlined above, including Housing First, Indigenous-led and culturally relevant programs, integrated health and housing services, mental health outreach, and transformative drug policy. Each case study identifies potential opportunities for refinement to the BCS model to address existing gaps and challenges in the DTES, while following key principles and best practices in the field.

INDIGENOUS-LED AND CULTURALLY RELEVANT PROGRAMS

Cultural knowledge and connection are a determinant of health and wellbeing among Indigenous peoples.[lxvii] Solutions to homelessness and health challenges must be culturally relevant and promote social and cultural connection for Indigenous communities.[lxviii]

Any programs or services developed to serve DTES residents with complex needs should thoughtfully partner with Indigenous leaders and organizations in the DTES community and incorporate Indigenous knowledge and cultural programs. There are many opportunities to include cultural programming in health and housing services, such as connecting residents or service users to Elders, language-based teachings, travel to home communities, and reconnection with family and connection to community. Culturally relevant programming, Indigenous staff, and peer workers, as well as cultural safety training are currently in practice in many of the DTES organizations serving residents with complex needs, such as in supportive housing.

Ambrose Place, Niginan Housing Ventures (Edmonton)

Ambrose Place[lxix] is an example of an effective housing and support program for people with complex needs, with Indigenous led and culturally relevant programming. This program implements a Housing First approach, with culturally sensitive support services for Indigenous people experiencing homelessness and those in need of affordable housing. Ambrose Place operates on a set of principles and best practices to support people homelessness and have complex needs, which have proven effective by:

- meeting people where they are at;

- focusing on improving the quality of the individual's life, health, and well-being;

- educating the person on options and consequences, thus enabling the individual to improve their quality of life, health, and well-being; and

- working with residents in a non-judgmental and gradual fashion.

There are 14 units available for people seeking safe, affordable housing and 28 units with supports, as well as a communal ground floor that is accessible to all residents. Having a mix of affordable and supportive housing in one building enables residents to move as their level of needs for supports and independence change overtime, while still maintaining their relationships within their existing community

HOUSING FIRST

Housing is much more than a place to sleep; it supports health and wellness, stability, safety, and privacy. Suitable and secure housing can help create and maintain independence, stability, routines, self-worth, and social connectedness.

Housing First (HF) is the leading approach worldwide for helping people experiencing chronic homelessness to achieve stability. There are numerous empirical studies that provide strong evidence of its effectiveness across the world, including in Canada, the United States, and Europe.[lxx] The results have shown that this model supports housing stability and improves quality of life and health outcomes related to mental health and substance dependency. HF reduces involvement with criminal justice and results in lower overall costs associated with emergency services, including hospital and emergency visits.

The model first emerged in the early 1980s in the United States and Canada to respond to the growing rate of chronic homelessness. Today, it informs the strategies and policies for homelessness response at all three levels of government within Canada, including Canada's Reaching Home Strategy, the Province of B.C.'s homelessness response, and the Vancouver DTES Plan[lxxi] and Housing Vancouver.

The goal of HF is to end chronic and recurrent homelessness by providing immediate, permanent housing and supports that promote recovery, stability, and wellbeing. Departing from previous housing continuum models, HF does not require stability, psychiatric treatment, or sobriety in order to be eligible for housing. Instead, community-based services and supports are provided alongside housing, as well as opportunities for community integration and social connectedness. It is a client-driven model, where housing and supports provided are individualized and responsive to the needs and desires of their recipient. Its core principles are immediate access to housing, consumer choice, and self-

determination. HF harnesses a harm reduction approach and is oriented towards achieving recovery over the long-term.

HOUSING FIRST CASE STUDIES

At Home/Chez Soi

The most prominent HF research in Canada was the Mental Health Commission of Canada's At Home/Chez Soi study, which took place over four years in five cities: Vancouver, Winnipeg, Toronto, Montreal, and Moncton.

The Vancouver case study[lxxii] examined the quality of life for people experiencing homelessness, with moderate to high mental health and substance use challenges. The results demonstrate that an HF approach is effective in reducing homelessness, improving stability, and health outcomes, as well as reducing the scale and frequency of crises experienced by people when they are housed.

Finland Housing First

HF was introduced in Finland in 2007 through a program to provide permanent housing with individually tailored support services to the most vulnerable people experiencing homelessness across the country. Several housing organizations, including the Y-Foundation, Finland's fourth largest landlord, provided housing as part of the program and hostels were also converted into self-contained units.

The government of Finland's[lxxiii] PAAVO programs[lxxiv] (2008-2015) targeted people experiencing chronic homelessness, and the AUNE program[lxxv] followed (2016-2019) to prevent homelessness. The current focus of government policy is to halve the number of people experiencing homelessness over the next four years (2020-2024) and end homelessness by 2024.[lxxvi]

In 1987, there were approximately 19,000 people experiencing homelessness in Finland and recent data indicates a significant drop, with 4,600 single people and 264 families experiencing homelessness.[lxxvii] Experiences of chronic homelessness have seen a significant decrease and there are almost no people sleeping outside.[lxxviii]

INTEGRATION ACT AND ICM CARE TEAMS

A key component of the HF approach is providing intensive clinical support services such as Assertive Community Treatment (ACT) and Intensive Case Management (ICM) teams alongside housing. The At Home/Chez Soi Study provided strong evidence that integrating

ACT teams within an HF approach is effective in improving outcomes for people with high needs.

Some communities in Canada integrate ACT and ICM teams into their HF programs, yet it is not a common approach.[lxxix] The Federal Government's Homelessness Partnering Strategy added HF as an approach in 2014, however, ACT teams were not included because health services are funded by the provincial or territorial governments in Canada.[lxxx]

Currently, there is a lack of ACT services integrated within supportive housing in the DTES. Many of the residents experiencing homelessness or supportive housing are followed by ACT and ICM teams. However, most supportive housing programs in the DTES do not provide in-house health supports; this means that when people with complex needs are housed in supportive housing, they may not receive the individualized health supports to maintain housing stability. This is particularly true for many tenants with a mental health diagnosis not connected to an intensive care team.

INTEGRATED SERVICE APPROACHES

Many countries worldwide are facing a growing number of people experiencing two or more concurrent chronic conditions, including mental health and substance dependency. Often the health and housing systems in-place are not integrated or working together to address complex and interconnected issues. People are not accessing the care that they need and, when left untreated, their health, housing, and social circumstances are impacted, often resulting in life crises such as homelessness and an increased demand on healthcare, emergency services, and the criminal justice system.

The current network of services in the DTES is complex and fragmented, making it challenging to navigate. Gaps and barriers to accessing services exist and are most impactful on the people with the highest and most complex needs. A study in 2017 found DTES residents with two or more chronic conditions, many of whom were living in SROs, were unable to access effective treatment nor sustain long-term participation in treatment[lxxxi].

Complex Care

The National Centre for Complex Health and Social Needs in America has developed a "person-centred approach to addressing the needs of a relatively small, heterogenous group of people who repeatedly cycle through multiple healthcare, social service, and other systems, yet do not derive lasting benefit from those interactions."

The Complex Care approach seeks to be person-centered, as a relational practice where the individual's strengths, goals, choice, routines, and relationships are leveraged to support

healing. It is cross-sectoral in its delivery through integrated and whole-person care that breaks down silos between health and housing sectors, as well as interprofessional and inclusive teams. The approach recognizes the structural barriers to health and seeks to work with communities to improve equity. Cross-sectoral data is shared in a timely and free manner across team members and partners, to enable effective support and monitor impacts.

A blueprint[lxxxii] for implementing the complex care approach was developed through input from stakeholders across the country, with several key recommendations made:

- Create standardized educational resources and core competencies: A cross-sectoral and diverse team is required for providing complex care. Core competencies can help guide these teams and support the creation of standardized educational programs and resources, as well as standards that can be measured and evaluated.

- Develop quality measures: Standard measures can support learning and improve quality service, as well as demonstrate the impact of the care provided, through measuring the overall wellbeing and health outcomes.

- Cross-sector data: Improved access to integrated data is critical to serve people with complex needs.

- Identify research and evaluation priorities: Convene a research community to help fill identified research and knowledge gaps on a priority basis.

- Engage and build partnerships: Collaboration between sectors is integral, and values, principles, and tactics of service providers can become better aligned. Potential partners include criminal justice, housing, social services, palliative care, primary care, substance dependency treatment and medicine, population health, community advocates, and public health.

- Value the knowledge and leadership of people with lived experience: The people who experience the issues at-hand know most about the systemic issues and gaps in services. Hearing from and amplifying the voices of people most impacted by the problem will help to identify opportunities and solutions.

- Expand public investment: Advocacy is required for improved and reliable public funding to support the development and implementation of complex care models.

- Create a structure that supports systems change: The creation of a multi-organizational coordinating structure is recommended to build accountability in practice, as well as opportunities to be flexible and responsive.

Housing is Health Initiative, Portland Oregon

The Central City Concern (CCC) convened six healthcare organizations in order to build a new affordable housing building with integrated health supports. Together, Adventist Health Portland, CareOregon, Kaiser Permanente Northwest, Providence Health & Services – Oregon, Legacy Health, and the Oregon Health and Science University invested $21.5 million to fund 382 new homes. Of the six groups, five represent the major local hospitals and the sixth is a health insurance provider. The housing development is currently underway, with the outcomes and effectiveness of the initiative not yet known.

The CCC developed buy-in across the health sector through engagement and recruitment of local health organizations' leadership to their board of directors. They have also partnered with the Center for Outcomes Research and Evaluation[lxxxiii] (CORE) to conduct a program evaluation. In addition to designing the health clinic, the group is designing medically intensive respite and palliative care beds at the Eastside Health Center.

