BRITISH COLUMBIA | Ministry of Mental Health and Addictions

DRAFT Complex Care Housing: Access Framework

Version 3.3 – Abridged Version

March 2023

Introduction

The Ministry of Mental Health and Addictions (MMHA) has been mandated to develop Complex Care Housing (CCH) with support from the Ministry of Health (HLTH) and Ministry of the Attorney General and Ministry Responsible for Housing (AG). CCH will provide a suite of enhanced services and supports to people with significant mental health and substance use issues, or other complexities. These services and supports will wrap around individuals, ensuring they can attain safe and stable housing as a foundation to thrive.

About the Complex Care Housing Access Framework

The Complex Care Housing Access Framework ("the Framework") was developed to provide direction, guidance and information for establishing and implementing pathways into CCH. It will help ensure there is consistency across projects making up the initial phase of CCH. The Framework has been developed to support the CCH Leads: the organizations receiving funding to implement CCH across B.C. At the time of this version, this includes regional health authorities, the Aboriginal Housing Management Association, Ktunaxa First Nation, and the Provincial Health Services Authority.

In their systematic review of coordinated and centralized access mechanisms in Ontario, Dr. Brian Rush and Birpreet Saini acknowledge that there are many variations in how to approach access, and that there are "mixed feelings about the effectiveness of coordinated access models".[1] Generally, coordinated or centralized access works to simplify access to services by using consistent processes and tools to assess and refer individuals. However, while there are a number of promising approaches and practices, more research is required to know which models are the most effective. The research does not point to any single, optimal approach for access and referral pathways. The initial phase of CCH will build on promising practices while monitoring and evaluating the effectiveness of approaches across regions.

The initial phase of CCH implementation is not the first time that health and housing services have collaborated in B.C. In some regions, coordination of service provision between health and housing services is well-established; in others, it is becoming formalized. CCH is intended to build on this collaboration whenever possible—by adapting and leveraging existing systems, services can be implemented more quickly.

There will be no universal, province-wide pathway to access CCH during the initial phase of projects. Rather, organizations implementing CCH will develop their own regional access pathways that are responsive to local needs and compatible with existing processes if they

[1] Rush, B. and Saini, B. 2016. Review of Coordinated/Centralized Access Mechanisms: Evidence, Current State, and Implications. Report submitted to the Ontario Ministry of Health and Long-Term Care.

are in place. The Framework, therefore, is not intended to detail the specific roles and responsibilities of each organization involved in CCH delivery. Instead, it is intended to support regional or community-led planning and implementation by articulating the essential components that need to be in place, while providing guidance on how to ensure that access pathways are responsive to client needs.

The Framework includes sections on governance, points of contact, referrals, assessment, list management, matching, and process review. Each section includes **minimum requirements:** the essential components of pathways into complex care that CCH Leads must establish for their respective access processes. The Framework also highlights considerations to support the planning and implementation of CCH projects. Sections are laid out to follow the journey of an individual accessing CCH—from initial contact with a service provider in the community to placement and matching with housing and services.

This Framework was developed in consultation with members of MMHA's Provincial Implementation Committee and its Access Working Group:

- Provincial Health Services Authority
- First Nations Health Authority
- Northern Health Authority
- Island Health Authority
- Vancouver Coastal Health Authority
- Fraser Health Authority
- Interior Health Authority
- Aboriginal Housing Management Association
- BC Housing
- Community Living BC
- Ministry of the Attorney General
- Ministry of Social Development and Poverty Reduction

Works Consulted:

Abt Associates Inc. 2015. A Coordinated Entry System for Los Angeles: Lessons from Early Implementation. Evaluation of the Conrad N. Hilton Foundation Chronic Homelessness Initiative. Retrieved from: https://www.abtassociates.com/insights/publications/report/coordinated-entry-system-for-los-angeles-lessons-from-early

Built for Zero Canada. 2019. Case Conferencing Overview. Retrieved from: https://bfzcanada.ca/wp-content/uploads/Case-Conferencing-Overview-and-Examples.pdf

Canadian Association to End Homelessness. Coordinated Access Webinar Series, 2019-2021. Retrieved from: https://training.caeh.ca/upcoming-webinars/webinar-archive/

