Complex Care Housing

Initial Proposals

Date: September 24, 2021

Organization: Fraser Health

Title of Project: Medically Enhanced Complex Housing - Surrey #34

BRITISH COLUMBIA | Ministry of Mental Health and Addictions

If you have any questions regarding the information or requirements in this form, please reach out to:

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Purpose:

The purpose of this document is to describe initial plans for Complex Care Housing services in BC. These initial plans are to be developed by BC health authorities, in partnership with housing partners (including BC Housing), Indigenous partners and other key service delivery partners. Services and supports must be aligned with recently developed Complex Care Housing (draft) Strategic Framework (see Appendix A), which aims to deliver person centered and integrated health, housing, social and cultural supports to improve housing stability and health outcomes for people with severe mental illness and substance use challenges. The Framework will be used, alongside our current understanding of community need, to assess initial plans and prioritize requests for funding.

Initial plans should focus on services and supports that can be operationalized quickly. Once MMHA has prioritized initial plans, health authorities will be asked to submit collaboratively developed proposals with fully scoped out plans for implementation in 2021/22 and 2022/23.

Submissions must include all of the following content

Overview

Description of the housing service you are proposing:

Please keep the summary description brief (no more than 250 words). This is to be a high-level description; the details will be captured below.

This model proposes to leverage new BC Housing partnership opportunities in selected communities and to provide enhanced health support for complex populations tenanting the new modular housing units and new BC Housing purchases. These partnership opportunities will materialise in 21/22, 22/23 and 23/24 depending on the timing of the purchases and new modular installations.

Mixed model - total beds do not exceed 30% of the building capacity

Intensive Supportive Housing level for a specific number of beds in a BC Housing, non profit health service provider building is supported by:

- Integrated Response Teams (IRT)

I. multi disciplinary including peers and Indigenous peers

II. Inclusive of mental health and substance use and community health services

III. connect person with primary care
IV. person led wellness plans
V. in reach and onsite services space permitting
VI. Team based care model follows the person
- ACT and ICM

I. Does not duplicate IRT
- Health Service Provider

II. A Service agreement between FH and the HSP for added support worker and peer support staff

The IRT will provide ongoing support for a specified number of people who require longer term intensive support to sustain their tenancy in congregate settings. This includes supports for the person and HSP for symptoms and behaviours in order to prevent eviction.

Transitional and Stabilization Housing level for a specific number of beds in a BC Housing, non profit health service provider building is supported by:

- Same as above and includes on- site nursing staff in the service agreement with the HSP.

The IRT will provide support for a specified number of people who have significant comorbidities including medical complexity, hospital step-down and IV antibiotics and medication management needs. Support is included for the person and HSP for symptoms and behaviours in order to prevent eviction. Flow through every six months.

Community Considerations

Location: Surrey

Summary of the identified need in the community:

Please include references to any reports or data that help describe the service need in this community.

Community of Surrey is comprised of eight Community Health Service Areas (CHSA), namely North and South Surrey, Cloverdale, Fleetwood, East and West Newton, Whalley, and Guilford.

There are a number of needs that require additional health services supports in Surrey. There is a consistency in repeat presentations of complex clients to hospital and health services. Homelessness has increased since the most recent homelessness count with a large number of street entrenched individuals. Surrey has an increasing number of immigrant and refugee residents with an ethnically diverse population, including a high proportion of urban indigenous individuals. There is an increasing number of individuals suffering from Substance Use Disorder, which has led to alarming rate of illicit drug overdoses. New and enhanced health supports are needed to provide care for this growing community.

Key population being served: People who are homeless or at risk of homelessness. Population will be mixed. The Transitional and Stabilization spaces will prioritize people in hospital who are homeless and ready for community with wrap around supports.

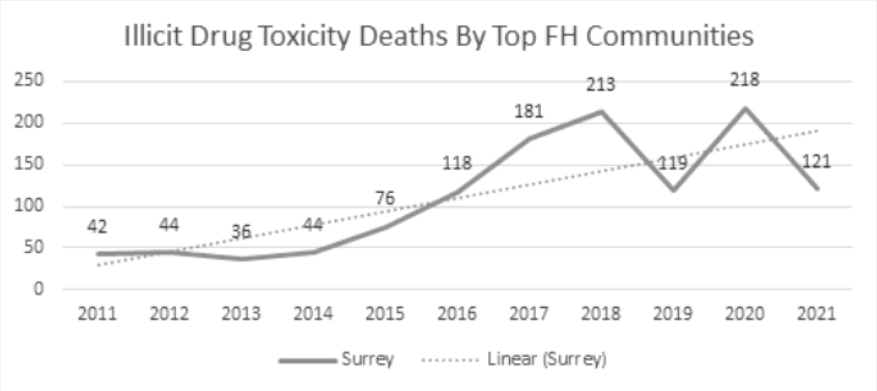
The community of Surrey is an urban centre with a population of 518,467 (2017). Total population of North Surrey is 51,170 with 48.6% of the population being female with population median age being 37.3 years. Total

population of South Surrey is 69,970 with 50.8% of the population being female with population median age being 36.7 years. Total population of Cloverdale is 69,970 with 50.8% of the population being female[1] with population median age being 36.7 years. Total population of Fleetwood is 58,695 with 50.8% of the population being female with population median age being 39.8 years. Total population of East Newton is 62,740 with 50.1% of the population being female with population median age being 36.4 years. Total population of West Newton is 41,460 with 50.3% of the population being female with population median age being 35 years. Total population of Whalley is 53,400 with 49.6% of the population being female with population median age being 37 years. Total population of Guildford is 60,540 with 50.6% of the population being female with population median age being 40 years. (Census of Popu. Statistics Canada, 2016)

The percentage population who are indigenous is 4.1% in North Surrey, 3.4% in South Surrey, 3.4% in Cloverdale, 2.1% in Fleetwood, 2.6% in East Newton, 2.1% in West Newton, 3.1%, 2.7% in Guildford, and (Census of Popu. Statistics Canada, 2016)

The homeless count as of Mar 3rd/4th, 2020 for communities of Surrey is 644, with Surrey being one of five communities in Metro Vancouver that saw an increase in homelessness (+42) (2020 Homeless Count in Metro Vancouver)

Coroners Service – Illicit Drug Toxicity Deaths in BC (Jan – June 30, 2021)



(e.g., Indigenous people, women, young adults, general population, corrections, forensics, mixed etc.)

How many net new people do you expect to house through this project? 53 (23 beds flow through every 6 months)

Type of Site

Step of the Complex Care Housing model: Mixed Model*

**Mixed model includes a site that incorporates more that one step of the CCH model, as well as sites that have CCH clients residing in a location with other clients (regular supportive housing, Independent living, etc).*

The model is person centred and the services will be flexible to follow the person within the building (ie, the person may move from Transitional Stabilization to Intensive Supportive) and also with transition from the building.

Congregate Site Model ☒

This model proposed a site serving multiple clients on location and may include a mix of onsite and in-reach services that move with the individual.

Scattered Site Model ☐
The model proposed is based on clients living in market rent environments with intensive inreach of services.

Site Features:
I.e., Number of units, client mix, purpose built or renovations, accessibility considerations etc.
Physical Space- BC Housing

- 77 supportive, 23 enhanced health services, 30 shelter- Foxglove
- Accessible units
- Purpose built in Surrey
- Population who are homeless, at risk

How will clients be identified for care/referred to this housing?
Referrals to the building are via BC Housing usual processes and may come from non profits, Fraser Health, Aboriginal Liaisons, FNHA or self referral.

Transitional and Stabilization services for the 23 spaces requires a clinical referral as well as the BC Housing application. Central assessment, tracking process and pathway has been established with BCH and the provider. The Regional Referral Coordination Service is currently supporting the process. A Regional Referral Coordinator will be established to assess and screen all referrals to similar programs for complex care and housing. The IRT will participate in the screening and providing follow-up services in addition to the non profit on site services.

The non profit provider can use an online referral for anyone in the building for the IRT team. All people in the building area eligible. People already connected to ACT/ICM will continue to be served by those services.

Transitions to other housing arrangements will be supported by IRT, ACT, ICM

Programming and Services (DRAFT Integrated Support Framework)
*Please note, this is based on a DRAFT Integrated Support Framework that is confidential and in development. The inclusion of ACT/ICM teams, team based primary care, overdose prevention, prescribed safe supply, cultural supports and some psychosocial supports are expected. Other services **are not less important** but may need to be phased in dependent on client needs.*

Service Type	*Description*	Method of delivery
Physical Health, Mental Wellness & Substance	☒ Team based primary care ☒ Overdose prevention services ☒ Prescribed safe supply ☒ ACT team (net new team or part of a team)	☐ On-site ☒ In-reach ☒ On-site ☐ In-reach ☒ On-site ☒ In-reach ☐ On-site ☒ In-reach

Service Type	*Description*	Method of delivery
Use Supports	☒ ICM team (net new team or part of a team) ☒ Managed Alcohol Program ☒ Communicable disease prevention including infection prevention/control, immunization, STBBI harm reduction ☐ Environmental Health ☐ Built Environment/Occupational Health ☐ Oral Health ☒ Addictions medicine ☒ Psychiatry ☒ Recovery coaching ☒ Medication adherence support ☒ Mental health assessments/screening ☒ Others (please describe): Wound care, IV antibiotics, substance use assessments/counseling/referrals	☐ On-site ☒ In-reach ☒ On-site ☐ In-reach ☐ On-site ☒ In-reach ☐ On-site ☒ In-reach ☒ On-site ☐ In-reach ☐ On-site ☒ In-reach ☐ On-site ☒ In-reach ☐ On-site ☒ In-reach ☐ On-site ☒ In-reach ☒ On-site ☒ In-reach ☒ On-site ☐ In-reach ☒ On-site ☐ In-reach ☐ On-site ☐ In-reach ☐ On-site ☐ In-reach
Indigenous Cultural Supports *Services acknowledging distinct Metis, First Nations, Inuit and Urban Indigenous needs	☒ Ceremonial supports ☒ Elders ☐ Traditional food ☒ Art ☐ Music ☒ Land based healing ☐ Others (please describe): _____ _____ _____	☒ On-site ☐ In-reach ☐ On-site ☒ In-reach ☐ On-site ☒ In-reach ☒ On-site ☐ In-reach ☐ On-site ☐ In-reach ☐ On-site ☒ In-reach ☐ On-site ☐ In-reach
Housing Supports	☒ Landlord/operator liaison ☒ Negotiation and conflict management support ☐ Others (please describe): _____ _____ _____	☐ On-site ☒ In-reach ☐ On-site ☒ In-reach ☐ On-site ☐ In-reach
Social, Emotional & Community Supports	☒ Family Services ☒ Peer Support ☒ Recreation ☐ Music/art ☒ Income support ☒ Employment and skills training supports ☒ Counselling ☒ Community Inclusion ☐ Others (please describe): _____ _____ _____	☐ On-site ☒ In-reach ☒ On-site ☒ In-reach ☒ On-site ☐ In-reach ☐ On-site ☐ In-reach ☐ On-site ☒ In-reach ☒ On-site ☐ In-reach ☒ On-site ☒ In-reach ☒ On-site ☒ In-reach ☐ On-site ☐ In-reach ☐ On-site ☐ In-reach