Integrated Community Care Models, Europe

In recent years, innovative integrated community care models for people with complex needs have been developed and implemented across Europe.[lxxxiv] The SELFIE project (Sustainable intEgrated chronic care modeLs for multi-morbidity: delivery, FinancIng, and pErformance) has developed a framework for integrated community care programs. Seventeen effective integrated care programs were identified and evaluated in eight countries including Austria, Croatia, Germany, Hungary, the Netherlands, Norway, Spain, and the United Kingdom. Each case study showcased a coordinated, pro-active, person-centred, multidisciplinary care program by two or more well-communicating and collaborating care providers either within or across sectors.

The framework supports stakeholders to develop, implement, and evaluate unique integrated care models in their local communities. Four overarching factors of success[lxxxv] were identified:

1. Use a holistic view of health, including mental and physical health, as well as the social conditions of the patient;

2. Provide a continuity of care in the form of single contact points through aligned services;

3. Building trusting relationships between patients and professionals is enabled through integrated and continuous communication; and

4. Patients are active leaders in developing their care plan, including in goal setting and decision making.

Seniors with Complex Needs[lxxxvi]

Research led by the Center for Consumer Engagement in Health Innovation explored the unique barriers felt by older adults with complex needs and social issues when trying to access health and housing supports. A strategy has been developed to better integrate these services and three recommended actions are proposed:

1. scale a model of on-site service coordination and wellness programming in affordable senior housing communities;

2. increase investment in developing new affordable senior housing in a way that supports partnerships with health care entities and builds services into the infrastructure; and

3. foster intentional partnerships between affordable senior housing communities and health care entities in order to break down the silos between the two stakeholder groups

Program of All-Inclusive Care for the Elderly (PACE) CNY and Christopher Community, Syracuse, New York

This model co-locates housing and on-site clinical services such as primary care. PACE CNY is located next to two affordable senior housing properties operated by Christopher Community. Residents can access health supports as needed on weekdays, as well as benefit from program staff aides after hours. Approximately 75% of residents are enrolled in the program and they are able to shift their level of support based on their changing needs overtime.

MENTAL HEALTH OUTREACH & CRISIS RESPONSE

Specialized health-centered responses to emergency mental health calls are becoming more common in large metropolitan cities around the world.

Behavioral Health Emergency Assistance Response Division (B-HEARD), Harlem, New York

Beginning with a pilot in East Harlem and parts of Central and North Harlem, 911 call operators dispatch B-HEARD[lxxxvii] teams including paramedics and a mental health professional as the default first responders to people experiencing a mental health emergency. These teams use their experience and training to de-escalate emergency situations and provide immediate care for a range of health issues including suicide ideation, substance dependence, and mental health distress. Part of the model also includes a social worker and credentialed peer counselor, to offer hope that recovery is possible, model what stability and wellness can look like, and provide empathy and understanding.

The goals of the team are to implement mobile crisis rapid response, meaning responding to urgent calls within two hours, reduce unnecessary visits to the Emergency Room, connect patients to care within 24 to 48 hours, as well as reduce 30-day re-admissions from the Emergency Department and inpatient care. The team responds to urgent calls within two hours, non-urgent calls within 48 hours and post-crisis follow-ups within 72 hours. Between 2017 and 2018, evaluations report that approximately 87% of referrals were responded to within two hours.

TANDEMplus, Brussels, Belgium

TANDEMplus is a mobile crisis service that supports people during or shortly after they experience a mental health crisis. The goal is to provide short-term interventions, in order to connect and reconnect people to their existing support networks, with an average intervention of approximately 29.5 days.[lxxxviii] TANDEMplus actively liaises with existing support services to prevent fragmented service provision and helps a person navigate and connect to services that meet their needs.

The service is free and operates in areas of Brussels with lower socioeconomic status, serving adults over 18 years of age experiencing a crisis or not connected to psychiatric services. The team includes eight outreach workers, clinical psychologists, social workers, nurses, educators, and one psychiatrist.

The Human Rights Watch conducted a cost-benefit analysis and found that this service is more economical than hospital-based care. Mobile health teams are a rights-affirming service, and this service is in-part a response to the high rates of forced hospitalizations in Belgium. The country has one of the highest numbers of psychiatric beds per capita in the European Union, with an average 136 beds per 100,000 people while the European average is 69.

Experiences of mental health distress can often be met with delay or detainment, which hinders a person's ability to access the treatment they need to stay healthy and housed. These early interventions can support people to live in community and prevents burdens being placed on law enforcement, emergency departments, and justice systems.

TRANSFORMATIVE DRUG POLICY

Safe Supply

Advocacy for safe and regulated drugs, referred to as 'safe supply', has been ongoing for decades.[lxxxix] The Canadian Association of People Who Use Drugs (CAPUD) defines safe supply as "a legal and regulated supply of drugs with mind/body altering properties that

traditionally have been accessible only through the illicit drug market."[xc] This includes replacing common drugs currently illegal and unregulated in Canada, such as heroin, cocaine, and methamphetamines. There are numerous empirical and clinical studies[xci] that provide strong evidence that by giving people who use drugs access to regulated pharmaceutical-grade substances from a legal source, rather than toxic versions from illicit markets, lives are saved along with other improved social, economic, and health outcomes. Current opioid use disorder treatments available in the DTES, primarily methadone substitution prescriptions, are insufficient or ineffective for many people dependent on heroin, particularly people using heavily. Some of the evidence to support safe supply to treat opioid dependence includes:

- Providing access to a drug with a known quality and strength will help people to stop or reduce their use of illicit heroin;

- Prescribing people their drug of choice likely attracts more people to the treatment and retains their participation in the treatment for longer;

- Safe supply saves lives by preventing overdoses and deaths, as well as preventing other health issues such as the transmission of HIV and hepatitis B and C;

- Safe supply often improves other social outcomes such as a person's ability to maintain employment, housing, and social connections; and

- Can enable a gradual reduction in drug use or form of use, such as from injecting to oral.

In September 2021, the Centre for Addiction and Mental Health (CAMH) published a first of its kind policy statement advocating for immediate drug policy reform, including replacement of the unregulated, toxic drug supply with safe supply, as well as the decriminalization of all drugs in Canada through a Controlled Drugs and Substances Act.[xcii] Medication assisted therapies such as OAT, including injectable (iOAT, and psychosocial treatment were recommended to be made readily available.

Research on effective treatment interventions for substance use disorders related to stimulants, particularly methamphetamine, is needed to address current needs. Decriminalization would also entail expunging convictions for simple possession and consider formal redress of the harms of prohibition and related policies. These efforts would help to implement the Truth and Reconciliation Committee's calls, in particular calls to action 30-32, which aim to eliminate the overrepresentation of Indigenous people in custody, as well as the historic and ongoing over-policing and over-incarceration of Black and Indigenous people and communities.

Prescription Heroin, United Kingdom

Heroin is prescribed in the treatment of opiate dependence in the United Kingdom, Switzerland, and the Netherlands. Clinical trials are either planned or are underway in several countries including Germany, France, Belgium, Spain, and Canada.[xciii]

The United Kingdom has the longest known prescription treatment program for heroin that has been in practice since the 1920s.[xciv] At its outset, the program was intended to support people using to maintain their employment, housing, and social relationships by avoiding using illegal drugs. In the 1970s, the policy shifted towards substitution treatments such as methadone and other abstinence-based models. In practice, the treatment is rarely used with less than 500 participants in the early 2000s. However, the policy conversation has shifted back to its original focus more recently with proposals to expand the program to achieve outcomes such as reduced crime and improved health.

Environmental Scan Closing Remarks

The Environmental Scan section highlights the structural barriers people with complex needs experience when trying to access services and highlights current government policy. Promising practices and case studies have been identified that provide opportunities and learnings to address the existing gaps and barriers in services in the DTES. Understanding the community context helps to frame the feedback received during community engagement, which is highlighted in Part 2 of this report.

Part Two: What We Heard

Introduction

This section of the report summarizes feedback received during engagement activities completed in September and October 2021. The approach to engagement was defined collaboratively with service providers that work with people with complex needs. The input of these agencies helped to ensure engagement activities were respectful and created space for meaningful dialogue.

The DTES is home to many distinct service providers and organizations providing important health and housing services for people with living and lived experience of homelessness, substance use, and/or mental health challenges. Given the complexity of the non-profit and service delivery landscape, the project team relied on feedback received from key agencies in an initial stakeholder mapping session to define which organizations and staff members should be engaged as part of this process. Following this initial engagement session, CitySpaces convened multiple conversations with service providers who offered valuable input on the BCS draft service delivery model.

In addition to interviews with service providers, the project team met with people with living and lived experience of homelessness, substance use dependence, and/or mental health disorders. These interviews were structured in a way to foster trust and connection, meeting people 'where they were at'[9] to learn from their experiences.

It was important for the project team to better understand what makes housing and health services work for people with complex needs. Feedback received on the engagement questions (Appendix A on page 66) has provided a more fulsome understanding of gaps and barriers people experience in trying to access housing, retain housing, and receive the assistance needed to stay healthy. This information can help BCS to refine their draft service delivery model.

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[9] The idea of "meeting people where they are at" considers present circumstances, past experiences, personality, and mental and physical health needs. This concept recognizes the unique challenges someone may experience and prioritizes building a connection and relationship that is effective for them.

ENGAGEMENT AT A GLANCE

31 PEOPLE INTERVIEWED AS KEY INFORMANTS

20 SENSITIVE LISTENING INTERVIEWS

WE SPOKE WITH 51 PEOPLE IN TOTAL

25 NON-PROFIT OR GOVERNMENT AGENCIES WERE ENGAGED

ENGAGEMENT ACTIVITIES

Stakeholder Mapping

Effective engagement relies on relationships. While the CitySpaces team has existing connections to many service providers in the DTES, the non-profit and service delivery landscape is complex, and many organizations have limited time and resources to participate in interviews. The project team convened an initial virtual engagement mapping session to determine which organizations and agencies should be engaged for this project. Key representatives from DTES organizations working in the health, housing, and substance use sectors were invited to participate (i.e., WATARI, Overdose Prevention Society, Vancouver Coastal Health) in a virtual focus group.