Employment and Social Development Canada. 2019. Reaching Home Coordinated Access Guide. Retrieved from: https://publications.gc.ca/site/eng/9.880741/publication.html

Professional Ethics in Rehabilitation Network. 2017. Toolbox of wait list management strategies in rehabilitation. Retrieved from: https://oppq.qc.ca/wp-content/uploads/Boite-outils-strategie-gestion-attente-eng.pdf

Region of Waterloo. 2013. Coordinated Access Administrative Guide. Retrieved from: https://www.regionofwaterloo.ca/en/living-here/resources/Documents/Housing-Services--Renters-Toolkit/docs_admin-2350119-v1-coordinated_access_admin_guide_-feb_2017access.pdf

United States Department of Housing and Urban Development. 2017. Coordinated Entry Core Elements. Retrieved from: https://www.hudexchange.info/resource/5340/coordinated-entry-core-elements/

We acknowledge with respect that the BC Public Service operates throughout British Columbia on the traditional lands of Indigenous Peoples. The BC Public Service is deeply committed to true and lasting reconciliation with Indigenous Peoples in BC.

Contents

Purpose

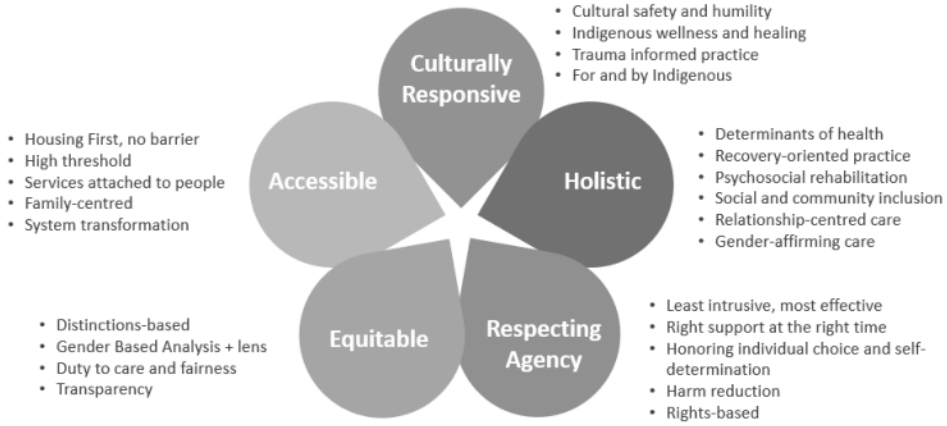
The Framework provides direction, guidance and information to CCH Leads to ensure consistency in access pathways into CCH. It identifies the minimum requirements for pathways into CCH, while allowing for regional flexibility in establishing and operating access systems. In addition, the Framework highlights guiding principles and considerations that can support improved accessibility.

It will help housing, health, Indigenous and community partners ensure that accessing CCH is streamlined and that individuals with the greatest needs are prioritized. It also provides direction on how to approach decision-making when multiple implementation partners are involved. Ultimately, the Framework will support people with complex mental health and substance use issues, and other health concerns, to access CCH services.

MMHA will lead the monitoring and evaluation of this initial phase. As CCH is a new approach, monitoring and evaluation will support an iterative implementation process, which may see projects change as we learn more about the impacts of particular staffing models, housing settings, and services provided. As such, the Framework is a starting point that may come to be refined over time.

Guiding Principles

All implementation of Complex Care Housing is to be guided by the principles outlined in the Complex Care Housing Strategic Framework. The principles in the Strategic Framework are captured in the diagram below; for definitions of the principles, see Appendix A.



The principles in the Strategic Framework were developed collaboratively with representatives from Indigenous agencies, persons with lived or living experience, and a myriad of partners from health and housing sectors across BC. There are, however, specific principles that are most relevant to access, namely:

Collaboration: As a principle, being collaborative simply means people working together. Many people, agencies, organizations, Nations and governments are involved or connected to the health and housing systems. CCH is also being implemented in existing systems with established processes. When it comes to access, local implementation partners should collaborate to ensure access to CCH is streamlined and known to local stakeholders and eligible clients.