Service Type	*Description*	Method of delivery
Personal Care & Personal Living Supports	☒ Activities of daily living supports (hygiene, continence, dressing, feeding, ambulating) ☒ Life skills ☒ Laundry ☒ Cleaning/tidying ☒ Hoarding prevention/support ☒ Medication management ☒ Managing finances ☐ Others (please describe): _____ _____ _____	☒ On-site ☐ In-reach ☒ On-site ☐ In-reach ☒ On-site ☐ In-reach ☒ On-site ☐ In-reach ☒ On-site ☐ In-reach ☒ On-site ☐ In-reach ☒ On-site ☐ In-reach ☐ On-site ☐ In-reach ☐ On-site ☐ In-reach
Food Security Supports	☒ Cooking and meal prep skills ☒ Nutrition supports ☒ Providing meals ☐ Others (please describe): _____ _____ _____	☒ On-site ☐ In-reach ☒ On-site ☐ In-reach ☒ On-site ☐ In-reach ☐ On-site ☐ In-reach

Description of staffing model to deliver services

- Experience with high risk populations
- Non judgemental
- High threshold services
- Understanding of the inequities of marginalized persons
- Strong Peer and emerging Indigenous organizational structures

Stabilization and Transitional: Non profit service agreement (over and above the BC Housing funded tenant support staff) **17.14 FTE**

IRT will designate a responsible clinician (under a team based care model) for collaborative care planning with the provider and client and natural supports.

Intensive Supportive: Non profit on site supports (over and above the BC Housing funded tenant support staff) **2.8 FTE**; honorariums for peer witnessing, Elders and cultural activities.

Fraser Health: IRT in reach and onsite **9.26 FTE**

ACT and ICM enhancements refer to other proposal documents for Surrey

Description of staffing model for building operations (congregate site)

E.g. Janitors, security, building management.

BC Housing model for supportive housing includes building security, janitorial services and building management

Timelines:

Estimated timelines for implementation once funding is approved

July 2021 – Integrated Response Team operating with the Emergency Response Centre and Isolation Centre. *(Working groups already developing the operational processes for the Transitional Stabilization level of service and for the Intensive Supportive level, including Primary Care and Aboriginal Wellness Clinic, Addiction Medicine, Virtual Health and Infectious Disease, for example.)*

August 2021- Referral process and coordination in place. Referrals to the Intensive Supportive units and to the Stabilization and Transitional units began. *(Service Agreement with the non profit provider in draft and MOU with BC Housing in development*)

September 2021 – A Regional Manager started for the Integrated Response Teams and hiring in progress to enhance the IRT. *(Education and Orientation working group for IRT includes the non profit provider and a Cultural Safety Educator)*

November 2021- the building is expected to begin tenanting. Implement complex care model

Risks and Mitigation Strategies

Please note any risks associated with your proposal and the associated mitigation strategies

The building occupancy permit may be delayed. This is managed by BC Housing working with the City of Surrey. Regular communication is established with BC Housing

There may be hiring delays. Fraser Health has prioritized support for this hiring process.

Budget:

Capital Costs

Please add rows as needed

Expense	2021/22	2022/23	2023/24	TOTALS
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Operational Costs

Community	Service	Anticipated start FY	COST ESTIMATE ($)				
			Base FTE	2021/22 FY prorated	2022/23 FY	2023/24 FY	Total
Surrey Fox Glove	MHSU Embedded Clinical Supports (MECS)	21/22	29.24	2,030,000	4,702,000	4,672,000	**11,404,000**

Please include the FTEs included if appropriate – please add rows as needed

Expense	2021/22	2022/23	2023/24	TOTALS
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The following is not required for the initial proposal

However, please include any of the below information if it is available at the time of this initial proposal

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IF approved, detailed implementation plan will be required. Other considerations that will be required at that time

- Description of meaningful partnerships in the proposal
    - Housing service provider and BC Housing
    - Across the health authority
    - Municipality (if appropriate/available)
    - Community based organizations, including Indigenous service providers
- Plan for legislative framework
- Plan for engagement with local Indigenous communities, PWLLE/potential tenants
- Plan/protocol for maintaining housing in event of hospitalization/facility engagement
- Plan/protocol for information sharing with service delivery partners (health, housing, social, cultural services)
- Training plan, in alignment with core competences/principles of the framework
- Monitoring and evaluation considerations, including data collection to support
- Operational protocols (safety plans, decision guides)
- Eviction prevention policy
- Rapid rehousing plan

APPENDIX A – Complex Care Housing Framework

COMPLEX CARE HOUSING: DRAFT STRATEGIC FRAMEWORK AUGUST 30, 2021

BRITISH COLUMBIA | Ministry of Mental Health and Addictions

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INTRODUCTION AND PURPOSE

The Ministry of Mental Health and Addictions (MMHA) has been mandated to develop Complex Care Housing with support from the Ministry of Health (HLTH) and Ministry of the Attorney General and Ministry Responsible for Housing (AG). Complex Care Housing is a suite of services and supports aimed at ensuring people with significant mental health, substance use and other complexities attain safe and stable housing as a foundation to thrive. These services and supports wrap around people, supporting them through transitions and with the appropriate intensity as their needs change over time.

This policy framework provides strategic direction to the health, housing and social sector on enhanced services for a key population in British Columbia (BC) that are currently underserved. It details the core elements of new or enhanced service models, as well as policy direction to guide investment and implementation. These include guiding principles, clear roles and responsibilities, staffing and training supports, and intended outcomes. To address the current gaps in services, this Framework balances direction to improve service consistency and quality, while allowing for flexibility to react to local and regional contexts, and support client-driven responses.

This is not an operational framework – more is needed to bring this policy framework to life and describe how Complex Care Housing can be operationalized. This includes funding models, legislative oversight, operational structures and accountability mechanisms. It also includes practical things like referral pathways, coordinated access, needs assessments, transition pathways, tenancy support models for market rentals, and training requirements. Effective operationalization of Complex Care Housing will require cross-sectoral collaboration and partnership.

This DRAFT strategic framework for Complex Care Housing (the Framework) represents the public facing recommendations developed in collaboration with health, housing and municipal partners, Indigenous partners, people with lived experience, community service providers and experts. Further engagement is planned with a broader network of people with lived and living experience, and urban Indigenous, Métis and First Nations partners and communities. This is vital to ensuring Complex Care Housing services and supports are person centred and community driven.

BACKGROUND

Housing and access to health services are determinants of long-term wellness. While significant investments have been made in BC to expand access to specialized health services as well as supportive and affordable housing, there are persistent gaps in adequate care and supports that lead to people with significant mental health and substance use challenges to experience unstable housing. A lack of stable housing can contribute to poorer mental and physical health outcomes, leading to a cycle of homelessness and harm which is increasingly difficult to break.

These gaps are longstanding, and disproportionately affect some communities in the province. People are left to navigate a fragmented set of services to have their basic needs met. Details can be found Appendix A, and major themes include:

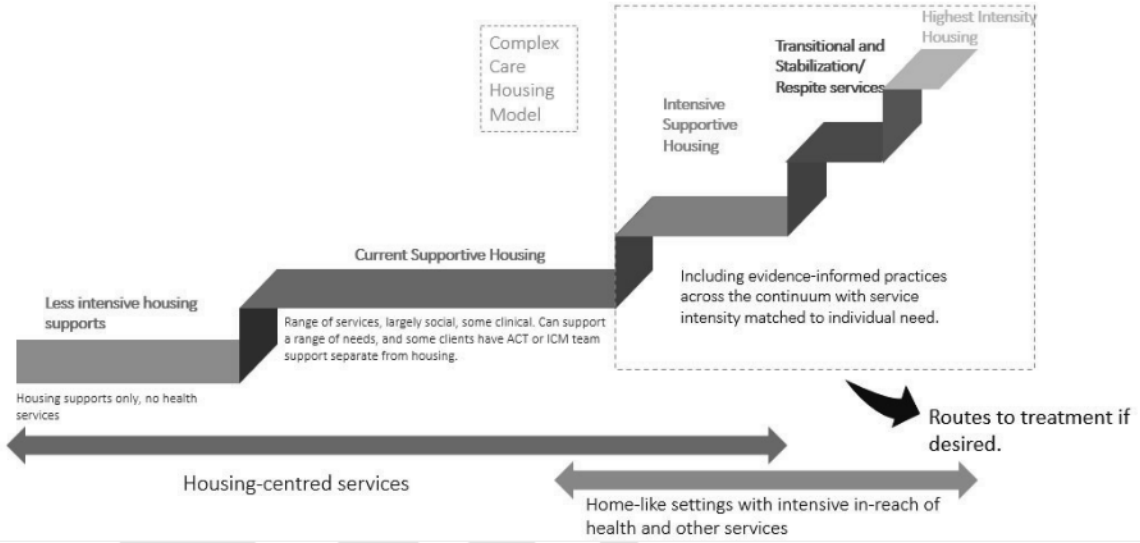
- Gaps in services for people with concurrent mental health and substance use challenges.
- Gaps in treatment for people with mental health and substance use challenges alongside things like developmental disability, acquired brain injury and/or history of violent behaviour.
- Challenges for people who are inadequately reached by services and living in the traditional model of supportive housing.
- Inadequate health and housing support for Indigenous people, who are impacted by generations of colonization, trauma, systemic racism and discrimination[1], and as a result disproportionately experience mental health and substance use challenges and homelessness.
- Inadequate health and housing support for young adults with severe mental health and substance use challenges transitioning from government care.
- Disproportionate interaction of clients with mental illness, substance use challenges, and experience with the criminal justice system, and insufficient health and housing supports for people leaving the corrections system (facilities or remand).
- Loss of housing during times of increased service need or entering facility-based care such as a hospital, other treatment and recovery services (including substance or and addictions treatment), or correctional facilities.
- Inadequate health and housing support in rural and remote areas of BC.