The mapping session focused on service gaps in the housing, health, and substance use sectors. CitySpaces facilitators asked participants for suggestions on who to connect with as part of this engagement exercise (e.g., which organizations work closely with people with complex needs? Are there specific people at these organizations with whom to connect?)

The conversation also focused on the importance of designing engagement to be culturally safe, as many DTES residents with complex needs identify as Indigenous. Focus group

participants were asked for suggestions as to which Indigenous organizations to connect with to better understand how they would like to be engaged for the project. Based on feedback received at this meeting, the CitySpaces team was able to identify organizations and key contacts to connect with and interview as part of this project.

Listening to Partners

Before beginning interviews with service providers and persons with living and lived experience, CitySpaces hosted a second virtual workshop with two representatives from organizations that work closely with Indigenous people (Bloom Group and Dude's Club Society). During this session, the project team listened and learned about the barriers and gaps in service that Indigenous people encounter, particularly for those individuals with complex needs.

It was also important to better understand how people with living and lived experience would like to be engaged in a way that is convenient, respectful, and meaningful. Suggestions received focused on meeting people 'where they are at', providing honorariums, and offering cigarettes and food. This input was essential in helping to define appropriate engagement activities with people identifying as Indigenous.

Interviews with Service Providers

CitySpaces completed 31 interviews with service providers to understand gaps and barriers in the way services are currently provided for people with complex needs. These interviews also provided an opportunity for the project team to obtain feedback on the BCS draft service delivery model. Many of these conversations were held virtually to ensure convenience and safety.

Feedback received at the initial stakeholder mapping session outlined which health, housing, and substance use agencies and programs should be contacted as part of this engagement exercise. These suggestions and existing relationships were helpful in connecting the CitySpaces team to different individuals at key organizations. Many service providers identified additional agencies or programs to interview as part of this project. It was important to ensure this aspect of the engagement process was comprehensive yet scoped, given the extent of service providers on the DTES. Agencies and programs interviewed as part of this project included:

- Aboriginal Front Door
- Atira Women's Resource Society
- BC Housing

- Bloom Group Community Services Society

- Carnegie Cultural Sharing Program

- Dude's Club Society

- First United Church Community Ministry Society

- Homelessness Services Outreach Team (Carnegie Outreach)

- Kilala Lelum Health Centre

- Lookout Housing and Health Society

- Lu'ma Native Housing Society

- MPA Society

- Overdose Prevention Society

- Pender Community Health Centre

- PHS Community Services Society

- Providence Crosstown Clinic

- RainCity Housing and Support Society

- Vancouver Aboriginal Community Policing Centre

- Vancouver Assertive Community Treatment (ACT) Team

- Vancouver Coastal Health

- Vancouver Intensive Supervision Unit

- Watari Counselling & Support Services Society

- Western Aboriginal Harm Reduction Society

Through these conversations, the project team was able to "ground-truth" the draft BCS service delivery model and learn more about what makes housing and health services work for people experiencing chronic homelessness, substance dependence, and/or mental health challenges.

Interviews with People with Living and Lived Experience

Based on feedback received from Indigenous groups and other service providers that work closely with people who identify as Indigenous, the project team scheduled meetings with four different organizations that work closely with people with complex needs. It was important to define a time that was convenient – the project team relied on the guidance of building managers and shelter operators for scheduling. Overall, the project team interviewed 20 individuals with lived and/or living experience of homelessness, substance use dependence, and/or mental health challenges. These conversations focused on where

housing and health services have worked and where service barriers and gaps have been encountered.

These interviews were held in person over three days in late October. Two CitySpaces facilitators visited **Klahowya Tillicum Lalum**, a new emergency shelter located at 875 Terminal Avenue; **Aboriginal Front Door**, a culturally safe meeting place and drop-in centre for Aboriginal Peoples at Main and Hastings; **C'owaa**, permanent supportive housing operated by Lu'ma Native Housing Society in the former Ramada Hotel at 435 Pender Street; and, **Powell Street Getaway**, a drop-in centre and safe consumption site operated by Lookout Housing & Health Society at 528 Powell Street. At certain organizations, staff had already identified people with lived/living experience with the capacity to participate in an interview. At other organizations, the project team worked with a peer to identify people to interview. The project team structured visits at convenient times (e.g., after lunch, during an afternoon snack break), an approach recommended by service provider staff.

Given the draft BCS service delivery model focuses on people with complex needs, the project team structured an approach to connect with people experiencing health, housing, and/or substance dependency challenges. While this was a priority of the project team, it became evident that people with complex needs experience multiple challenges making it difficult to connect with them for an interview. Many of the people interviewed were experiencing homelessness or had recently accessed housing and had varying levels of stability. The pictures included in this report reflect the diversity of individuals with whom the project team was able to connect with as part of this engagement initiative.

CitySpaces offered food and cigarettes to people at these organizations and provided honorariums ($20 Tim Hortons gift certificates) for those able to participate in an interview. The project team asked interviewees if they would be interested in having their picture taken to be included in the report, obtaining written consent from those who agreed. The stories and feedback given during these interviews is further summarized in following sections and reflects important considerations to be evaluated as the BCS draft service delivery model is refined.

Key Themes

Based on feedback received from service providers and people with living and lived experience of homelessness, substance dependence, and/or mental health challenges, several key themes have been identified. More detailed feedback on the BCS draft service delivery model is provided in following sections, yet these initial points provide a representative summary of the comments heard consistently throughout interviews with service providers and people with living and lived experience.

MEET PEOPLE WHERE THEY ARE AT & BE RESPONSIVE TO THEIR NEEDS

Housing and health services that work well are person-centered. There is no assuming what a person might need or want, as imposing services is not effective treatment. When people can retain housing and stay healthy, services provided have been tailored to suit their needs. This is applicable across the physical and mental health sectors, substance use programs, and housing providers. Each person experiencing homelessness, a substance use disorder, and/or a mental health diagnosis has distinct needs and flexible services tailored to meet them 'where they are at' in a non-judgmental manner can be highly effective.

> *"I'm barred from BC Housing buildings. My wife lives at a BC Housing building, but she sleeps outside with me. I got evicted during COVID. I was living there for 6 years. VACFSS took my kids away from me…they were six years and ten months old at the time. I haven't seen them since. My son was just learning to crawl. I want to get them back, but we can't because we have to live together and there's no where we can find.*
>
> *I was working at the UGM program and was three years clean. Then I lost my place and fell back into it. I can't get into treatment for opioids, with the reduced capacity because of COVID. I can't get on Income Assistance because of my RRSPs. I need new teeth, but they're not covered. I've been living in my tent."*
>
> *– Person with Living Experience*

PROVIDE EVIDENCE-BASED SOLUTIONS FOR SUBSTANCE USE DISORDERS

Harm reduction supplies are widely available – many people interviewed with living and lived experience remarked that improved access to supplies for substance use was needed. However, within this context, there continue to be gaps in services as safe supply is not

widely available and available substances are frequently toxic. Given the potency of street drugs, higher dose alternatives (e.g., diacetylmorphine, hydromorphone) are needed to support individual needs and save lives.

> "I was clean for 13 years. But I relapsed last January. It's been almost two years since I became homeless because I was fleeing abuse. My kids are in care now and I'm living outside. The shelter kicked me out because I fell asleep with a lit cigarette, and it started a grease fire. I need a place soon.
>
> We need more help for mothers and victims of abuse. The cops make it work and I can't access any of the victim services supports. I feel safe in the DTES, at WISH, and at the DTES market.
>
> There's too much stigma. We all need to be honest about our drug problems. We have the right to self-medicate, we're in pain."
>
> – Person with Living Experience

FACILITATE CONNECTIONS TO CULTURE

Feedback from engagement highlighted the central role of culture in the healing process. People with lived/living experience referenced the powerful relationships with community and Elders that can be a source of strength and support in challenging times. There was a desire to see service provision reflect Indigenous ways of knowing and being, as well as

> "I got out of detox, but then had to go back to the same environment because the waitlist for treatment was too long. I joined group treatment but there was no confidentiality and people shared my story outside of the room...I was hurt and angry and became violent...But culture saves lives. If each person could bring someone back to their culture, that would have a big impact. My mom always told me I'd have potlatch to think about, but she didn't tell me I would be a chief one day...she didn't want to tell me that knowing I was using on the DTES.
>
> But culture has played a big role in my healing process...I run wood workshops for other residents now."
>
> – Person with Lived Experience

through program and building design. Service providers also referenced the importance of capacity building and providing services that are For Indigenous, By Indigenous.

PRIORITIZE SUPPORTIVE HOUSING WITH INTEGRATED HEALTH SUPPORTS

Feedback from engagement indicates there is wide variety in the services offered at supportive housing buildings. The project team heard that many tenants living in supportive housing are not able to access the physical and mental health supports they need to stay healthy, and without these supports, their housing is often at risk as they may not be able to stabilize and maintain their tenancy. It is important to note that when tenants are housed in supportive housing, many are not able to connect to a primary care clinic or an outreach care team. Integrated physical and mental health supports are part of the Housing First model, yet there is little integration between health and housing in the current DTES services network. Although the wide variety of supportive housing allows a diversity of needs to be served, it also means that many buildings are not able to provide sufficient and effective supports for people living with complex needs. Service providers indicated there is no need

"Ten years ago, I was married with three kids. They are now 17, 22, and 27 years old. I am a sexual abuse survivor. My kid's dad is an alcoholic, he's abusive, we had violent incidents and he cheats. We were separated in 2011 and had spent 12 and a half years together.

I fled to Bella Coola with my kids, and then made my way to Mission to live with my mom. I had been sober, but I started using alcohol and then tried crack. I've been homeless in Vancouver for 11 years. I lost a lot with my addiction.

The last two years, I've been in an abusive relationship and am now living on my own in my own room. I need to stay strong and have boundaries to not see him. I fell through the cracks in my own relationship patterns. There needs to be more support for women fleeing abuse, more transition houses.

I've been fighting hard to get clean and sober. I started school at VCC this September. Feels good to share my knowledge with teachers and the other students. They love hearing from me, I just gave an oral presentation instead of a written report.