Confidentiality: Confidentiality is the principle that an individual's data and privacy will be protected. There is sensitive personal information involved, especially with the referral and assessment stages of access.

Cultural Safety: 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. For access, the principle of cultural safety is enacted by ensuring

the access process is welcoming for those of all cultures. In the context of a history of trauma and violence towards Indigenous Peoples, this principle is actioned through support for Indigenous-led projects and cultural supports in CCH projects.

Distinctions-based approach: The explicit recognition of the unique rights, interests, priorities and concerns of status and non-status First Nations, Metis and Inuit peoples that are collectively referred to as Indigenous peoples. For access, implementing organizations should consider how to integrate a distinctions-based approach into the access pathways, recognizing that clients have unique service needs.

Equity: Equity in access ensures that the process and decisions involved in connecting individuals to CCH services would be free of discrimination and prioritize those with the greatest need for services and support. Equity in access is also the recognition that individuals have different circumstances that necessitate an approach tailored to the needs of the individual.

Housing First: The Housing First approach identifies that housing is the first step to wellness and should not require any level of housing "readiness", including requirements related to mental health or substance use treatment. It is a recovery-oriented approach that helps establish a supportive environment to provide other services and supports. Access pathways for CCH must take a Housing First approach.

Person-centred: Individual choice and agency in decision-making are important to supporting many of the other key principles of CCH and supports; for access, this can be actioned by involving an individual in placement and service decisions in a meaningful way. This means that individuals are informed and engaged throughout the entirety of the access process, from referral to placement or matching to service.

Privacy: Privacy refers to maintaining the security and confidentiality of an individual's personal information. For access, personal information should be shared between agencies only if the necessary information-sharing agreements are in place and it is only pertinent to accessing CCH.

Transparency: Transparency is actioned by having a clear and understandable process for those receiving services, as well as those seeking to access services for themselves or others. It should be apparent what the points of entry into CCH are and how the decisions are made throughout the access process. Transparency also includes the ability to follow up with the CCH Lead if one has questions about the process. Access pathways should be communicated to local stakeholders and the public.

Key Concepts and Definitions

The following key concepts and definitions are used through the Framework.

Alternate Level of Care (ALC): Is when an individual is in an acute environment in a hospital setting and does not require the intensity of resources/services provided in that setting. Once this is established, the individual's status at the hospital is designated ALC. The designation ends when an individual is discharged, or their needs change and the designation no longer applies. This may be someone who needs mental health or substance use services that are not currently available. For CCH Access, it is anticipated that some individuals designated ALC may be transitioning into CCH.

Acuity: In health care, acuity is a measurement of the depth or severity of need. "Higher acuity" is generally associated with a higher level of need for supports or services. For CCH Access, acuity would be captured during the referral/assessment process and would later inform prioritization and matching/placement.

Assessment: Assessment is the process by which information is gathered to determine an individual's eligibility for CCH and acuity/depth of need. Assessment takes place either during or after the referral process. This involves using an assessment tool or process to make sure the individual meets the client profile and inclusion criteria for CCH while identifying the needs of the individual.

Assessment Tools: The documents and tools used to assess the depth of need and collect information that will support the prioritization and placement/matching processes. Assessment tools can focus on vulnerability, service needs, history of violence or functional ability. Examples of assessment tools include the Vulnerability Assessment Tool (VAT), used by BC Housing to match individuals with appropriate housing services, or the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT), which is currently under consideration as a tool for CCH Access by several CCH Leads.

Case Conferencing: In CCH Access, case conferencing refers to a collaborative approach to identifying eligible individuals, reviewing referrals and assessments, and/or matching. It may include a number of partners from across the health and housing systems.

CCH Access: The process from the initial point of contact to the matching of an individual into CCH services. It also includes transitions between services, including stabilization or respite services. Currently, CCH Access is regionally- or community-led; there is no universal CCH Access system in place for all of BC.

CCH Lead: An organization being funded via the Ministry of Health to implement CCH projects. At this time, CCH Leads include the regional health authorities, Provincial Health Services Authority, the Ktunaxa Nation Society and the Aboriginal Housing Management

Association. CCH Leads may also be the CCH Service Provider, or they may partner with or contract other organizations to deliver services.