[1] For context on systemic racism and discrimination in the BC health system and associated recommendations for response, see the "*In Plain Sight*" report at https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report.pdf

COMPLEX CARE HOUSING AS PART OF A SYSTEM OF CARE

Complex Care Housing represents a system response with a foundation of strong partnerships among health, social services, and housing organizations and providers. It is crucial that these services do not create further fragments, but contribute to a seamless system of care for people that is seamless with broader health and housing services. Figure one details the model, including three levels of housing and health supports to fill significant gaps for people with complex mental health, substance use challenges and other unmet needs.

Figure 1: Complex Care Housing as part of a System of Care



The existing services on the left meet the needs of many people experiencing housing precarity or homelessness, including some people with complex challenges for whom more services or supports are not wanted. However, for those that continue to struggle with inadequate service access and supports, the dotted box details three new or enhanced and voluntary housing services:

Intensive Supportive Housing: The first new step is supportive housing with increased services and supports that wrap around people in community housing settings. These services are attached to people (as opposed to specific settings), and clients are supported to choose from congregate or scattered site home options. These services are not time-limited.

Transitional and Stabilization/Respite Services: The second step includes two types of services, both meant to be time-limited and shorter duration. *Transitional or "step down" services* bridge people discharged from acute care, other health or addictions treatment settings, correctional facilities or forensic services. These services promote engagement and/or return to community.

Stabilization or respite services provide an immediately response during a period of temporary escalation and prevent break down in tenancy relationships and evictions.

Highest Intensity Housing: This step provides a home-like setting for people who may benefit from more focused care and supports over a longer term. Key elements at this level are low client to staff ratios, access to specialized services (if desired), very small numbers of clients in one setting along with indefinite supports.

These three levels of housing and care are described in more detail later in the framework.

Rural and remote communities

There is no one-size-fits-all solution when it comes to services and supports for mental health and addictions challenges. The realities and challenges of service delivery in rural and remote communities must be considered when designing and implementing Complex Care Housing, including distance to clinical care and treatment, housing infrastructure, and human resource constraints. This Framework aims to provide the overall strategic direction but allow for flexibility and innovation to account for these realities.

POPULATION

Complex Care Housing is intended to support adults (19 and over, including young adults) with significant mental health and substance use challenges and other health issues not adequately supported by the current model of supportive housing. These gaps can mean they are unstably housed/at risk of homelessness, are "living" in acute care or transitional bed-based services without a home to go to, or are homeless.

This is a diverse population, but some common system gaps have resulted in significant challenges for people in BC accessing stable housing.

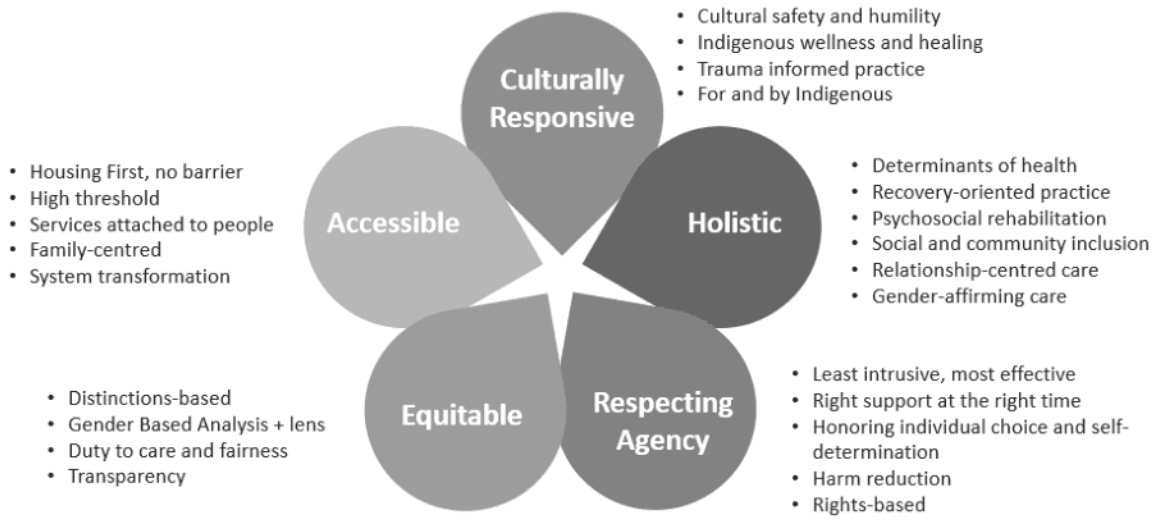
- Histories of poverty, unstable housing, enforcement, stigma, discrimination, racism, marginalization, criminalization has contributed to significant trauma and mistrust.
- The lack of a robust system of mental health care can result in people experiencing severe, persistent symptoms of mental illness and/or substance use, often together, and worsening of symptoms.
- Services have also not been tailored to adequately meet the needs of individuals with developmental disabilities and/or significant functional impairments.
- Housing providers are not currently equipped or supported to safely address episodes of worsening symptoms, which can result in incidents of aggression, violence or self-harm, and engagement with the criminal justice system and high use of crisis services.

- The toxic drug supply, paired with extreme marginalization and stigma, creates a significant overdose risk for people, and more people experiencing acquired brain injury.

Due to the lasting effects of colonization, intergenerational trauma, and systemic racism and discrimination, Indigenous people experience greater barriers to services and must navigate multiple systems to have their basic needs met. This Framework includes space for Indigenous-led solutions, recognizing that communities know what their members need, and that self-determination underpins health and wellness.

PRINCIPLES

Strong guiding principles are needed to address current system gaps and drive change in the health and housing systems. These principles have been co-developed with multiple partners and reflect the approaches needed throughout planning and implementation of Complex Care Housing. More detail can be found in Appendix A.



INTENDED OUTCOMES FOR COMPLEX CARE HOUSING

Complex Care Housing aims to improve housing stability, improve health outcomes, and improve community inclusion; reduce use of acute care and emergency services, and reduce criminal justice system involvement. Some outcomes and associated measures will take time before the effects begin to be realized, and outcome tracking will be reliant on data gathering capacity. Further work is needed identify ways to measure success, but also to understand and

describe what success looks like to Indigenous communities, and people who are receiving services.

Intended Outcomes	Examples of Metrics for Complex Care Housing Clients (TO BE FINALIZED THROUGH FURTHER ENGAGEMENT)
Improved housing stability	For Complex Care Housing clients: • Reduced chronic homeless[2]. This would be disaggregated for key populations, including youth transitioning from government care.
Improved health outcomes	For Complex Care Housing clients: • Increased OAT retention[3] • Fewer overdose deaths[3] • Less time spent in acute care while no longer requiring acute level services (Alternate Level of Care, or ALC designation) • Quality of care metric TBD[3] • Client quality of life/self reported mental health metric TBD[3]
Reduced use of acute care and emergency services	For Complex Care Housing clients: • Fewer emergency room visits[3] • Fewer hospital admissions[3]
Reduced involvement with the criminal justice system	• To be developed
Improved community functioning/inclusion	For Complex Care Housing clients: • Client self reported connection to community metric TBD[3] • Cultural safety metric TBD • Client goal metric TBD

[2] Aligned with *Belonging in BC*
[3] Aligned with *A Pathway to Hope*

ROLES AND RESPONSIBILITIES

TBD

INTERIM GOVERNANCE AND ACCOUNTABILITY

Currently, housing, health and social services are separate and fragmented. A clear governance structure is required to integrate services for Complex Care Housing services into a cohesive system. An interim governance structure will guide expedited implementation of initial sites and services, with a focus on:

- Assess site and service proposals against the Framework and ensure allocation of resources is aligned with regional/population need
    - This includes using available health and housing data to ensure proposals are matched to locations of greatest need.
- Ensure accountable service delivery bodies create the necessary partnerships to develop proposed sites
    - This includes proactively bringing partners together to facilitate proposals for key populations, including Indigenous-led Complex Care Housing, or in areas of the province where need is great.
- Remove institutional barriers to implementation
- Promote change management in the integration of health/housing/social services
- Oversee early evaluation oversight and reporting

Governance oversight will be led by MMHA, alongside AG and HLTH. Lead ministries will work through existing accountability structures to direct and oversee service delivery partnerships between health authorities and BC Housing. This governance should include Indigenous partners; and MMHA will continue work to identify the most effective mechanism to enable them as full partners in decision making. This section will be finalized once Cabinet decisions are communicated.

A long term governance will be developed based on lessons learned from the interim structure. Over the long term, the governance body will be responsible for ongoing implementation and accountability, including:

- Progress reporting
- Data Integration
- Project evaluation
- Ongoing oversight and decision-making (including any expansion)

COMPLEX CARE HOUSING MODEL

Each step of Complex Care Housing is first and foremost a home-like environment. Care must be taken to not perpetuate institutionalization. While it is represented as a stepped model, we know that people's journeys are not linear – individual needs ebb and flow over time. Complex Care Housing aims to reduce the impact of these ebbs and flows on housing stability.

There are pathways to treatment and recovery at every step in the model. However, services are to be designed to meet people where they are at, including honouring individual choice and goals. For some, the goal will be safety and stability, not treatment. Complex Care Housing services promote connection, relationships, and building trust.

Complex Care Housing represents *voluntary* services. Some residents may be under involuntary conditions related to the *Mental Health Act,* or subject to other judicial conditions – for example, requirements to live in a certain location, adhere to treatment, or on parole. This is neither required to access Complex Care Housing services, nor is it a barrier to these services.

At each step in the continuum, there are two key considerations:

1) Physical space
2) Services

Operationalizing this framework requires the development of referral pathways into services, including coordinated access and protocols and guidelines to adequately support people who may move into/out of Complex Care Housing services.

In addition, policies and procedures must be implemented to bring the principles of Complex Care Housing to life. These could include decision guides that include a prescribed set of steps for operators and service providers to de-escalate conflict or address other challenges and prevent evictions, or policies related to gender informed care, cultural safety and humility and trauma informed care.

In Intensive Supportive Housing and Highest Intensity Housing, two policies and procedures are crucial:

- Eviction prevention policies:

  Eviction prevention policies must be established and operationalized. This will provide ways to manage challenges and de-escalate situations and create paths that are alternatives to eviction.

- Rapid rehousing plans:

  If an eviction prevention policy doesn't fully prevent eviction, clients are not to be evicted to homelessness. Residents must have somewhere to go where they maintain connection to services and supports at the intensity that meets their needs. These are to be standardized across Complex Care Housing and will require work once governance processes are determined.