Culture has always been important to me. Now I'm a leader in my community, a role model. It's what our people do. It all starts with yourself. If you can stay mentally strong, you can do anything."

– Person with Living Experience

to "re-invent the wheel" – the primary issue is the limited supply of supportive housing with integrated health supports for people with complex needs.

LACK OF MENTAL HEALTH SUPPORTS

There are limited mental health services available for people with complex needs, particularly for people with traumatic brain injuries. For people with complex needs accessing supportive housing, it can be challenging to connect with a mental health care team. Although mental health care services are offered in clinics throughout the DTES neighbourhood, the project team heard from both supportive housing tenants and service providers that accessing these programs can be difficult for people with complex needs. This can be particularly challenging for people in crisis exhibiting violent or aggressive behaviour, as support staff cannot always de-escalate conflict. Due to the lack of outreach or integrated mental health response options, service providers often must wait until a person is in distress

> *"I'm from Ontario. I've been on the BC Housing waitlist for 14 years. I've been told I'm not a candidate for modular housing because of my aggressiveness. I tried to get into mental health housing, but couldn't BC Housing has barred me…they said I uttered death threats. I'm angry because I've been on this list for too long.*
>
> *I was at a BC Housing SRO, but I got evicted because I was robbed by another tenant. I've been living outside for two years in a tent. I had five tent fires. I've been at a private SRO for almost a year now.*
>
> *The room is $550 a month, comes with a fridge but no bed. My cable just got turned off. I really need my privacy to relax and watch TV, but now I don't even have that. It's messy, broken glass pipes in the hallway. Staff don't care about people, they don't check rooms, even when people aren't seen for 48 hours. They ask me to check up on people. I've found two dead people on two separate occasions.*
>
> *I used to have a Counselor at the Heatley Clinic, but they retired. Now I don't have one. I need one for my mental health and my PTSD. I've lost people that I deeply care about. I lost two friends at the same time. It's really hard and it's really scary.*
>
> *I work hard. I like giving back to my community as a peer. I need a home where I can recharge, rest, and have some privacy. I would like to find housing outside of the area, with my own bathroom."*
>
> *– Person with Living Experience*

before they can call emergency services to respond. Feedback received emphasized that finding a proper responder to a mental health crisis is an impossible task. The project team also heard that CAR 87 has limited capacity to respond to calls from supportive housing providers, requiring that police officers respond to the call, which can often escalate the situation further.

For people with complex needs, service providers also questioned the necessity of medical intervention as a first response given the living conditions on the DTES. Feedback received highlighted the importance of providing safe and affordable housing, safe drugs, and a guaranteed income, and then exploring a comprehensive mental health response. It was suggested mental wellness could be more attainable if living conditions were improved and employment opportunities were available and accessible.

SINGLE ROOM OCCUPANCY BUILDINGS ARE NOT ADEQUATE HOUSING

People with living and lived experience of homelessness, mental health challenges, and substance dependence specified that single room occupancy (SRO) buildings do not meet their needs. Many people who have experienced homelessness have a history of trauma and do not feel safe in shared spaces, including shared washrooms. Feedback received focused on the need for self-contained units where people can feel safe, secure, and dignified. This was identified as essential to healing, health, and recovery. People with lived and living experience also expressed a desire for autonomy; no-visitor policies at certain SROs re-enforce a client/service provider relationship and do not promote independence. SROs are not dignified – the quality of housing is such that many people chose to live outside when SROs are the only housing option. This is accelerated by the understanding that once housed

> *I've been volunteering at PSG [Powell Street Getaway] for a while. I want good housing – which means my own bathroom and kitchen. A medical room in the building would probably be helpful. I refuse to live in an SRO. SROs aren't housing and I've been kicked out of a few of them. But it's hard finding other options – my rent has gone up a lot. And I've been renovicted before…I was paying $375 and then they renovated the building and posted the rent at $1,350 which I can't afford. It would be great if there were more modulars. And more modulars without active use!"*
>
> *– Person with Living Experience*

in an SRO, the only way to access other housing is to become unhoused and re-start the process of navigating BC Housing's waitlist for supportive housing.

SUCCESSFUL HOUSING IS DEPENDENT ON STAFFING AND RELATIONSHIPS

Feedback received from both service providers and people with living and lived experience highlighted the importance of adequate staffing models. Typically, supportive housing buildings have two staff on shift 24/7; however, this tenant to staff ratio does not increase with the number of tenants in the building. In buildings where there are sufficient staff available to support tenants, relationships can foster trust and connection. Additionally, the project team heard that smaller buildings can increase the number of opportunities for residents to build connections and relationships with neighbours and staff. Strong relationships create community where tenants know one another and can participate in different activities that involve food, culture, and storytelling. This is a key component of successful housing – residents feel connected and feel at home.

> *"I was evicted from Marguerite Ford because I was robbed twice and had to bolt a safe to the floor to keep my stuff safe. But I wasn't given a walk through, so I didn't know the floors were heated and a water main broken when we tried to drill a bolt in the floor.*
>
> *I hate having my dog in the shelter. I want my own bathroom and suite – how do you make a file attractive to BC Housing?*
>
> *I'm a functioning addict. My back pain has gotten me started on fentanyl patches. I've lost my two brothers to fentanyl and both my parents to pills and addiction.*
>
> *All I want is my own key. I want to cook my own meals, feed my dogs, and be able to sit down, look around and say 'this is mine!'*
>
> *I don't understand why my file has been open for so long. I've never had a phone call. I'm tried of waiting and of waiting in these places...it's so hard for my dogs to be in the shelter. "*
>
> *– Person with Living Experience*

Feedback on BCS Draft Service Delivery Model

Interviews with service providers and people with living and lived experience provided an opportunity to "ground truth" the BCS draft service delivery model. Given some of the model components are still under development, it was challenging to explain how the model would work in practice, yet valuable feedback was still obtained that can help to inform how the model is structured as it becomes more defined.

WELCOMING CENTRE

- **Feedback received on the Welcoming Centre was mixed.** Service providers indicated support of centralized, coordinated services located under one roof as it can be challenging for people with complex needs to access services at multiple different locations. However, service providers also specified that it is unlikely people with complex needs will access supports at a centre given the complexity of their health and housing challenges. Feedback received from service providers focused on the importance of meeting people with complex needs in ways convenient to them, typically through outreach services. In order to make the Welcoming Centre a truly welcoming environment, it is likely transportation services would need to be provided to ensure people with complex needs can easily access the centre on their own terms. Many providers were confused about the role and function of the Welcoming Centre and how it would relate to the existing service landscape in the DTES.

- **Certain providers questioned how the Welcoming Centre would be distinguished from other service centres in the DTES,** including BC Housing's Navigation Centre and indicated service centres with housing to be their preference given the limited availability of shelter beds and supportive housing units.

- **Providers and people with lived experience emphasized this centre should be Indigenous-led.** Given the over-representation of Indigenous people among those with complex needs in the DTES, it will be important to design the centre to be culturally safe, reflective of Indigenous design, and supportive of different cultural practices.

> *"It's about making a space feel safe… have Indigenous people on all the teams, provide cultural training, add a cultural aspect to everything –*
> *life skills, traditional foods, cooking, building design"*
>
> *– Person with Lived Experience*

- While the notion of coordinating services was applauded by certain providers, it was recognized **this sort of a centre would continue to struggle with the systemic issues impacting service provision in the DTES.** Without the addition of more supportive housing units, any housing worker at the Welcoming Centre would not be able to connect their clients to housing. Similarly, a lack of mental health supports would continue to be an issue, regardless of a new centre. It was suggested that additional funding should instead focus on the systemic issues impacting service delivery in the DTES.

MULTIDISCIPLINARY SUPPORT TEAM

- **Service providers expressed some confusion over the multidisciplinary support team, given its similarity to Assertive Community Treatment (ACT)[10].** ACT staff indicated they adhere to a transdisciplinary service model, which they feel is superior to a multidisciplinary structure. It will be important to define the role of this support team

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[10] ACT is a recovery-oriented mental health service delivery model that uses a psychosocial rehabilitation (PSR) approach and has received substantial empirical support for facilitating community living, psychosocial rehabilitative services, and recovery for persons who are living with the most serious mental illnesses, have severe symptoms and impairments, and have not benefited from traditional outpatient programs.

and how it might fit within the existing landscape of outreach services (*see Table 1 on page 47 for a breakdown of the different delivery service models*).

- **Service providers specified the need to provide long-term supports as recovery is complex** and it can take many years for people to achieve stability. Care teams, such as ACT, can be effective when available as they are not bound to a specific program or housing provider. When someone's life circumstances change, they can still access the support of a care team. Service providers identified long-term supports to be beneficial for people with complex needs and it was recommended a similar approach be taken with this multidisciplinary support team.

- **Feedback received from providers indicated ACT teams are highly effective in providing the supports and care people with complex need require to stay healthy and housed.** However, there is a need for additional flexibility for ACT and other crisis response teams to respond to requests outside of the Monday-Friday, 9am-5pm timeframe. The issue is also one of scale – there are not sufficient resources available to support more ACT teams and many people who could benefit from ACT have not been able to receive such services because of a lack of capacity. Feedback received from service providers also referenced the challenges they have experienced when ACT and ICM teams are unable to help people exhibiting aggressive behaviour. Service providers suggested ACT teams include a peer with lived experience and acknowledged additional training to de-escalate violence may be beneficial. ACT teams are also governed by union policy, which can limit the extent to which ACT team members can assist someone who has verbally abused them. Service providers suggested scaling up services that are currently working and adjusting ACT where necessary, rather than defining a new model of service delivery.

"ACT is short on doctors... during intakes, we have to go with who is most in need."