CCH Provincial Implementation Committee (PIC): The PIC drives the implementation of CCH across the Province. It is responsible for planning, providing direction and guidance, and providing space for implementation partners to share information and troubleshoot challenges. The full membership can be found in Appendix B.

CCH Regional Table/Committee: Each CCH Lead has established a Regional Table/Committee to support the planning and implementation of all CCH projects. In some cases, these tables/committees support an entire health region; in others, they focus on a smaller geographic area (e.g. Greater Victoria). These regional tables report up to the PIC via CCH Lead representatives.

CCH Service Provider: The agency or organization, generally a regional health authority or contracted non-profit, that provides CCH services in a particular region or for a particular project.

Community Integration Specialist: Community Integration Specialists (CIS) provide a system navigation service for people who are at risk of losing their housing or experiencing homelessness, and people who have mental health and/or substance use challenges. They connect individuals to community-based supports and services as well as help them to navigate available Ministry services and programs. CIS workers are managed by the Ministry of Social Development and Poverty Reduction.

Congregate Supportive Housing: Congregate supportive housing is a multi-unit building, generally with self-contained living units, where there is on-site staff to provide supports for residents. The level of service provision and the nature of the services are variable, and rent is typically paid via the shelter allowance as part of Income Assistance. In BC, most congregate supportive housing buildings are owned by BC Housing and operated by a non-profit, contracted service provider. Some congregate supportive housing buildings may also have staff contracted by a regional health authority.

Coordinated Access Systems (CAS): CAS are intended to streamline and bring consistency to the process by which people access services. In the context of housing services in BC, CAS most often refers to regional coordinated tables that support entry into BC Housing's subsidized housing services, which include supportive housing. BC Housing is establishing various CAS tables across the province. CAS tables usually involves community service providers, the regional health authority, and BC Housing.

Highest Intensity Congregate Site: Smaller (e.g. 4-6 residents) congregate housing arrangements. For CCH Access, Highest Intensity Congregate Sites are one type of living

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arrangement to which an individual could be matched based on their assessment and choice of housing.

Indigenous Peoples: Refers to the status and non-status First Nations, Inuit and Metis people in British Columbia.

Matching: The process by which individuals are attached to housing or services. For CCH Access, matching would occur after an individual has been assessed, and is based on available vacancies, service capacity, and an individual's choice.

Other/Community Service Provider: In this framework, Other/Community Service Provider refers to an agency or organization that provides non-CCH service. Agencies or organizations that **do** provide CCH services are referred to as a 'CCH Service Provider'

Point of Contact: The initial contact between an individual seeking services and the CCH service provider or a service provider that makes referrals to CCH.

Prioritization: The process by which a CCH Lead determines an individual's priority for services. For CCH Access, prioritization can be based on information gathered during the assessment and on system capacity and management.

Referral: The process by which an individual is formally introduced to services. For CCH Access, referral follows an individual making contact at a point of contact, CCH service or community/other service provider. Referrals involve a form that is submitted to the CCH service provider, who will then follow up with individuals for assessment or prioritization. In some cases, multiple organizations or individuals can refer someone to a CCH service, including self-referral. In others, such as in highly specialized services like forensics, referring agencies may be limited.

Respite/Transition Spaces: Spaces which offer short-term stays for individuals during periods of transition (e.g. discharge from inpatient health services or corrections) or of increased need. For CCH Access, these spaces may be available to those already attached to CCH or as a broader system management tool used to prevent people during periods of increased need from needing to access CCH over the long term. These spaces may be used until a vacancy for CCH services becomes available, or an individual may utilize the respite service and then return to their former living situation.

Scattered-site housing: Individual units that are distributed across multiple buildings. In the context of CCH Access, market scattered housing refers to private market rental apartment units of varying size. Non-market scattered housing refers to subsidized apartment units of varying sizes, including units in supportive housing buildings, where people live while receiving in-reach CCH services.