Intensive Supportive Housing

Intensive Supportive Housing represents an *added intensity* of services and supports in a community setting while promoting as much autonomy as possible. This includes a much broader range of services that are coordinated and integrated, and a shift in service delivery focused on *reaching and engaging* people into services, as opposed to expecting people to navigate and seek out care. However, **not everyone with complex needs requires or wants highly intensive services. Individual choice and self-determination are crucial to determining the intensity of services for individuals.**

What does added intensity mean? Added intensity means that services and supports are designed and delivered in a way that *reaches out* to people, and *actively* engages the client at a frequency that meets their needs and wishes. An example of different intensities for primary care are below.

- *Low intensity* – supporting someone to access services. This could include connection to a community primary care doctor or network, directions to a local clinic or urgent primary care centre.
- *Medium intensity* –nursing on-site 24/7; visits from a multidisciplinary team for people to access.
- *High intensity* –proactive engagement to reach people who may need support before needs escalate. This could include regular phone calls or visits for clients with the most severe needs in addition to other services. A key element of this level of care is meeting people where they are at, and actively working to develop trust relationships. Often this is done through ***in-reach* of services** – where services are brought to a person, much like home care - as opposed to waiting for the client to attend a community service centre.

Physical space

- Clients will, wherever possible, have a choice of where and in what kind of setting they will live. This includes:

  Scattered sites where individuals reside in private market residences with rent supplements. This would include significant in-reach services to support client needs.[4]

  Group home-type housing with a small number of residents. Group home sites would include a combination of in-reach and on-site services. Residents would have private spaces, but there would also be some communal spaces for residents.

[4] Implementation planning will identify the adequate supports for landlords to enable success in scattered sites

Congregate Sites are larger buildings with individual apartments or suites housing more than ten residents. There are base services on-site and in-reach or connection to community for other services and supports in the Complex Care Housing model.

Embedded in supportive housing congregate sites, where a floor or distinct area of a congregate supportive housing site is dedicated to complex care clients. This would allow for separate tiers of service/staffing and provide physical space for client/staff safety.

Other client centered options.

- Sites are ideally purpose-built:

  To create a welcoming place to live, sites should be built with input from residents on design, greenspace, decoration. Sites must be accessible to clients with diverse needs, including mobility challenges.

  24/7 security services are implemented to protect residents and their belongings.

- Client mix is intentionally created to promote community and inclusion:

  While people's needs change over time, attention must be paid to best practices on supporting people with very complex challenges. This includes housing *few people with very complex* needs in a larger congregate housing setting.

Services

- Whenever possible, services are connected to people, not locations. This means that implementation **must not** rely exclusively on services that are co-located with housing sites. Services must reach the individual regardless of where they are housed, and be maintained (i.e.: not interrupted) if someone's housing changes unless the individual chooses to change their services.
- All clients are reached with **the full spectrum of services in the Integrated Support Framework with the intensity required to match their needs (Appendix C).**
- Within the services included in the Integrated Support Framework, there are some that are particularly important in Complex Care Housing environments:
    - In-reach or on-site primary care services to manage health challenges and prevent escalating issues before they occur; overdose prevention and prescribed safer supply via in-reach or on-site depending on the housing site; psychosocial supports and rehabilitation.
    - People with moderate mental illness and substance use challenges are engaged with an Integrated Case Management (ICM) team; People with severe mental illness and substance use challenges are engaged with an Assertive Community Treatment (ACT) team or enhanced ICM team.
    - Cultural supports such as events, ceremonies, land-based activities and connection to Elders.
    - Personal care and living supports including medication management, lifeskills, home care.

Transitional and Stabilization/Respite Services

Transitional services provide housing during transition from institutions such as acute care, correctional facilities or forensic services in an effort to ensure success in long-term housing. *Stabilization Services* are essential for supporting individuals to maintain their housing in times of struggle by providing a short-term level of higher intensity supports to de-escalate an acute challenge, or provide respite for the individual to reconnect to supports or services if needed.

As with the other steps in this model, clients' individual needs will vary; the physical space and service model must be flexible in responding to shifting needs.

Physical space

- *Client choice is maintained wherever possible.* Settings for either transitional or stabilization services could include:

  Group-home or small housing could be used to support people with common goals, with a small number of individuals and where staff can provide supports to meet those goals.

  Space in a larger supportive housing congregate site where a floor or distinct area is dedicated to complex care clients. This would allow for separate tiers of service/staffing and provide physical space for client/staff safety.

  Existing Physical Spaces that meet clients where they are at. Stabilization services could be intensive time limited in-reach into someone's residence.

Services

- **Services follow the individual into and out of these time-limited supports.**
- As with the other levels, all clients are offered the full spectrum of services in the **Integrated Support Framework with the intensity required to match their needs.**
- **Transitions** from institutional services (“step down”):

  For those who are transitioning from more institutional care, including those discharging from addictions recovery, early planning is necessary to promote housing and medical stability. This must be undertaken as early as possible and involve the broader health and housing teams to prepare for transitions. Services follow the individual to promote success in their longer term housing. However, additional clinical or other supports may be needed in this short term step.

- **Stabilization/Respite** Services (“step up”):
  This could include a higher intensity of supports through the Integrated Support Framework but could also represent a physical change for the individual with no change in services. This may represent an opportunity to identify changes the individual may wish to

make in their care plan, such as accessing clinical treatment services or prescribed safer alternatives to the toxic drug supply.

A note on transitions

Further work is required by implementing partners to identify referral pathways, protocols and guidelines for people moving into/out of these short term supports as their needs change.

Highest Intensity Housing

This is the most intensive tier of care for Complex Care Housing. It is an indefinite housing support for the smallest subset of the population that needs an intensive, health-focused model of care that includes:

- A home setting
- Small number of residents in a setting
- Intensive oversight by staff to identify opportunities for care and prevent escalation of needs where possible
- Very low client-to-staff ratios

Transitions out of this level of care are supported if it aligns with the clients goals. As with the other steps in the Complex Care Housing continuum, the service is voluntary, and connection to the broader community is crucial.

It is important to note that there is no ability to permanently ban clients at this level of care from health or housing services. Alternative housing must be provided that better meets the individual where they are at. This must balance client safety and wellbeing with staff safety and wellbeing, without preferencing one over the other. Once governance processes are in place, decision plans for these situations must be proactively created by implementing partners.

Physical space

- Client choice is maintained wherever possible. Settings could include:

  Group home-type housing with a small number of residents.

  Embedded in supportive housing congregate sites where the physical space would allow for client/staff safety and would be conducive to separate tiers of service/staffing.

  Client-focused alternatives such as home-shares or other innovative service models and solutions that are determined by the client and care providers, based on individual needs.

Services

- Whenever possible, services are connected to people, not locations.
- All clients are reached with **the full spectrum of services in the Integrated Support Framework with the intensity required to match their needs.**

- Additional services should be considered for this step based on clinical need and individual goals.

STAFFING

The complexity of the challenges for people receiving Complex Care Housing services requires robust staffing from interdisciplinary teams of health, housing, social and cultural service providers that are adequately trained and supported.

This means:

- Service providers are given the time, space and skills to develop relationships with clients.
- There are opportunities and mechanisms for staff to debrief with colleagues
- Staffing should reflect the diversity of clients – First Nations, Métis, and Inuit service providers, as well as other diverse backgrounds and cultures.
- Fully integrated and funded peer support and peer employees.
- There is focused work to support staff wellbeing – this could include mental health supports, supports to prevent burnout, and manage vicarious trauma.
- Partners have flexibility in staffing to address local and client needs. This is especially crucial for implementation outside urban and centre centres.

Although staffing mix and ratio to clients will vary depending on the nature of the service and housing setting, there are certain key aspects to delivering services. Congregate sites may have a combination of on-site and in-reach supports. Scattered sites will require more intentional in-reach of services by staff. Team-based care will leverage the strength of the interdisciplinary care teams.

Staffing levels and composition will be formalized through implementation planning. The following are professions/staff that may deliver Complex Care Housing services in some form:

- On-site care teams
  - Registered/Psychiatric Nurses
  - Mental Health & Addictions Support Workers
  - Peer Support Workers
- On-site or intensive in-reach supports (depending on site and service)
  - Case Managers
  - Social Workers
  - Occupational Therapists
  - Recreational Therapists
- Intensive in-reach supports
  - Indigenous Engagement/Knowledge Keeper/Elders
  - Community Inclusion Worker/System Navigators
  - Addictions Medicine Specialist
  - Primary Care practitioners
  - Psychiatrists
  - Clinical Psychologists

- Counsellors
- Dieticians
- Assertive Community Treatment and Intensive Case Management team support

Other staffing associated with Complex Care Housing include those who deliver the range of Integrated Support Framework services – from building maintenance, janitorial and security, to cultural support practitioners, traditional healers and Elders, to social support workers and others.

Training and Support

Further work will be undertaken to identify and create standardized, competency-based training for all staff who are delivering Complex Care Housing services. This includes training that brings to life the principles of Complex Care Housing, with a focus on building skills in relationship-driven care, trauma-informed practice, gender-affirming approaches, cultural humility and cultural safety. In addition, communities of practice may facilitate and support providers working with common populations to share learnings and maintain competencies over time.

Indigenous-led solutions require that Indigenous-serving organizations have the tools to deliver supports in the way their communities need and wish. Further work with Indigenous providers and communities will identify core training needs for Indigenous-led organizations as well as non-Indigenous led organizations.

Finally, there is a recognition of the potential for vicarious trauma and burnout, particularly for historically under-supported staff. Training and supports must include ways to proactively support staff to maintain their physical, mental health and wellness.

LEGISLATION

Currently, in BC, supportive housing is generally understood to fall under the *Residential Tenancy Act*. The *Residential Tenancy Act* does not apply to the following settings: [5]

- emergency shelter or transitional housing;
- housing in a community care facility under the *Community Care and Assisted Living Act*;
- residence in designated facilities under the *Mental Health Act*;
- residence in a housing-based health facility that provides hospitality support services and personal health care; or
- housing that is made available in the course of providing rehabilitative or therapeutic treatment or services.

[5] BC Laws (2021) Residential Tenancy Act. Retrieved August 9, 2021 from https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/02078_01

MMHA has identified the need to assess appropriate legislative oversight for Complex Care Housing, recognizing that AG intends begin a review of the *Residential Tenancy Act* in Fall 2021 due to ongoing concerns related to its applicability to supportive housing. This work will continue as the Framework is finalized, alongside analysis to understand the implications of the *Community Care and Assisted Living Act*. Crucial to this analysis will be the ability for an individual to have access to the appropriate administrative functions related to tenancy and disputes.

In addition to the statutes that govern housing, there are other relevant statutes that Complex Care Housing must acknowledge and work within, including the *Adult Guardianship Act* and the *Mental Health Act*.