– Clinical Supervisor

Table 1: Different Disciplinary Service Models

Source: Vancouver Coastal Health

	Multidisciplinary	Interdisciplinary	Transdisciplinary = ACT
Assessment	Separate assessments by team members	Separate assessments with consultation	Team members conduct comprehensive assessment together
Client Participation	Clients meet with individual team members	Clients meet with team or team representative	Clients are active and participating team members
Service Plan Development	Team members develop separate plans for disciplines	Team members share plans with one another	Team members and clients develop plans together
Service Plan Implementation	Team members implement part of the plan related to their discipline	Team members implement their section of the plan and incorporate other sections where possible	The team is jointly responsible for implementing and monitoring the plan
Lines of Communication	Informal lines	Periodic, case-specific team meetings	Regular team meetings with ongoing transfers of information, knowledge, and skills shared among team members
Guiding Philosophy	Team members recognizes the importance of contributions from other disciplines	Team members are willing and able to develop, share, and be responsible for providing services that are part of the total service plan	Team members make a commitment to teach, learn, and work together across disciplinary boundaries in all aspects to implement unified service plans
Staff Development	Independent with each discipline	Independent within, as well outside of, own discipline	An integral component of working across disciplines and team building

- Given the over-representation of Indigenous people among those with complex needs in the DTES, **providers and people with lived experience felt this support team should be Indigenous-led and involve peer support workers**. By meeting people 'where they are at' with empathy and an understanding of their lived experiences, it can be easier to understand what services and supports can help connect someone to housing and healthcare.

- There was mixed feedback on providing additional outreach supports, as certain providers felt in-reach and in-house supports to be more effective. Ultimately, the common theme referenced was about the quality and consistency of supports. **For a new multidisciplinary support team to be effective, sufficient funding is necessary to ensure low staff turn-over and extensive staff training**. This can help to ensure staff are flexible and responsive to client needs and can help to build trust and relationships, which is a key component of the healing process.

- **Several providers and people with living and lived experience referenced the importance of connections to culture, particularly through ceremony, food, and land-based healing programs**. It was suggested the multidisciplinary support team could help to connect people back to the land, through partnerships with organizations that offer land-based programming.

> *"It's about good staff, good management – no judgement."*
>
> *– Person with Living Experience*

SUITABLE HOUSING

Many conversations with service providers and people with lived/living experience focused on the importance of providing supportive housing with integrated health supports that is well funded and resourced to care for people with complex needs. A high-level summary of what makes housing work for people with complex needs is provided below; more detailed feedback follows this summary.

- Self-contained units that promote dignity, privacy, and security

- Greater housing choice (e.g., providing people with housing options) & a sense of autonomy for tenants

- Flexible housing arrangements (e.g., people can move to different units within the same building, or to a different building if needed)

- Smaller buildings for people with complex needs

- Well-staffed buildings

- Connection to culture and community

- Wrap-around supports, including physical and mental health supports

- Indigenous-led services and peer support workers

- Strong relationships between staff and tenants centred on empathy and trust

- Purpose-built and innovative housing solutions for people with complex needs (e.g., soundproof units, pod-style trailer units, fire-proof units)

- Meeting people 'where they are at'; no one solution that fits all

- Many of the conversations with service providers focused on what makes housing work for people with complex needs. **Most housing providers indicated supportive housing is successful when integrated health supports are offered and staff can build relationships with tenants to support them 'where they are at'**. It was recognized that this model of supportive housing is not always available and given there is no agreed upon definition of supportive housing, the supports offered in buildings designated as supportive can vary significantly.

> *"It's important to create a bond that isn't based on a supervisor/client relationship"*
>
> *– Person with Lived Experience*

- Many providers indicated funding models and staffing burnout limits the extent to which supportive housing with integrated health supports can be offered.

- Service providers and people with lived/living experience expressed a desire for **more purpose-built supportive housing** as there are not enough supportive housing units available for people with complex needs. While temporary modular housing has been successful in providing dignified, self-contained units in neighbourhoods outside of the DTES, there is a need for more supportive housing specifically designed to support people with complex needs. This refers to buildings that have incorporated fire-proof units, sound-proof units, flexible units with lock-off suites, communal spaces with clear sightlines for staff safety, designated health-related spaces with appropriate equipment, and cultural rooms and healing spaces.

> *"No one can move on from supportive housing as there is no below-market housing available"*
>
> *– Non-Profit Housing Provider*

- **The housing continuum is broken.** Feedback received from providers suggests there is not enough second stage and transitional housing, as well as subsidized rental housing, to provide options for people leaving emergency housing or shelter-rate units. This has resulted in bottlenecks – when people are ready to move out of supportive housing, there are no available options and a multi-year waiting list. It is also challenging to access the limited second-stage housing that does exist, as certain programs are higher-barrier environments.

- **Successful supportive housing programs for people with complex needs have flexibility to meet people 'where they are at'.** Feedback received from providers and people with lived/living experience referenced innovative housing solutions that have been explored for tenants living with mental health challenges and substance dependency, such as more one-on-one support services, separate pods for people who need quiet spaces away

from other tenants, designated mental health supports, access to health services, and opportunities to connect to culture and build community. It can be challenging for supportive housing providers to deliver these kinds of services in larger complexes with limited staff and supports; however, this kind of model was seen to be highly effective in keeping people healthy and housed.

> *"When we are working with people with complex issues, we need to work with people in smaller settings"*
>
> *– Non-Profit Housing Provider*

- **People with lived/living experience spoke about how they have fallen through the cracks when housing hasn't work for them.** Those interviewed spoke of being evicted because they were unable to access the health supports they needed and then experienced crisis and were evicted. People with lived/living experience also indicated their pathway into homelessness was often due to a traumatic event, such as the end of a relationship, loss of a job, relapse, death of a family member or loved one, or an experience of abuse.

> *"We need more outreach. I waited for six hours at Carnegie Outreach and I didn't have time to get it all done and need to go back. They helped me get my ID's replaced, but I still need to find housing and a job...my EI just ended. We could have at least two of those offices."*
>
> *– Person with Living Experience*

Once homeless, people spoke of the challenges they experienced trying to access housing that could support their mental and physical health needs. Without these supports, eviction was a common experience. People with lived/living experience also indicated how challenging it was to end the cycle of homelessness, as the cost of market housing is prohibitive and there are limited suitable options that are affordable. Those interviewed also highlighted the difficulties they have experienced navigating the services network and getting the assistance they need for housing, health supports, and employment. Many of these experiences are compounded by intersectional oppression.

Gender queer folks and racialized people experience additional barriers from racism, sexism, and other forms of discrimination that limit their ability to access services.

- Providers indicated certain **people with complex needs have been evicted from many supportive housing buildings in the DTES** and acknowledged the system is not working for those living with multiple challenges. Providers also referenced that without an official mental health diagnosis or substance use disorder diagnosis, it can be challenging for people to access the health supports they need to remain healthy and housed.

> *"I've been told I'm not modular material"*
>
> *– Person with Living Experience*

- Interviews with people who have lived experience illuminated the importance of different supports in helping people with complex needs stay healthy and housed. The following summary highlights **what has have worked well to ensure people stay healthy and housed**, particularly for people with complex needs who have experienced multiple evictions.

- Self-contained units that promote dignity, privacy, and security
- School and work/peer positions
- Connections to culture
- Mental and physical health supports
- Sense of community

- **Providers indicated there are limited housing options for older people with complex needs**. While it is important to ensure older adults have the supports they need to age-in-place, it was also recognized this gap is a positive sign that people in supportive housing are getting older, demonstrating supportive housing saves lives. Assisted living and long-term care facilities do not have the supports available to accommodate people with mental health challenges and substance dependency, but supportive housing programs do not have the necessary health care supports for older tenants. There is a need for housing that can accommodate older adults with complex physical health needs who

have also experienced chronic homelessness, substance dependency, and/or mental health diagnoses.

> "Long-term care won't take people that smoke. People that have chronic and enduring mental health issues smoke… so older people with mental health diagnoses aren't accepted into long-term care. Where will they go?"
>
> – Non-Profit Housing Provider

- **It was also noted that challenging behaviour, particularly violence and aggression, is a common cause of eviction**. One provider noted that violence is the presentation of a condition, such as a mental health diagnosis or substance use disorder. These conditions are not always adequately supported and **there is a need for greater training and understanding of how to make housing work for people living with these challenges, in addition to ensuring mental health crisis response teams are available when situations escalate**. The police are often called as a last resort if a mental health crisis results in violent or aggressive behaviour. Providers expressed a desire for alternate supports that could respond in these instances, such as a designated mental health outreach team. There was also a desire to focus on prevention and ensure people with complex needs have the housing and health supports they need to stay healthy, which would likely limit the occurrence of violence or aggression.

> "Unpack violence. Look at de-escalation training. Back to training and to knowledge. Know who you're working with and what's going on. It's about prevention – make the fight not happen."
>
> – Social Worker

- **There is a need for greater flexibility and choice in the current housing system**. This is reflected in feedback received both from service providers and people with living and lived experience. Service providers referenced the challenges they encounter in trying to move tenants to other buildings – once someone is housed, it is very difficult to find them alternate housing. This can be required for many reasons; however, providers primarily emphasized the importance of autonomy and choice in finding housing that works for

people with complex needs. Certain providers try to keep units vacant within their building to allow people the option to move around if needed, as tenant dynamics and changing personal needs and circumstances require more flexibility that is provided within the system.

- Similar feedback was received from people with living and lived experience as they expressed frustration that **once housed in an SRO (or other housing), there are no options for finding alternative housing**; it often felt like the only way to apply for alternate housing was to become homeless. The project team also heard that people have lost their housing or have felt stuck in unsuitable housing as their life circumstances change overtime (e.g., moving in and out of recovery, changing physical needs due to a disability, different household sizes) and they aren't able to access new housing arrangements that meet their needs.

> "We need more shelters like Triage where floors have different types of supports…"
>
> – Social Worker

- **There was mixed feedback provided on the housing system. Certain providers and people with lived/living experience found its' rigidity challenging**, as its' bureaucratic and institutional structure can be difficult for people with living and lived experience of colonialization to navigate. People with living and lived experience also expressed distrust and confusion regarding BC Housing's waitlist and felt the process to be unfair and complicated. Some social workers expressed a desire to connect people to housing based on relationships and their understanding of different building managers.