Services: Various resources and supports provided to individuals to address physical and mental health, substance use, cultural, emotional, social and other needs. In the context of CCH Access, services refer to the supports provided through CCH; services provided outside of CCH are generally referred to as specialized or other health and community services. For a full list of services delivered by CCH service providers, see Appendix C.

Waitlist: The waitlist(s) are often used by CCH service providers to manage and prioritize individuals that have been referred to CCH. In the first phase of implementation, there is no universal access system. There may be waitlists that are project by project, or for an entire region. For CCH Access, CCH service providers may have multiple sub-lists for those that have been assessed, those who have been prioritized, and those who are receiving CCH services. The waitlist(s) for CCH Access may integrated or connected to existing waitlists for other services or housing placements. The Framework will refer to a range of lists at each point of the pathway into CCH. In some cases, there may be projects as part of the first phase that do not utilize waitlists.

Complex Care Housing: Eligibility Criteria

The following criteria are to be used by CCH service providers when considering referrals and assessments for those individuals "in greatest need" of CCH services. As regional partners begin implementation, they may consider additional criteria should it ensure those that would most benefit from CCH are able to access services.

Adults (19 and over) living with serious mental health and/or substance use challenges who may have health issues that severely impact function and ability to maintain housing. Formal diagnoses of mental health disorder, substance use disorder, acquired brain injury and other conditions are **not** required.

AND

whose needs are not met by existing supportive housing that are homeless (unsheltered or sheltered) or are precariously housed, including:

- Those with unstable tenancy/residency in market or subsidized housing
- Those with no fixed address
- Those living in in-patient or transition services that are likely to be discharged to homelessness or housing that lacks appropriate supports
- Those living in or recently discharged from the corrections system
- Those who have had frequent stays in institutional health care settings (e.g. acute or tertiary care, forensics)

AND

that would benefit from access to round-the-clock, 24/7 mental health or substance use services and/or functional supports

Requirements and Guidance

1.0 Governance Structure

While MMHA leads the planning and implementation of CCH at a provincial level, the CCH Lead and their partners will lead planning and implementation at a regional or community level. The CCH Lead is the organization funded by the Ministry of Mental Health and Addictions to develop complex care in their region/community. In most cases, the CCH Lead is also the CCH Service Provider. However, in some regions, non-profit organizations will be contracted to serve the CCH Service Provider role.

MINIMUM REQUIREMENT(S):

1. **The CCH Lead and their regional or community/local table will plan and implement a regional, community, or local CCH Access process OR identify an appropriate existing process that can be adapted for CCH. Whether new or adapted, the process will:**
    - Delineate roles and responsibilities for CCH service providers, including roles of decision-makers at each point along the referral pathway, from the point of contact to matching with housing and services. For projects that partner with a BC Housing site to provide housing, there will be an agreed upon decision-making process for placement/matching.
    - Identify access points for services and ensure these access points are known to people eligible for CCH, referring organizations/services, and the community more broadly.
    - Describe how eligible clients will be referred, assessed, prioritized and matched to housing (including the specific assessment tool(s) or processes used to support decision-making across access the pathway).
    - Describe all protocols for obtaining consent to retain and share client information along the pathway.
2. **Once this process is finalized, the CCH Lead will share it with the MMHA Complex Care Housing team.**
    - CCH Leads will be responsible to report on the process for all projects for which they are funded.
    - MMHA will review the process for alignment with the CCH Access Framework and the CCH Strategic Framework. If misaligned, MMHA will work with the CCH Lead to ensure revisions are made.

2.0 Points of Contact

Points of contact are the initial place of contact between an individual seeking or needing services and the CCH service provider or organizations that can make referrals to the CCH service provider. In the health and social service literature, points of contact have also been referred to as "points of entry" or "points of access". Not all CCH Leads are the service provider in each project. For example, CCH Leads may contract a non-profit organization to provide services.

MINIMUM REQUIREMENT(S):

1. **CCH Leads must clearly define points of contact for CCH services:**
   - Identify all organizations or individuals that can make referrals.
   - Ensure organizations or individuals that can make referrals are aware of how referrals are to be made.
   - If individuals can self-refer, ensure that information on how self-referrals are to be made is communicated to local service providers and the public.
2. **CCH Leads must ensure points of contact are communicated to organizations serving the priority population:**
   - This will ensure that CCH service providers, other service providers and community members can support individuals to access services.