CONCLUSION AND NEXT STEPS

This Framework represents strategic direction to the health, housing and social systems, but requires additional work to fully operationalize into new services. Given the commitments to moving swiftly and sizable system gaps, this Framework can be used to guide the implementation of some initial sites in the very near term. This will allow for rapid assessment of outcomes and client/provider experiences, and continuous improvement of the model and services through scale up.

APPENDIX A – Assessment of System Gaps

Gaps in the health and housing systems create fragmented services that are difficult to navigate, particularly for people who are facing significant trauma, stigma and health challenges.

System/Service Gap	Description
Concurrent Disorders	Existing services and supports are generally tailored to support individuals with mental health *or* substance use challenges, not both. This means that people cannot access the care they need, leading to worsening health and housing precarity.
Tertiary care for people with mental health and substance use challenges and developmental disabilities, acquired brain injury and/or history of violent behaviour	Specialized mental health care (tertiary care) service models have, over time, narrowed and become more even specialized, leaving individuals with diverse and complex realities ineligible to access these services. The 2016 BC Auditor General's report on *Access to Tertiary Mental Health Services*[6] identified a lack of health services to support people with severe mental illness and/or substance use alongside developmental disability, acquired brain injury or history of violent behaviour. This has meant that people are unable to get the treatment they need when they need it, which can lead to housing loss.
Traditional model of supportive housing	The current supportive housing model meets the needs of many in BC, often housing multiple people in congregate settings with services delivered on-site. However, housing operators report an increasing complexity in the clients they serve, a lack of access to the right intensity of services to link them to, and challenges meeting the needs of multiple diverse people in one setting. This can result in evictions or bans aimed at maintaining comfort and safety of the remainder of tenants. Over time this has resulted in significant push back from some communities when new housing is proposed. In addition, the current supportive housing model is built on an assumption that people can "transition" out of supportive housing into less intensive housing. For people with significant mental health and substance use challenges, which are often relapsing and may be life-long, artificial end dates for housing are stressful.

[6] Office of the Auditor General (2016) Access to Adult Tertiary Mental Health and Substance use Services. Retrieved August 9, 2021 from https://www.bcauditor.com/sites/default/files/publications/reports/OAGBC_Mental_Health_Substance_Use_FINAL.pdf

System/Service Gap	Description
Housing and supports for Indigenous peoples	Indigenous people have experienced generations of colonization, trauma, systemic racism and discrimination, and as a result, First Nations, Métis and Inuit and urban Indigenous people/people away from their home community are disproportionately affected by mental health and substance use challenges and homelessness. The housing system has not sufficiently supported Indigenous-led housing for Indigenous people, which is vital to self-determination, reconnection to culture, and healing.
Transition supports for youth	Young adults (19 and over), particularly those who are under government care and "ageing out" of that care are at significant risk of homelessness and disconnection from health services. Those with significant mental health and substance use challenges are even more vulnerable while navigating new health and social services aimed at adults, and often losing their stable housing due to change in age. There are insufficient supports across this lifecourse transition, and lack of adequate, youth friendly housing options that are welcoming and accessible.
Transitions from corrections	People who are experiencing homelessness often experience more enforcement actions, and there can be significant lack of trust as a result. Once someone is involved with the criminal justice system, they often face additional barriers to housing such as court conditions, stigma, and previous offences. Currently, people are often released without notice or the opportunity to connect to adequate care, leaving. shelters as the only temporary housing option other than homelessness. This lack of permanent housing can be extremely detrimental, often leading to recidivism.
Loss of housing during times of increased need or entering institutional care	People's needs change over time, and mental health and substance use challenges are often lifelong. The current systems create situations where individuals lose their housing or need to move when their needs change – examples include if people are admitted to hospital, enter substance use treatment, or enter the criminal justice system. This also results when services are attached to settings and housing sites are designated for "high" "medium" or "low" needs – removing any ability for people to have housing stability during times of other instability. In addition, changing housing often results in people having to reconnect to health and social services in a new housing site, as opposed to being followed by services that are attached to the person.

System/Service Gap	Description
Housing and supports in rural and remote areas	There are fewer services available for people with severe mental health and substance use challenges, a smaller workforce and less housing availability in rural and remote areas. Due to a critical mass of services and individuals with complex challenges who access specialized services, urban centres tend to be prioritized for health and housing supports, leaving large gaps in housing and care for rural settings.

APPENDIX B – Guiding Principles

Culturally Responsive

Cultural safety and cultural humility

Cultural safety is an outcome that is a response to power imbalance and inequality in the health system; it is actioned by creating a safe environment free of discrimination or racism. Cultural humility is the ability to treat others with respect and build trust by positioning oneself as a humble learner when trying to understand the experience of another. Cultural safety and humility also include seeking to understand the legacy of trauma and harm brought to the Indigenous peoples through colonization. In Complex Care Housing services, cultural safety would ensure that services wrap around a person, their family and community, to support self-determination and healing that is rooted in culture, ceremony, Elders, and land. It also recognizes that there are many cultures that residents connect to and supports must come from a place of humility.

Indigenous wellness and healing

Indigenous wellness is a whole and healthy person expressed through a sense of balance of spirit emotion, mind and body. Central to wellness is belief in one's connection to language, land, beings of creation, and ancestry supported by a caring family and environment.[7] Complex Care Housing must be built on a foundation of wellness, including Indigenous Elders, practitioners and Indigenous healing practices.

Trauma-informed practice (including from an Indigenous perspective)

Trauma-informed practice involves understanding trauma and its impacts on providing care and adjusting to reduce power imbalances that may perpetuate trauma. In the Complex Care Housing context, services and supports and planning are informed by experiences of trauma and the physical environment is arranged to limit re-traumatization. A focus on trauma-informed practice from an Indigenous perspective involves a strengths-based individual, family and community-centred approach that considers the legacy of systemic racism and trauma resulting from colonization.

For Indigenous, by Indigenous

In alignment with the principle of self-determination, implementation of Complex Care Housing should include services that are owned, operated and staffed by Indigenous organizations and Indigenous community members for Indigenous people.

[7] Thunderbird Partnership Foundation (2020) "Indigenous Wellness Framework: Reference Guide". Retrieved from https://thunderbirdpf.org/iwf-ref-guide/

Accessible

Housing First/no barrier

The Housing First approach first and foremost identifies that housing is the first step to wellness and should not require any level of housing "readiness." It is a recovery-oriented approach that helps establish a supportive environment to provide other services and supports. In Complex Care Housing, this includes a combination of settings that accept people who are not connected to treatment as well as those who are.

An inability to maintain stable housing is often due to a lack of the right kind and intensity of supports. Complex Care Housing must include solutions that have no barriers – be they engagement with treatment or needing to attain some level of readiness. As Complex Care Housing is designed to provide housing to those with complex mental health and substance use challenges who are not adequately supported in other supportive housing environments, it is important that there are no barriers to accessing the service.

High threshold Services (no bans)

As Complex Care Housing is at the upper threshold of housing, there is no option to ban individuals from care, support and housing permanently. Permanent bans to health or housing services inflict additional trauma and leave individuals homeless. While it may be necessary for someone to change housing, wherever possible additional supports should be added to prevent moves, and rapid rehousing plans must be executed.

Services attached to people, not locations

Wherever possible, Complex Care Housing services should be connected to people, not locations to prevent people from getting disconnected from care. This is an important part of the "safety net" that reduces gaps in services, particularly if someone needs to move housing. This does not preclude services on-site, in fact some services are best positioned on-site. But attachment to clients will allow choice in how someone wishes to engage and enables connection to care through transitions.

Family oriented

For people who wish it, housing services must be family-oriented, allowing families to stay together in housing. This includes housing that allows pets and is aligned with honouring individual choice.

Systems Transformation

Complex Care Housing is a service that is nested in a greater system of care and supports. Hallmarks of true system transformation include addressing challenges with navigation, transitions and communication among services. Systems transformation, and integration through collaborative, reciprocal working relationships, is necessary to support communities in a fulsome way, especially when integrating clinical and community-based approaches.

Holistic

Determinants of Health

Social, spiritual, biological, economic, developmental, and environmental conditions all contribute to wellbeing. Complex Care Housing recognizes that housing is a core determinant of health and wellness but acknowledges that other factors contribute to wellbeing and must be addressed. This is the foundation of the DRAFT Integrated Support Framework.

Recovery-oriented practice

Recovery-oriented practice is a strength-based approach that emphasizes resilience and supports individuals to take responsibility for their recovery and wellbeing. In a Complex Care Housing environment this includes opportunities for growth so that the individuals can live the life they choose and meet their individual goals. This model prioritizes treating individuals with dignity and respect, reducing stigma. *It does not prioritize abstinence from substances unless that is the individual's goal and complements a harm reduction orientation.*

Psychosocial rehabilitation

Psychosocial rehabilitation aims to promote community integration, personal recovery and quality of life for people with mental health concerns. Services are collaborative, person directed, individualized and skill building.

Actively promoting social and community inclusion

Social connectedness and community inclusion are key factors in housing stability and wellbeing. Active work to include people into the broader community in which they live is a cornerstone to strengthening social connections and wellness.[8]

Relationship-centred care

Relationship-centred care refers to the healing process that occurs in relationships, both with self and with others. It emphasizes the importance of the personhood of the 'client,' the impact of their emotions on relationships, that relationships include reciprocal influence, and the formation of genuine relationships have value.

Gender-affirming care and supports

Respectful, dignified care supports an individual, while recognizing and acknowledging their gender identity and expression. This includes providing spaces and services that are inclusive and tailored to the needs of men, women, trans and non-binary people. Lack of this acknowledgement can lead to mistrust and disengagement in care.

[8] Adapted from British Columbia Psychosocial Rehabilitation Advanced Practice (2021) What is psychosocial rehabilitation? Retrieved August 9, 2021 from https://www.psyrehab.ca/pages/what-is-psr.

Equitable

Distinctions-based approach

A distinctions-based approach recognizes that First Nations, Métis and Inuit peoples are distinct groups, and that policy, planning and services are tailored to their unique needs, interests, and priorities. This includes acknowledgement that cultural supports do not look the same for all Indigenous people.

Gender Based Analysis+ Lens

The Gender-based Analysis Plus (GBA+) lens is an intersectional analytical process to explore how gender and other factors of an individual's identity ((i.e., race, religion, age, culture, language, mental or physical disability, etc.)affect how different people experience policies, programs, and services. In the context of Complex Care Housing, GBA+ is important in understanding things like the population and inequities they experience, the different services and supports they want, ensuring they are implemented to address those inequities, measurement and evaluation to understand the disproportionate impact of programs, staffing demographics and training requirements.