Simultaneously, providers highlighted the importance of a structured, centralized system that uses a standardized process to house people from BC Housing's Registry. Such a process was seen to be essential in creating a more equitable housing system, as previous reliance on individual relationships privileged well-connected programs and individuals. Much of this feedback was provided with the frustration that there is not enough supportive housing with

integrated health supports, making it challenging for providers to ensure people with complex needs can access the supports they need. The tenant prioritization process is complex, and feedback received reflects the different perspectives on this issue.

- **Indigenous people experience systemic racism when trying to access housing**. Feedback from people with living/lived experience highlighted the extent of the structural barriers Indigenous people encounter when trying to secure the limited housing that is available. This is particularly the case for young Indigenous men, as there are few housing programs with this specific focus, and they are often discriminated against in the private market. Indigenous women also struggle to access suitable housing and experience intersectional discrimination, highlighting the importance of housing programs that are For Indigenous people, By Indigenous people.

> *"It's challenging to find housing off-reserve... financial records are still a barrier. Payments given to Indian Affairs should be Indigenous-led and Indigenous-organized"*
>
> *– Person with Lived Experience*

- **Feedback received from people with living and lived experience specified SROs are not adequate housing.** Many people indicated they have chosen to continue living outside or in shelters when offered housing in a SRO as the quality of housing is abysmal. People also want privacy, dignity, safety, and security – which comes from having a unit that is self-contained. There was a strong desire for all housing offered to be self-contained – with a bathroom and kitchenette ideally. Service providers and people with living/lived experience highlighted the success of the new temporary modular housing (TMH) buildings in providing units that are dignified and self-contained.

> *"In a SRO, I have to worry about what's being stolen... it's very emotionally draining"*
>
> *– Person with Living Experience*

- **Many people with living/lived experience referenced a desire for housing options outside of the DTES**. Given that so much of Vancouver's shelter-rate housing is concentrated in the DTES, there are limited subsidized housing options in other

neighbourhoods of the city. Current tenants at C'owaa (former Ramada Hotel on Pender Street) specified the appeal of securing housing somewhat outside of the DTES – while 435 West Pender Street is still in Downtown Vancouver, it is several blocks away from the DTES neighbourhood, which has been beneficial for certain tenants. Finding housing outside of the DTES was seen to be particularly important for people who have completed detox and recovery looking for affordable housing options. Service providers

> *"I'd love to leave the DTES ideally… so much negative energy here"*
>
> *– Person with Living Experience*

and people with living/lived experience referenced the benefits of new TMH buildings located outside the DTES and expressed a desire to see more TMH in neighbourhoods across Vancouver.

- Providers and people with lived experience emphasized the important improvements that have occurred with harm reduction. Harm reduction supplies are widely available and there are many housing options that employ a harm reduction model. Within this context, **feedback from engagement identified a need for additional housing options to support people at different stages of the recovery process**. Currently, housing is predominantly low-barrier with some abstinence, high-barrier options available. There was interest in exploring other models along this spectrum that provide more flexibility for people using and not using substances. There were different ideas provided of possible models worthy of consideration (e.g., different building floors employ higher barrier approaches while other floors remain lower barrier), yet the main feedback received focused on the need to understand and explore what a spectrum of housing might look like in practice.

- **People with living and lived experience specified the importance of building connection between residents and staff through programming, meals, and culture**. Feedback received referenced the power of connecting to culture with Elders, music,

> *"There is nothing in between abstinence based buildings and full-blown harm reduction… we need to provide other options that meet people where they are at"*
>
> *– Non-Profit Housing Provider*

ceremony, and access to cultural practices, such as smudging. In addition to cultural practices, people with living and lived experience referenced a desire to know their neighbours, share food together, participate in events for different holidays, and access general programming. These sorts of activities were seen to be an important element of successful supportive housing programs.

- **People with living and lived experience highlighted the need for more housing that can accommodate couples, youth, as well as pet-friendly housing.** Feedback received during engagement referenced the frustration people experience when offered housing that doesn't meet their needs. This reflects the importance of housing choice, as certain housing arrangements or buildings might not be well-suited to individual circumstances or needs.

LONG-TERM RESIDENTIAL TREATMENT

- Feedback received during engagement highlighted the importance of providing treatment programs for people who are in active substance use and experiencing mental health challenges. **The current detox, treatment, and recovery programs cannot always accommodate people with complex needs, particularly those living with mental health challenges**. Providers highlighted this gap and referenced the need to meet people where they are at – particularly as they navigate treatment and recovery.

- **There are gaps in the continuum of care for people using substances**. The progression from active use, to detox, treatment, and housing comes with prescribed timelines and there are not always spaces available in the next stage of current recovery models. With such gaps and waiting periods, people are at risk of relapse and overdose. Providers specified that this has happened and will continue to happen unless sufficient supports are provided for people navigating the recovery process.

> *"…the system is not seamless… we need to define a continuum of care for addictions"*
>
> *– Physician*

- **Current treatment options are not long enough**. It can take years for people to become healthy and many individuals will need to access treatment programs multiple times. People with living/lived experience specified there is a need for flexible detox and

treatment programs with different timelines to support people who require more time in treatment.

- **There was mixed feedback provided on mandated care**[11]. Feedback from people with living and lived experience specified change can only happen when people want it to occur. Service providers discussed how challenging it can be to watch people continue to hurt themselves, yet there is a hesitancy to certify given the complexities of mandating care. There is a need to better understand the continuum of care for people experiencing mental health challenges and provide a range of supports to meet people 'where they are at'.

- **Providers indicated there are insufficient supports available for people with Fetal Alcohol Spectrum Disorders (FASD), as well traumatic brain injuries**. More tailored treatment programs are needed to ensure people living with these challenges can receive the supports needed. This is particularly an issue for people experiencing homelessness, substance dependency, and/or mental health challenges.

INDIVIDUAL FINANCIAL SUPPORTS

- Providers were predominantly interested and curious about this aspect of the draft service delivery model. There was an understanding that **many people living with complex needs are low-income and cannot afford the costs of housing, medication, and health services such as dental and counselling supports**. An additional financial "top-up" (similar to a crisis grant) would be beneficial in making these services accessible for people living with complex needs, particularly if accessing this funding was straight-forward and did not involve significant paperwork. However, it was also expressed that a guaranteed basic income and free dentist and counselling services could help to solve these issues. Feedback received regarding financial supports included a suggestion to consider including an

[11] Under the Mental Health Act, a person can be certified as an involuntary patient only if a doctor has examined you and believes you meet all four of these criteria: i) your ability to react to your environment and associate with others is seriously impaired because of a mental disorder; ii) you need psychiatric treatment; iii) you need care, supervision, and control: to protect you or others, or to prevent you from deteriorating substantially, either mentally or physically, iv); you cannot be admitted as a voluntary patient.

income assistance office at the Welcoming Centre to help with streamlined intakes, crisis grants, PWD applications, and cheque splitting.

- **Providers were concerned about how this element of the model would be administered**. An additional gateway to accessing services can be seen as colonial and disempowering – several providers asked how the funds would be accessed and who would be responsible for allocating the funds and making decisions on suitable uses for the funds.

> *"We could contract extra individualized supports… that would work, but we need to think about how the administration could be responsive to client's needs, autonomy, and individual requests"*
>
> *– Social Worker*

- There was recognition that **systemic issues will continue to result in barriers for people accessing services if not addressed.** While additional funding may help to alleviate certain concerns in the short-term, the lack of supportive housing will continue to be a major barrier for people with complex needs.

- One provider expressed concern that a **fixed per capita amount would limit service provision by effectively putting a "cap" on how much funding can be provided for people with complex needs**. Many providers expressed a desire for funding flexibility as it can be challenging to provide the necessary supports for people with complex needs.

OVERSIGHT PANEL

- **Providers recognized the importance of intersectoral collaboration on these issues but felt the framing of an "oversight panel" to be problematic given the top-down, colonial insinuations.** It was suggested different language be used to describe this oversight panel and it was recommended that the oversight panel meet regularly with an advisory group comprising people with living and lived experience of homelessness, substance dependence, and/or mental health challenges, as well as service providers who work closely with people who have complex needs.

- Greater clarity was needed around the end goal of the panel – providers were interested to understand the **specific role of the panel in implementing this service delivery model**. Would the panel be a gateway to care? How would the panel be used to ensure people are able to access services they need to stay healthy and housed? Providers highlighted the need to clearly define the panel's purpose and provide a framework for implementation to ensure services are provided effectively. It was also felt that people with complex needs should be made aware of the panel to ensure transparency and obtain their consent. There was a concern that the panel would create more bureaucracy for service providers and people with complex needs.

- There was a strong desire to ensure **meaningful representation and inclusion of Indigenous people and people with living/lived experience** on the oversight panel and in the suggested advisory group.

DATA & MONITORING

- **Feedback received from providers generally expressed support of a system inventory**, particularly as such information may help to ensure services can better meet the needs of people experiencing complex health and housing challenges. Simultaneously, there is a lack of trust in data collection exercises, especially from Indigenous people and people who use substances. Any monitoring system will need to consider a decolonial approach that is empowering and centres the perspectives of those with living and lived experience.

> *"When you know who is involved with a patient's care… you need to ask people lots of questions, reach out to collaborate, the client has to agree to share information… it can work well, if you're communicating and working together"*
>
> *– Physician*

- Providers also emphasized it will be **important to be transparent about how the data will be used and how success will be defined and measured**. Involving people with

living and lived experience in these conversations is highly beneficial. Some service providers expressed distrust and concern about sharing data given data has been used to perpetuate harm toward Indigenous people and their communities.

- Currently, there is **limited coordination between health authorities and within health departments and smaller health teams**. Providers would like to see greater coordination across the health and housing sectors to ensure people with complex needs are receiving the services they need to stay healthy and housed.