Duty of care, fairness

A duty of care ethical principle is one of the clauses of the Declaration of Geneva, which details that a physician "will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing to intervene between my duty and my patient".[9] The ethical principle of fairness is an assessment of the distribution of goods in society,[10] including health and housing systems. For Complex Care Housing, these are right of all to receive care in a way that is fair and just.

Transparency

Building trust is a significant element of relational care, and better reaching and engaging people into supports and services. Sometimes this trust is difficult to develop, particularly with clients who have experienced ongoing oppression, racism, discrimination and persistent stigma and trauma. Complex Care Housing planning and implementation must strive to be transparent in all regards in an attempt to overcome barriers to trust and connection.

[9] Khan, R.I. (2005) Clinician's Duty to Care: A Kantian Analysis. *Law and Governance.* Retrieved July 23, 2021 from https://www.longwoods.com/content/17389/law-and-governance/clinicians-duty-to-care-a-kantian-analysis
[10] Varkey, B. (2021) Principles of Clinical Ethics and their Application to Practice. *Medical Principles and Practice* 30:17-28.

Respectful of Individual Agency

Least intrusive/most effective

The ethical principle of the least intrusive/most effective care is to assure that an individual is offered supports (or when desired, treatments) that balance effectiveness and intrusiveness or limits on personal freedoms. For Complex Care Housing this is the foundation for augmenting services as much as possible in community housing settings to ensure personal freedoms are balanced with effective care.

The right supports at the right time

It is important to provide flexibility in services and supports, that can respond to changing needs and priorities of individuals in Complex Care Housing. In conjunction with services attached to people, not locations, this principle reinforces the importance of a person-centered model of care. It also acknowledges that services and supports are part of a broader system of health care that must aim to reach people with services quickly, when they are needed.

Honouring individual choice and self-determination

Individual choice and agency in decision-making that affects an individual's life is important to supporting many of the other key principles of Complex Care Housing and supports. Two main areas of choice and agency not covered elsewhere include housing placement (including a decision to remain unhoused) and the services they receive. Self-determination[11] is supported across the policy process and implementation, foundationally that services for Indigenous people are led by Indigenous people, as Indigenous people have the wisdom of what they and their communities need.

Harm reduction approach

Harm reduction is a set of strategies that reduce harms associated with substance use. A key principle in harm reduction is non-judgmental support and care without pressure on the cessation of substance use. In Complex Care Housing, harm reduction can range from a policy of supporting safe use (monitoring), providing supplies, and/or a safe space for individuals to inhale or inject their substances.

Rights-based approach

Complex Care Housing must uphold human rights, and the rights of individuals as guaranteed under statutes. Of key interest are the rights of clients to dispute issues related to their tenancy, their right to informed consent for care, their right to refuse care in the absence of existing legislation considerations.

[11] United Nations (2008) United Nations Declaration on the Rights of Indigenous People. Retrieved July 23, 2021 from https://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf.

APPENDIX C – Complex Care Housing Services (DRAFT Integrated Support Framework)

In addition to housing, a suite of robust health, housing, social and cultural services will support the whole person to maintain housing and wellness

*initial sites may need to phase in full services

Physical Health, Mental Wellness & Substance Use Supports include:
Team based primary care
Overdose prevention Services
Prescribed safer supply
ACT team
ICM team
Managed Alcohol Program
Other public health (infection prevention, immunization, STBBI services and harm reduction)
Environmental Health
Built Environment/Occupational Health
Oral Health
Addictions Medicine
Psychiatry
Recovery Coaching
Medication adherence support
Mental Health Assessments/Screening
Others
Indigenous Cultural Supports include;
Ceremonial Supports
Elders
Traditional food
Art
Music
Land based healing
Others
Housing Supports include:
Landlord/operator liaison
Negotiation and conflict management support
Others
Social, Emotional and Community Supports include:
Family Services
Peer Support
Recreation
Music/art
Income Support
Employment and skills training supports
Counselling
Community Inclusion
Others

Personal Care and Personal Living Supports include:
Activities of daily living supports (hygiene, continence, dressing, feeding, ambulating)
Life Skills
Laundry
Cleaning/tidying
Hoarding prevention/support
Medication management
Managing finances
Others (please describe)
Food Security Supports include:
Cooking and meal prep skills
Nutrition supports
Providing meals
Others (please describe)

Complex Care Housing

Detailed Implementation Plan (DIP)

Date:

Organization: Fraser Health Authority

Title of Project: Medically Enhanced Complex Housing – Foxglove, Surrey

Project Contact:

BRITISH COLUMBIA | Ministry of Mental Health and Addictions

If you have any questions regarding the information or requirements in this template, please reach out to:

Gina Gardner, Director, Strategic Policy (Gina.Gardner@gov.bc.ca)

Purpose:

The purpose of this document is to detail how the project will be operationalized and implemented.

Please validate information that has been carried over from the original proposal (which includes MMHAs understanding of shifts in scope during prioritization) and complete additional sections by **no later than January 14, 2022**

We understand that this is a work in progress and that we are working with expedited timelines. As such, there may be details that are still to be determined; if so, indicate that, particularly if there is a need for provincial coordination from your perspective

Submissions must include all of the following content

Project Overview *Please validate/update the following information:*

Number of Intensive Supportive Housing clients: **34**

Number of transitional and/or stabilization spaces: **5**

Number of Highest Intensity Housing clients: 0

Scattered site (includes rental supplements) ☐ Congregate site ☒ In-reach to congregate sites (No rent supplements) ☐

Do you expect to house any members of the following key CCH populations in this project:

People with acquired brain injury ☒ Young adults ☐ First Nations (including non-status) ☒ Métis ☒ Inuit ☒

Other Indigenous people ☒ Corrections ☒ Forensics ☒ Persons with developmental disability ☒

Changes from the original proposal

Please validate the scope changes below with your understanding with edits in tracked changes (~150 words max):

- 3~~4~~3 permanent intensive supportive housing clients and 5~~6~~ transitional spaces
- Operational budget
  - 21/22 changed $360,500
  - 22/23 unchanged $4.702M

- 23/24 unchanged $4.672M
- Added 24/25 operational budget of 4.672M

Congregate site housing:
Location where CCH clients will live (including address if known).
Foxglove, Surrey (9810 Foxglove Dr.)

Site owner: **BC Housing**

Housing operator (if known/confirmed)**: Rain City Housing**

Partnerships and Engagement: *Please specifically address BC Housing and housing operators, Indigenous, partners and communities, municipalities, community-based organizations, people with lived experience you have or are looking to consult on the development of the project. Please include how you have or will engage with people and organizations serving equity-deserving groups (e.g., BIPOC, 2SLGBTQ+ …) Where partnerships do not already exist, tables should be set up to convene partners to discuss planning, issues, risks, areas of need, and collaborative response.*

1) Meaningful partnerships involved in the proposal to date

(Meaningful partnership is defined as co-lead on proposals, or strong partnership otherwise described) ~150 words max.

Rain City Housing actively partnered on the CCH proposal. Fraser Health primary care, acute care, MHSU, Public Health, Community Health, Addiction medicine, Aboriginal Health and outpatient infectious disease services have been working on workflows and coordination of services through Integrated Homelessness Action Response Team (IHART) and Rain City.

The City of Surrey is a partner in the overall Foxglove project.

BC Housing meets weekly with the FH team about all ERCs and Isolations Centres and new developments/modulars for vulnerable populations are co-planned. CCH proposals involved BC Housing locations across the Fraser Health region.

FH will start with local homelessness table for engaging with organizations and developing partnerships.

2) Further engagement and consultation planned

Legislation:[1] *Please note your planned approach to tenancy oversight (if known)*

Residential Tenancy Act ☐ Program Agreements ☒ Community Care and Assisted Living Act ☐

Rationale:

Program agreement can be more flexible and understanding of behaviours and to promote growth and skill development (person-centred approach) for clients. Potential gap for clients in process for appeal. FH to work with Rain City Housing to have an appeal process as part of the service agreement.

Fraser Health contracted with a consultant to engage in a consultation process related to the Integrated Homelessness Action Response Team (IHART) and health service to people in ERCs and ICs. The consultation includes persons with lived and living experience, First Nation Health Authority, Metis Nation BC, FH Aboriginal Health, non profit operators and BC Housing. This consultation will inform the work of the IHART team serving complex care locations.

Also, IHART coordinators will be attending community homelessness tables in order to connect with non profit providers, municipal staff, first responders (Surrey Fire, EHS, Surrey Police Service)

Dec. 2021-Persons with Lived Experience, non profit providers, BC Housing

Jan. 2022 – FNHA, Metis Nation, Aboriginal Health

Future engagement with Forensics and CLBC, no timeline established as yet

Performance Indicators:

Development of performance indicators and evaluation is ongoing at a provincial level. This information is intended to contribute to that discussion.

PERFORMANCE MEASUREMENT TYPE	INDICATORS *Please include performance measures for the following categories*
PROGRAM METRICS	*Referral # received and source (ie, community, acute, tertiary/ ACT)* *# unique program users* *Shelter status at time of referral* *Status of primary care attachment at time of referral* *Referral # to specialized services/community FH teams, ie Virtual Health Addiction Clinic, Bed based treatment* *Client # transitioned to stable housing* *Client # attached to primary care* *Transition # to SCSP service* *#OD responses in the program* *# clients engaged in harm reduction related to substance use,*

[1] There is ongoing work provincially on legislative oversight for Complex Care Housing. We recognize that many clients will have existing program agreements or legislative oversight – please note your initial thoughts on legislative oversight for this project.

	# clients on OAT/pharmaceutical alternatives *# police calls – MH Act, Car 67 (pre- post)*
CLIENT DEMOGRAPHICS	*Age* *Gender* *Self-identify as Indigenous* *Ethnicity* *Health status indicators: ie, pregnancy*
CLIENT OUTCOMES	*# ED presentations and inpatient admissions pre and post program* *# hospitalizations and LOS pre and post for patients requiring IV antibiotics* *# planned hospitalizations to meet care/treatment need* *# clients engaged in community* *# clients self-initiated departure from housing and # who had program agreement end*
PROGRAM-SPECIFIC MEASURES	*Staff # with cultural safety training; # Indigenous positions hired* *Satff # with TRIP education; # with Harm Reduction training* *Managed Alcohol program referrals # and retention after 6 months* *# clients with a collaborative care plan*
DATA COLLECTION AND SOURCES *(e.g. Client surveys, chart reviews, program metric tracking documents, etc.)*	
EMR Program metric tracking document Non profit reporting	

Policies & Plans:

This information can be preliminary pending provincial standardization. The information provided below will support the Provincial Implementation Committee develop consistent approaches across CCH.

Temporary absence from housing

Plan/protocol for supporting clients to maintain housing in the event of a short-term entry into institutional services (hospital, other treatment including supportive recovery, corrections, etc.) ~200 words max.

The shelter portion is $375 and will be funded by MSDPR for most residents. By provincial policy, the shelter portion can be paid for 3 months if someone enters treatment and intends to return. Each resident will have a health worker who will review the status of hospital stays and other institutional admissions.

Safety Plans and/or Decision Guides

Please describe your planning related to safety plans and/or decision guides (i.e. a prescribed set of steps to de-escalate conflict or address other challenges). ~150 word max.

The team will use a collaborative care plan that is recovery oriented and includes safety planning FH team will have violence prevention training

Eviction prevention policy

Please describe the policy and plan to prevent eviction for CCH clients. ~150 word max.

Requires further planning

Rapid Rehousing plans

Please describe the process for rapid rehousing should their needs exceed what can be provided in that space. ~150 word max.

Requires further planning

Harm Reduction policy

Please describe the policy and plan for harm reduction for this project. Please also clarify if medication assisted treatment and overdose prevention services are fully permitted and supported. ~150 word max.

Harm Reduction is part of the team orientation and education

OPS is on site and operator is very experienced in a harm reduction approach

IHART facilitates assessments with virtual health addiction clinic

Cultural Safety

Please describe your planning and policies to ensure the services provided through this proposal are culturally safe for all potential clients. ~250 word max.

The Education and orientation committee includes an Indigenous Cultural Safety Educator

Cultural safety is embedded in the interview tool

Rain City and FH will have positons that will be Indigenous specific

Education/Training:

Please describe education and training plans for both internal staff and with community partners that are supporting the project.~250 word max.

Internal staff training:

Required Training for IHART.docx

Training with housing provider: TRIP, Harm Reduction, Recovery oriented service, Cultural Safety

Services for People in Complex Care Housing

The Integrated Support Framework (ISF) represents a full package of wrap around services to successfully support clients to maintain wellness and preserve housing. Please validate the information captured below from the initial proposal, add in as requestred and **mark any changes from the original proposal in yellow**

Service	On-site or In-reach Remove if N/A	Service Provider(s)	New funding requested or leveraging existing services	*Briefly describe plan for service delivery (i.e. frequency, availability in off hours if appropriate)*	
Physical Health, Mental Wellness & Substance Use Supports					
Team based primary care	On site ☐ Inreach ☒	FH and Rain city	New Funding ☒ Existing ☒	24/7	
Overdose prevention Services	On site ☒ Inreach ☐	FH and Rain city	New Funding ☒ Existing ☒	24/7	
Prescribed safer supply	On site ☒ Inreach ☐	FH	New Funding ☐ Existing ☒	Virtual appts	
ACT team	On site ☐ Inreach ☒	FH	New Funding ☐ Existing ☒	7 days/week	
ICM team	On site ☐ Inreach ☒	FH	New Funding ☒ Existing ☒		
Managed Alcohol Program	On site ☒ Inreach ☐	FH and Rain city	New Funding ☒ Existing ☒	Daily 7 days/week	Estimated number of CCH clients served by MAP 25
Other public health (infection prevention,immunization, STBBI harm reduction)	On site ☐ Inreach ☒	FH	New Funding ☒ Existing ☐		
Environmental Health	On site ☐ Inreach ☒	FH	New Funding ☐ Existing ☒		
Built Environment/Occupational Health	On site ☒ Inreach ☐	FH	New Funding ☐ Existing ☒		
Oral Health	On site ☐ Inreach ☒	FH	New Funding ☐ Existing ☒		
Addictions Medicine	On site ☐ Inreach ☒	FH	New Funding ☒ Existing ☒	Virtual appts	
Psychiatry	On site ☐ Inreach ☒	FH	New Funding ☒ Existing ☒	Virtual appts	
Recovery Coaching	On site ☒ Inreach ☒	FH and Rain city	New Funding ☒ Existing ☐	Recovery coaching is a cross team and organization function to provide recovery oriented services	
Medication adherence support	On site ☒ Inreach ☐	FH and Rain city	New Funding ☒ Existing ☒	7 days/week	
Mental Health Assessments/Screening	On site ☒ Inreach ☐	FH	New Funding ☒ Existing ☒	7 days/week	
Others (please describe) • **Wound care, IV antibiotics, SU assessments/counselling/referrals**	On site ☒ Inreach ☒	FH	New Funding ☒ Existing ☒	7 days/week	
Cultural Supports					
Ceremonial Supports	On site ☒ Inreach ☐	Click or tap here to enter text.	New Funding ☒ Existing ☐		
Elders	On site ☐ Inreach ☒	Click or tap here to enter text.	New Funding ☒ Existing ☐		
Traditional food	On site ☐ Inreach ☒	Click or tap here to enter text.	New Funding ☒ Existing ☐		

Service	On-site or In-reach Remove if N/A	Service Provider(s)	New funding requested or leveraging existing services	*Briefly describe plan for service delivery (i.e. frequency, availability in off hours if appropriate)*
Art	On site ☒ Inreach ☐	Rain City	New Funding ☒ Existing ☐	
Music	On site ☐ Inreach ☐	Click or tap here to enter text.	New Funding ☐ Existing ☐	
Land based healing	On site ☐ Inreach ☒	Rain City	New Funding ☒ Existing ☐	
Others e.g. traditional healers (please describe)	On site ☐ Inreach ☐	Click or tap here to enter text.	New Funding ☐ Existing ☐	
Housing Supports				
Landlord/operator liaison	On site ☐ Inreach ☒	FH	New Funding ☒ Existing ☐	5 days/week
Negotiation and conflict management support	On site ☐ Inreach ☒	FH	New Funding ☒ Existing ☐	5 days/week
Others (please describe)	On site ☐ Inreach ☐	Click or tap here to enter text.	New Funding ☐ Existing ☐	
Social, Emotional and Community Supports				
Family Services	On site ☐ Inreach ☒	FH	New Funding ☒ Existing ☒	5 days/week
Peer Support	On site ☒ Inreach ☒	Rain City	New Funding ☒ Existing ☐	7 days/week
Recreation	On site ☒ Inreach ☐	Rain City	New Funding ☒ Existing ☐	
Music/art	On site ☐ Inreach ☐	Click or tap here to enter text.	New Funding ☐ Existing ☐	
Income Supports	On site ☒ Inreach ☒	Rain City	New Funding ☒ Existing ☐	7 days/week
Employment and skills training supports	On site ☒ Inreach ☐	Rain City	New Funding ☒ Existing ☐	7 days/week
Counselling	On site ☒ Inreach ☒	FH	New Funding ☒ Existing ☐	7 days/week
Community Inclusion activities	On site ☒ Inreach ☒	Rain City	New Funding ☒ Existing ☐	7 days/week
Others e.g. transportation supports (please describe)	On site ☐ Inreach ☐	Click or tap here to enter text.	New Funding ☐ Existing ☐	
Personal Care and Personal Living Supports				
Activities of daily living supports (hygiene, continence, dressing, feeding, ambulating)	On site ☒ Inreach ☐	FH and Rain city	New Funding ☒ Existing ☐	7 days/week
Life Skills	On site ☒ Inreach ☐	FH	New Funding ☒ Existing ☐	7 days/week
Laundry	On site ☒ Inreach ☐	Rain City	New Funding ☒ Existing ☐	7 days/week
Cleaning/tidying	On site ☒ Inreach ☐	Rain City	New Funding ☒ Existing ☐	7 days/week
Hoarding prevention/support	On site ☒ Inreach ☐	Rain City	New Funding ☒ Existing ☐	7 days/week
Medication management	On site ☒ Inreach ☐	FH and Rain city	New Funding ☒ Existing ☐	7 days/week
Managing finances	On site ☒ Inreach ☐	Rain City	New Funding ☒ Existing ☐	7 days/week

Service	On-site or In-reach Remove if N/A	Service Provider(s)	New funding requested or leveraging existing services	*Briefly describe plan for service delivery (i.e. frequency, availability in off hours if appropriate)*
Others (please describe)	On site ☐ Inreach ☐	Click or tap here to enter text.	New Funding ☐ Existing ☐	
Food Security Supports				
Cooking and meal prep skills	On site ☒ Inreach ☐	Rain City	New Funding ☒ Existing ☐	scheduled
Nutrition supports	On site ☒ Inreach ☒	FH	New Funding ☒ Existing ☐	
Providing meals	On site ☒ Inreach ☐	Rain City	New Funding ☒ Existing ☒	7 days/week
Others (please describe)	On site ☐ Inreach ☐	Click or tap here to enter text.	New Funding ☐ Existing ☐	

Milestones for Implementation

HIGH-LEVEL IMPLEMENTATION TIMELINE (2021/22 – 2023/24)

NOTE: Please provide a high-level overview of your timeline for planning and implementing this initiative
Please note when project plans are anticipated to be developed, service frameworks or service models created, new FTEs will be hired or contractors identified, monitoring and/or evaluation approaches designed and estimated start times for the delivery of services.

Please describe the intended project planning approach this initiative. Please identify who will be doing the work, what are the required steps and how you intend to implement the initiative (e.g. hire a contractor, new dedicated FTE, plan already developed, etc.)

Project planning has been underway for several years with recent changes given the CCH opportunity. FH project planning leader works with Rain city on a project workplan. Partner meetings with BC Housing and FH and Rain City occur intermittently. BC Housing developing an MOU for all parties. Rain City developing an MOU for the onsite operations with FH.