Additional Service Gaps

In addition to feedback received on the BCS model, service providers outlined other barriers people with complex needs experience when trying to access housing and health services. This information can help to inform the draft BCS model.

- **There are a lack of mental health supports for people with complex needs**. Providers spoke at length about the difficulties they encounter when someone is in crisis or violent toward themselves, staff, or other residents. In many of these circumstances, providers have limited supports available and must call the police, who are also not well-equipped to respond to mental health crisis. Providers referenced a need to re-envision the current framework and provide more preventative options to ensure people with mental health diagnoses are well-supported and can access the treatment and medication they require. These services should also be trauma-informed and meet people 'where they are at', which supports the notion of a mental health outreach team with the specific goal of connecting people with complex needs to the health supports they require. It can be challenging for people to access psychiatrists and providers emphasized any mental health team should include a physician (ideally a psychiatrist) who can prescribe medication.

- There is a need for **evidence-based treatment options for people with substance use disorders**. Providers expressed frustration with the limited progress that has occurred since a public health emergency was declared in 2016. Methadone and suboxone are not always an appealing option for people who use substances and different, higher-potency alternatives (i.e., hydromorphone, diacetylmorphine) are needed to minimize the harm associated with using toxic street drugs. It can also be challenging for people with complex needs to access safe supply in a clinic environment – providers suggested outreach could help connect people to safe supply.

- Many interview participants focused on the importance of strong relationships between service providers and people with lived and living experience. In order to build these relationships and maintain them, staff must be well-supported in sustainable environments. Feedback received from a clinical and therapeutic supervisor who provides training on resisting burnout emphasized the need to focus on collective care, above and beyond self-care. Collective care refers to the importance of creating preventative support systems, including solidarity teams where staff can connect with others who understand the challenges of working with people experiencing crisis. It is also important for training to reflect individual needs, as each person has a unique manifestation of trauma, and their response and coping mechanisms must be tailored to suit their lived/living experiences. Trauma is rooted in disconnection and a sustainable collective care approach emphasizes connection, through solidarity teams.

Part Three: Further Considerations

Introduction

As BCS works to refine their service delivery model, it will be important to consider and integrate feedback received from the community. There is excitement around the idea of doing things differently and being able to provide the right kinds of support for people who have experienced chronic homelessness, substance dependence, and/or mental health challenges. With discussions regarding complex care ongoing at the provincial government level, there is a window of opportunity to provide better supports for people with complex needs. It is important to note additional engagement with people with living and lived experience will be needed as the draft service delivery model continues to evolve.

Key Takeaways

The following section provides a summary of recommended priorities, additions, or changes to the BCS model based on feedback received from service providers and people with living and lived experience.

FOR INDIGENOUS, BY INDIGENOUS

The interviews with people with living and lived experience highlighted the importance of providing Indigenous-led services to Indigenous people. Connection to culture was a central component of the healing process and the phrase "culture saves lives" was frequently referenced during engagement. Given the over-representation of Indigenous people among the DTES residents living with complex needs, this is of particular importance in ensuring a culturally safe, trauma-informed service model is developed.

FOCUS ON SUPPORTIVE HOUSING

Service providers and people with lived experience referenced the importance of providing people with safe, secure, and dignified housing options that are self-contained. There was consensus among those interviewed that there is not enough truly supportive housing available for people with complex needs. In addition to scaling up and providing more supportive housing options, there is a need to explore how supportive housing can better meet the needs of people who have experienced chronic homelessness, substance dependence, and/or mental health challenges. Suggestions received focused on individual solutions that require one-on-one supports, significant staff training, and flexibility.

EXPLORE SUPPORTIVE HOUSING WITH EMBEDDED HEALTH SUPPORTS

Feedback received during engagement highlighted how challenging it can be for people with complex needs to access the necessary physical and mental health supports. It was suggested further collaboration and coordination between BC Housing, the Ministry of Mental Health and Addictions, and the health authorities would be beneficial in defining more comprehensive supportive housing services with embedded physical and mental health supports.

PRIORITIZE MENTAL HEALTH SUPPORTS

Many providers referenced the improvements that have been made in recent years to provide Housing First and harm reduction services, yet there are gaps in how the social service sector supports people with mental health challenges. There is no mental health outreach team in the DTES, which means police are often the first responders in a mental health crisis. This is not trauma-informed – alternate supports are needed to provide people with the assistance they require, de-escalate conflict, and ensure people with complex needs retain housing. Many evictions from supportive housing facilities are the result of behaviour related to mental health diagnoses. If additional mental health supports could be provided to ensure people are able to access the care they need, housing retention would likely improve.

FIX THE SYSTEM, DON'T RE-INVENT THE WHEEL

While it was clear improvements to current models of service provision could help to ensure people with complex needs are better able to access housing and health services, feedback received focused on the need to address systemic issues before creating a new model for service delivery. With inadequate and insufficient housing supply, there are no housing options for people with complex needs. It would be challenging to implement elements of the BCS service delivery model (i.e., Welcoming Centre, multidisciplinary support team, individual financial supports) without addressing the lack of adequate housing options.

ELEVATE PEOPLE WITH LIVING AND LIVED EXPERIENCE

Feedback received during engagement highlighted the need to include people with living and lived experience in the discussions related to the draft service delivery model, as well as ensure the model will be adaptable and responsive to recommendations from people with living and lived experience. This was specifically identified in relation to the oversight panel, but comments received focused on the importance of elevating this perspective in all

discussions as people who are or have experienced these challenges are able to advise what might work for others in similar circumstances.

APPENDIX A
Engagement Questions

Engagement Questions

Living/Lived Experience Interviews	Leadership and Front-Line Staff Interviews
• Tell me about yourself.	• Tell me about the work you do.
• What has worked for you to get the services and housing you need?	• What kinds of supports or services have been successful in keeping people healthy and housed?
• Tell us about when and where you fell through the cracks. With housing, hospitals, medical services, mental health, and addictions. • Was it a person, a process, lack of funding, waitlists, services that didn't connect to each other?	• Where do people fall through the cracks? Where is the system failing the DTES residents living with complex health and housing challenges? Specifically, the folks who are experiencing chronic and recurrent homelessness, as well as concurrent substance dependency and mental health challenges.
• When has outreach worked for you? When has it not worked? What needs to change?	• The BCS model includes integrated health and housing support teams, including a welcome centre as a first point of contact, and a multidisciplinary team to support a person as they access services. • When has accessing the right health and housing services worked well, and when has it not worked well?
• Is there anything else you'd like to share?	• Part of the BCS draft model includes an oversight panel to monitor service delivery and respond to barriers or gaps that arise. Who needs to be on this panel? • How can we improve monitoring and reporting?
	• Part of the BCS model involves personalized income supports, to fund housing and health services to meet their unique needs, as these change over time (roughly $30,000 annually/person on average). • What do you think about this?
	• Part of the model includes suitable housing and long-term residential treatment. • What would you recommend this look like?
	• We are keen to learn more about housing and health services that have helped to keep people housed and healthy. • Do you have any examples of case studies or other models that have been successful in helping people get housing and the supports they need to stay housed? Examples from outside Vancouver?
	• If you could change any element of the way services are currently provided in the DTES, what would you suggest?
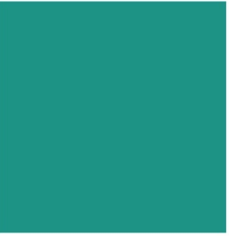
Endnotes

[i] Somers, J., Moniruzzaman, A., Rezansoff, S., Brink, J. & Russolillo, A. The prevalence and geographic distribution of complex co-occurring disorders: a population study (2016). Epidemiology and Psychiatric Sciences, 25, 267–277. https://doi.org/10.1017/S2045796015000347

[ii]
https://bridgingthegap.mentalhealthcommission.ca/sites/default/files/At%252520Home%252520Report%252520Vancouver%252520ENG_0.pdf

[iii] http://www.sfu.ca/content/dam/sfu/carmha/resources/c2abc/C2A-BC-June-2021.pdf

[iv] https://vancouver.ca/files/cov/downtown-eastside-plan.pdf

[v] https://www.euro.who.int/en/health-topics/environment-and-health/urban-health/activities/poverty-and-social-determinants

[vi] https://firstcallbc.org/wordpress/wp-content/uploads/2020/12/First_Call_Report_Card_2020_Dec_web_final.pdf

[vii] https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/initiatives-plans-strategies/poverty-reduction-strategy/togetherbc.pdf

[viii] https://www.canada.ca/en/employment-social-development/programs/poverty-reduction/reports/strategy.html

[ix] CBC News. B.C. income and disability assistance to increase by $175 per month (2021, Mar 16). https://www.cbc.ca/news/canada/british-columbia/income-assistance-increase-bc-1.5952538

[x] National Household Survey 2011, https://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/index.cfm?Lang=E and Census 2016, https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/index-eng.cfm

[xi] https://vancouver.ca/files/cov/social-indicators-profile-city-of-vancouver.pdf

[xii] Thistle, J. Canadian Observatory on Homelessness; York University (2017). Definition of Indigenous Homelessness in Canada. https://www.homelesshub.ca/IndigenousHomelessness

[xiii] **The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls (2019)** https://www.mmiwg-ffada.ca/final-report/ **and Downtown Eastside Women's Centre's Red Women Rising; Missing Women Commission of Inquiry and City Task Force on Sex Work and Sexual Exploitation (2013)** https://dewc.ca/wp-content/uploads/2019/03/MMIW-Report-Final-March-10-WEB.pdf

[xiv] https://www.fnha.ca/wellness/wellness-for-first-nations/first-nations-perspective-on-health-and-wellness

[xv] https://www.bcbudget.gov.bc.ca/2021/pdf/2021_Backgrounder_6_Reconciliation.pdf

xvi Mayors' Overdose Task Force Report, 2021. https://vancouver.ca/people-programs/drugs.aspx#task-force

xvii https://www.bchousing.org/COVID-19/community-sites

xviii Coroner's Report, Illicit Drug Report, 2021. https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug.pdf

xix Mayors Overdose Task Force Report, 2021. https://vancouver.ca/people-programs/drugs.aspx#task-force

xx Wyton, M. (2020 Sep 23). *Eight Months into 2020, BC Has Already Surpassed Last Year's Overdose Death Total.* The Tyee. https://thetyee.ca/News/2020/09/23/Eight-Month-Overdose-Toll-Surpassed-Last-Year/

xxi Wyton, M. (2020 Sep 23). *Eight Months into 2020, BC Has Already Surpassed Last Year's Overdose Death Total.* The Tyee. https://thetyee.ca/News/2020/09/23/Eight-Month-Overdose-Toll-Surpassed-Last-Year/

xxii Hulchanski, J David. Rethinking Canada's Housing Affordability Challenge (2006). https://tspace.library.utoronto.ca/bitstream/1807/71780/1/Hulchanski%202005%20Rethinking%20Housing%20Affordability%20Challenge%20-Discussion-paper.pdf

xxiii https://vancouver.ca/people-programs/homeless-count.aspx

xxiv https://www.homelesshub.ca/about-homelessness/homelessness-101/causes-homelessness

xxv https://vancouver.ca/people-programs/housing-vancouver-strategy.aspx

xxvi https://vancouver.ca/people-programs/city-of-reconciliation.aspx

xxvii https://vancouver.ca/home-property-development/dtes-local-area-plan.aspx

xxviii CCAP-2017-Hotel-Report-1.pdf (carnegieaction.org)

xxix https://www.bchousing.org/projects-partners/development-projects/sro-renewal#:~:text=Project%20Overview,Vancouver%20and%20preserve%20affordable%20housing

xxx https://vancouver.ca/people-programs/single-room-accommodation-bylaw.aspx

xxxi https://bylaws.vancouver.ca/8733c.PDF#page=18

xxxii St. Denis J. (2021 Nov 18). *Rent Control for Private SROs Passes in Vancouver. The Tyee.* Rent Control for Private SROs Passes in Vancouver | The Tyee

xxxiii BC Housing. (2021, Apr 26) *Housing for people experiencing and at risk of homelessness in Vancouver: 2012-2023.* Homeless to Sheltered – Vancouver Updates. https://www.bchousing.org/publications/supportive-housing-vancouver-2021-2023.pdf

xxxiv Ibid.

xxxv City of Vancouver (2020). Downtown Eastside Plan: Three Year Summary of Implementation, 2017-19. https://vancouver.ca/files/cov/dtes-plan-implementation-summary-2017-2019.pdf

xxxvi Ibid.

xxxvii https://vancouver.ca/people-programs/temporary-modular-housing.aspx

xxxviii https://www.bcss.org/family-advocacy/car-87-vancouver-police-department/

xxxix http://www.vch.ca/about-us/accountability/quality-care/service-reviews/downtown-eastside-health-strategy

xl http://www.providencehealthcare.org/rapid-access-addiction-clinic-raac

xli Nordtl, C. and Vogel, M. One size does not fit all – evolution of opioid agonist treatments in a naturalistic setting over 23 years. (2018). https://pubmed.ncbi.nlm.nih.gov/30209840/

xlii https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2587648/

xliii https://www.clinicaltrials.gov/ct2/show/NCT01447212

xliv https://www.mvaec.ca/downloads/services-guide.pdf

xlv http://www.providencehealthcare.org/hospitals-residences/providence-crosstown-clinic

xlvi van den Brink, W., Hendriks, V., Blanken, P., Koeter, M., van Zwiten, B., and van Ree, J. Medical prescription of heroin to treatment resistant heroin addicts: two randomised controlled trials. (2003 Aug 9). https://pubmed.ncbi.nlm.nih.gov/30209840/

xlvii http://mpap.vch.ca/wp-content/uploads/sites/6/2019/03/VCH-DTES-Womens-Strategy-Infographic-WEB.pdf

xlviii https://www.sumiqwuelu.com/the-project/master-plan-process

xlix http://www.bcmhsus.ca/our-services/provincial-integrated-mental-health-addiction-programs/red-fish-healing-centre

l http://www.bcmhsus.ca/our-services/provincial-integrated-mental-health-addiction-programs/burnaby-centre-for-mental-health-addiction

li https://firstunited.ca/first-forward-capital-campaign

lii https://vancouver.ca/files/cov/new-st-pauls-social-impact-assessment-summary.pdf

liii https://vancouver.ca/people-programs/four-pillars-drug-strategy.aspx

liv https://vancouver.ca/files/cov/downtown-eastside-plan.pdf

lv https://studylib.net/doc/6676806/mayor-s-task-force-on-mental-health-and

lvi https://council.vancouver.ca/20181220/documents/spec1.pdf

lvii https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/initiatives-plans-strategies/mental-health-and-addictions-strategy/bcmentalhealthroadmap_2019web-5.pdf

lviii https://caibc.ca/communityactionteams/vancouver-community-action-team/

lix https://caibc.ca/grants-training/oerc-cai-stream-grants/oerc-cai-stream-1/

lx https://news.gov.bc.ca/releases/2020MAH0090-001460

lxi https://www2.gov.bc.ca/gov/content/housing-tenancy/affordable-and-social-housing/homelessness/homelessness-cohort

lxii https://www.canada.ca/en/employment-social-development/programs/homelessness/hifis.html

lxiii https://www2.gov.bc.ca/gov/content/governments/organizational-structure/ministries-organizations/ministries/mental-health-addictions

lxiv https://cpa.ca/canadian-alliance-on-mental-illness-and-mental-health-camimh-calls-for-mental-health-and-substance-use-parity-act-june-2021/

lxv http://www.sfu.ca/content/dam/sfu/carmha/resources/c2abc/C2A-BC-June-2021.pdf

lxvi https://www2.gov.bc.ca/gov/content/governments/indigenous-people/new-relationship/united-nations-declaration-on-the-rights-of-indigenous-peoples

lxvii Chandler, M. and Lalonde, C. Cultural Continuity as a Protective Factor Against Suicide in First Nations Youth (2004). https://www.researchgate.net/publication/239921354_Cultural_Continuity_as_a_Protective_Factor_Against_Suicide_in_First_Nations_Youth

lxviii https://www.ohchr.org/Documents/Issues/Housing/IndigenousPeoples/CSO/NWAC%20Housing%20Engagement%20Final%20Report%20April%202019.pdf

lxix http://www.niginan.ca/welcome-to-ambrose-place

lxx https://www.homelesshub.ca/solutions/housing-first/canadian-housing-first-toolkit

lxxi https://vancouver.ca/home-property-development/dtes-local-area-plan.aspx

lxxii https://mobilizingmomentum.mentalhealthcommission.ca/English/document/33456/vancouver-final-report-homechez-soi-project

lxxiii
https://asuntoensin.fi/assets/files/2016/11/ACTIONPLAN_FOR_PREVENTING_HOMELESSNESS_IN_FINLAND_2016_-_2019_EN.pdf

lxxiv http://housingfirsteurope.eu/assets/files/2017/02/Intermediate_report_2012_2013_Paavo_2.pdf

lxxv https://housingfirsteurope.eu/assets/files/2017/02/Final_report_PAAVO_I_2008-2011.pdf

lxxvi https://valtioneuvosto.fi/en/marin/government-programme/housing-policy

lxxvii https://helda.helsinki.fi/bitstream/handle/10138/153258/YMra_3en_2015.pdf?sequence=5

lxxviii https://www.ara.fi/en-US/Materials/Homelessness_reports/Homelessness_in_Finland_2019(55546)

lxxix https://www.eenet.ca/sites/default/files/2018/OHFRN-CoI%20Policy%20Brief%20on%20ACT%20and%20HF%20(Dec%2018%202018).pdf

lxxx Ibid.

lxxxi https://pubmed.ncbi.nlm.nih.gov/28199798/

lxxxii https://www.nationalcomplex.care/wp-content/uploads/2019/01/Blueprint-Complex-Care-Infographic.pdf

lxxxiii https://oregon.providence.org/our-services/c/center-for-outcomes-research-and-education-core/

lxxxiv https://www.euro.who.int/__data/assets/pdf_file/0005/322475/Integrated-care-models-overview.pdf

lxxxv https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-020-05917-9

lxxxvi https://www.healthinnovation.org/resources/publications/policy-options-for-integrating-health-and-housing-for-low-income-older-adults

lxxxvii https://www1.nyc.gov/assets/nypd/downloads/pdf/public_information/b-heard-public-faqs-5-27-2021.pdf

lxxxviii https://cbcs.be/l-equipe-mobile-tandemplus/

lxxxix https://www.bccsu.ca/blog/news/canadian-groups-lobby-for-safe-supply-to-combat-opioid-crisis/

xc https://www.capud.ca/capud-resources/safe-supply-projects

xci Nordtl, C. and Vogel, M. One size does not fit all – evolution of opioid agonist treatments in a naturalistic setting over 23 years. (2018). https://pubmed.ncbi.nlm.nih.gov/30209840/

van den Brink, W., Hendriks, V., Blanken, P., Koeter, M., van Zwiten, B., and van Ree, J. Medical prescription of heroin to treatment resistant heroin addicts: two randomised controlled trials. (2003 Aug 9). https://pubmed.ncbi.nlm.nih.gov/30209840/

xcii https://www.camh.ca/-/media/files/pdfs---public-policy-submissions/camh-statement-on-decriminalization-sep2021-pdf.pdf

xciii Fischer B, Rehm J, Kirst M, Casas M, Hall W, Krausz M, Metrebian N, Reggers J, Uchtenhagen A, van den Brink W, van Ree JM. Heroin-assisted treatment as a response to the public health problem of opiate dependence. Eur J Public Health. 2022 Sep; 12(3):228-34. Doi: 10.1093/eurpub/12.3.228. PMID: 12232964.

xciv https://pubmed.ncbi.nlm.nih.gov/17570910/