Milestone Activities *Please identify the incremental goals necessary to the initiative's success*	**Target Timelines** *Please list the key dates in relation to incremental goals*	**Notes**
Please list and briefly describe all significant relevant project plan components including but not limited to: recruitment of planning staff, engagement activities, detailed budget development, service design and staffing plan development, monitoring and evaluation plan development and other relevant project planning activities		
Service provider agreement will be revised for the number of beds	*Feb. 2022*	
Confirming budget and recruitment	*Jan 2022*	
Service design for the site and MOU with non profit	*Feb. 2022*	
Evaluation plan in development- Rain city will lead and link with FH	*Feb. 2022*	
Tenanting of the building	*March 2022*	

Risks and Mitigation Strategies

Please note any risks associated with your proposal and the associated mitigation strategies

Risk	**Mitigation Strategy**
The building occupancy permit may be delayed.	This is managed by BC Housing working with the City of Surrey. Regular communication is established with BC Housing
There may be hiring delays	Fraser Health has prioritized support for this hiring process. Rain city has staff within the organization prepared for opening

Budget:

Please use this embedded excel table and include requested FTEs

CCH - Operational Budget for approved

For Reference

(Draft) Complex Care Housing Framework -

Require Training ****Submit Certificates to your Coordinator/CNE****		Time	Date completed
Online	**Fraser Health New Employee Orientation (Learning Hub)** • Learning Hub Course ID: 24631	4 hrs	
Classroom	**Violence Prevention – PVPC Classroom – Fraser Health** (one time only) • Learning Hub Course ID: 14898	8 hrs	
Online	**FH Paris - Fundamentals Online - Clinicians/ Final Preceptorship Students** • Learning Hub Course ID: 18449	6 hours	
Classroom	**FH Paris - Skills Assessment** • Learning Hub Course ID: 18448	2 hours	
Classroom	**Violence Prevention – PVPC Refresher – Fraser Health** (annual refresher) • Learning Hub Course ID: 16820	30 min	
Online	**Hand Hygiene** • Learning Hub Course ID: 5360	15 min	
Online	**Psychological Safety and Resilience (Learning Hub)** • Learning Hub Course ID: 24422	35min	
Online	**Introduction to Indigenous Health (Learning Hub)** • Learning Hub Course ID: 16926	15min	
Online	**Naloxone Training** • Learning Hub Course ID: 8458	45mins	
Online	**Adult Abuse and Neglect (Re-ACT)** • Learning Hub Course ID: 10968	5 min	
Online	**Work alone Program - Community** • Learning Hub Course ID 12902	30 min	
Online	**Hazardous Drugs Safety Awareness** • Learning Hub Course ID: 15950	15min	
Online	**TBC on the Run** • Learning Hub Course ID: 24178	2 hour	
Online	**Workplace Hazardous Materials Information System (WHMIS)** ** If you have completed this in the last year you do not need to complete	45 min	
Classroom	**Indigenous Cultural Safety 101** • Learning Hub Course ID: 22676	3.5 hours	
Online	**BC Mental Health Act – Education for Nurses, Allied Health & Medical Staff** • Learning Hub Course ID: 19570	1 hour	
Online	**Trauma Informed Course: NHA - CL - Trauma Informed Care - TIC eLearning Modules** • Learning Hub Course ID: 7621	6 hour	
Online	**Diversity Competency Module 1: What is Diversity** • Learning Hub Course ID: 11390	1 hour	
Online	**Diversity Competency Module 2: Cultural and Religious Literacy** • Learning Hub Course ID: 12089	1 hour	
Online	**Diversity Competency Module 3: Communicating with Diverse Populations** • Learning Hub Course ID: 15368	2 hours	
Online	**Diversity Competency Module 5: The Standards for Health Care Providers** • Learning Hub Course ID: 15367	2.5 hours	
Online	**Diversity Competency Module 6: Providing Care to Refugees** • Learning Hub Course ID: 15664	1 hour	

Online	**San'yas Indigenous Cultural Safety: Core Health Training** • Learning Hub – you will be directed to another site for learning	10 hrs	
Online	**Addiction Care and Treatment Online Course (ACTOC)** • Learning Hub 24331– you will be directed to another site for learning	16 hrs	
Online	**Respectful Workplace** • Learning Hub 23113	30 mins	

IHART In-services:

IHART In-services – ran throughout the year		Time	Date completed
Classroom	**Indigenous Cultural Safety 101** • Learning Hub Course ID: 22676	3.5 hours	
Classroom	**Harm Reduction 101A : Foundations of Harm Reduction** • Learning Hub Course ID: 24266	2.5hours	
Classroom	**Harm Reduction 101B: The Ins & Outs of Harm Reduction Supplies** • Learning Hub Course ID: 24267	1.5 hours	
Classroom	**Current CPR – C** • Learning Hub Course ID:12645	2 hours	

Optional Training for Clinical Platforms		Time	Date completed
Online	**FHA Meditech - Enterprise Medical Record (EMR) (Online)** • Learning Hub Course ID: 15771	1 hour	
Online	**FHA Meditech - Order Entry (OE) (Online)** • Learning Hub Course ID: 19040	1 hour	
Online	**PSLS – Introduction to reporting events** • Learning Hub Course ID: 19368	1 hour	
Online	**Integrating Virtual Health into Your Practice** • Learning Hub Course ID: 23600	30 min	
Online	**Unifying Clinical Information** • Learning Hub Course ID: 13658	45 mins	

Operational budget Medically Enhanced Complex Housing – Foxglove, Surrey

Please add rows as necessary.

Expense	# FTE (if appropriate)	2021/22	2022/23	2023/24	2024/25
MHSU Staffing					
Rehab/Occupational Therapist - 1day/week	0.20	$10,000.00	$24,000.00	$25,000.00	$25,000.00
Rec Therapist/Voc Counsellor - M-F	1.00	$56,000.00	$137,000.00	$142,000.00	$142,000.00
Physician Sessions (4x Addictions, 4x Psychiatry a week, 1x MAP, 1x Primary Care)		$132,000.00	$325,000.00	$325,000.00	$325,000.00
PPH Staffing					
Peer Support Workers - 11 hrs Days x 7 days/week	2.15	$68,000.00	$167,000.00	$173,000.00	$173,000.00
Subst Use Clinician (M) - M-F	1.00	$50,000.00	$124,000.00	$128,000.00	$128,000.00
Social Worker (B) - M-F	1.00	$50,000.00	$124,000.00	$128,000.00	$128,000.00
Woundcare / IV Antibiotics					
Comm Health Nurse - 11 hrs Days x 7 days/week	2.15	$117,000.00	$289,000.00	$298,000.00	$298,000.00
Comm Health Worker - Days & Nights x 7 days/week	4.30	$135,000.00	$333,000.00	$343,000.00	$343,000.00
Woundcare (Dressings / IV Antibiotics / Supplies)		$25,000.00	$60,000.00	$60,000.00	$60,000.00
Medical Supplies/Crisis fund (incl. foot care, medication, glasses, hearing aids, wheelchairs, walkers)		$21,000.00	$50,000.00	$50,000.00	$50,000.00
Alcohol (15 clients enrolled)		$5,000.00	$10,000.00	$10,000.00	$10,000.00

One time costs (lockable location for alcohol)		$5,000.00	$0.00	$0.00	$0.00
Aboriginal Health					$0.00
Cultural Contract $15K incl supplies for ceremonies		$7,000.00	$15,000.00	$15,000.00	$15,000.00
Indigeneous Art		$20,000.00			$0.00
Supplies/Sundry/Minor Equipment					
Office Supplies		$5,000.00	$12,000.00	$12,000.00	$12,000.00
IMIT Costs (Cell, Laptop, Headsets)		$16,000.00	$37,000.00	$37,000.00	$37,000.00
Milleage		$3,000.00	$6,000.00	$6,000.00	$6,000.00
Staffing Services		$0.00	$0.00	$0.00	$0.00
Hospital Bed x 6 units		$16,000.00			$0.00
Exam Room - Barriatric Bed/table x 1 room		$5,000.00			$0.00
Exam Room - Regular examination couch x 2 rooms		$4,000.00			$0.00
Exam Room - I.V. Chairs x 1 room		$5,000.00			$0.00
Portable lift x 1		$5,000.00			$0.00
Blood pressure monitoring supplies (cuff)		$1,000.00			$0.00
Virtual Care Equipment		$10,000.00			$0.00
HSP					
*Foxglove by HSP 21-25 beds 4.3FTE 24/7 MHCW 0.50FTE Nurse RN/RPN	4.80	$253,000.00	$626,000.00	$645,000.00	$645,000.00
Startup One-time		$78,000.00			$0.00
Health Care Worker - 7 days/week	2.15	$68,000.00	$167,000.00	$173,000.00	$173,000.00

Research & Evaluation Specialist 1x 18m		$32,000.00	$125,000.00	$32,000.00	$32,000.00
Indigenous Cultural Advisor (Elder)	1.00	$33,000.00	$81,000.00	$34,000.00	$34,000.00
Cultural Services Enhancements					
Cultural activities		$5,000.00	$20,000.00	$20,000.00	$20,000.00
Elder honorariums		$5,000.00	$25,000.00	$25,000.00	$25,000.00
2.9 Indigenous Cultural Liaison roles (off line/7 days	2.94	$160,000.00	$395,000.00	$395,000.00	$395,000.00
Indigenous Services Department		$10,000.00	$40,000.00	$40,000.00	$40,000.00
1.4 Cultural worker of Colour (off line/7 days a week)	1.47	$37,000.00	$90,000.00	$90,000.00	$90,000.00
Peer Services Enhancements					
2.9 Peer Support Workers (off the line)[1]	2.94	$93,000.00	$228,000.00	$235,000.00	$235,000.00
2.9 Peer OD outreach and engagement[2]	2.94	$93,000.00	$228,000.00	$235,000.00	$235,000.00
Funds for 2 6 hour honorarium paid peer witness shift 7 days a week (12 hours x $20 x 365 days)		$37,000.00	$91,000.00	$94,000.00	$94,000.00
Administrative support	1.00	$28,000.00	$67,000.00	$70,000.00	$70,000.00
Surrey ICM Team Sustainability					
Compensation		$175,000.00	$433,000.00	$446,000.00	$446,000.00
No-Staffing		$63,000.00	$155,000.00	$160,000.00	$160,000.00
Additional Clinical Staffing					
Clinical counselor	1.00	$32,000.00	$78,000.00	$81,000.00	$81,000.00
OT	1.00	$32,000.00	$78,000.00	$81,000.00	$81,000.00
Implementation Evaluation					

Evaluator fees and expenses	1.00	$25,000.00	$62,000.00	$64,000.00	$64,000.00
TOTAL	**34.04**	**$2,030,000.00**	**$4,702,000.00**	**$4,672,000.00**	**$4,672,000.00**

*4.80FTE under HSP was not initially included.

2021/22 Revised from above		
Rain City Additional (Fr MR)		$66,000.00
Original Contract + Add'l Admin Feb 21 - Mar 31/22 (Fr MR)		$68,000.00
1x Equipment & Staffing Costs (Fr MR)		$95,000.00
Research & Evaluation Specialist 1x 18m	1.00	$21,000.00
RN	0.50	$22,000.00
IHART		
Comm Health Nurse - 11 hrs Days x 7 days/week	2.15	$47,000.00
Comm Health Worker - Days & Nights x 7 days/week	2.94	$37,000.00
IMIT		$3,000.00
Office Supplies		$1,000.00
Mileage for 5 IHART Staff		$500.00
TOTAL	**6.59**	**$360,500.00**