3.0 Referrals

Referrals are the means by which an individual is formally introduced to CCH services after connecting at a point of contact. Referrals generally involve a form that is submitted to the CCH Lead or a CCH service provider. This form can be more detailed, serving as a first step in the assessment process, or less detailed, with a comprehensive assessment following the referral. Stakeholders have identified that a more detailed referral form can be challenging to work through with an individual, especially if they are in crisis. Moreover, a detailed form may force individuals to relive their stories and trauma.

MINIMUM REQUIREMENT(S):

1. **CCH Leads must clearly define how individuals can be referred to CCH services, including developing or adapting a referral form.**
   - This may be a new process, or referrals to CCH can be integrated wholly or partly into an existing referral system, such as BC Housing's Coordinated Access System.
   - CCH Leads will work with CCH service providers and other service providers, including Community Integration Specialists, to clearly delineate how referrals are made.
2. **CCH Leads must maintain a list of all individuals referred to CCH services. This list must include:**
   - The referring organization(s); and
   - The status of the referral (whether it was accepted or diverted to a more appropriate service).
   - This information will support monitoring and evaluation activities and will support implementers to adjust their referral process, should it be required.
3. **CCH Leads must have processes in place to manage referrals that are not eligible or not accepted. This includes:**
   - Ensuring that the referred individual is redirected or referred to an appropriate service (e.g. BC Housing's supportive housing service), or is otherwise supported by a service/team that will continue to support them; and
   - Ensuring there is a follow-up with the referring organization.

Commented [WSAM2]: Removed due to indicators shift

4.0 Assessment

Assessment is the process by which information is gathered to determine an individual's eligibility for CCH and measure one's acuity or depth of need. As noted in the previous section, the referral process may involve collection of detailed information and serve as a large component of the assessment process. Or, referrals can gather minimal information, and a detailed assessment could take place afterwards.

MINIMUM REQUIREMENT(S):

1. **CCH Leads must establish a clear and consistent assessment process that will support the assessment and prioritization of individuals for CCH. This process must include a new, existing or adapted assessment tool that will gather/consider the following:**
   - Personal contact information
   - Measurement of depth of need/level of acuity
   - Current housing status and recent housing history
   - Mental health and substance use history
   - Functional ability or developmental barriers
   - Existing supports or connections to care
   - Health and housing goals
   - Risk factors (e.g. overdose, self-harm)
   - Trauma-related concerns

2. **CCH Leads must establish a clear and consistent process to manage individuals that are assessed and not found to be eligible for CCH. This includes:**
   - Ensuring that the referred individual is redirected or referred to an appropriate service (e.g. BC Housing's supportive housing program); and
   - Ensuring there is a follow-up with the referring organization

5.0 Prioritization

Once individuals have been referred to the CCH service provider and their depth of need and risk factors are adequately assessed, they can be prioritized for placement. The initial phase of CCH is not anticipated to meet the full demand for housing and services, and prioritization will allow CCH service providers to rank and prioritize clients for services when they become available. Each regional CCH Access process will require a process for prioritizing individuals, and they will manage this by maintaining a waitlist of individuals prioritized for CCH (the following section provides more information on waitlists and list management).

MINIMUM REQUIREMENT(S):

1. **CCH Leads must establish a process for prioritizing people eligible for CCH services.** This process could weigh acuity, frequency of service use, system pressures, inclusion of priority populations, or other significant community factors.

6.0 List Management

CCH Access will be supported through several related lists that will allow CCH service providers to manage individuals as they move through the CCH Access pathway. The 'Prioritization list' described below is what may often be considered the primary 'waitlist'. CCH service providers may use one aggregated list to manage clients along each step of the pathway or choose to use several lists at various stages to manage client flow. The following are examples of the various lists or components of lists that can be used to manage CCH Access effectively:

- **Referral list:** a list of all individuals that have been referred to CCH, which identifies the referral source and the referral status (e.g. whether the referral is accepted or diverted to a more appropriate service). This list will allow CCH service providers to monitor the number of individuals referred to CCH services and to track common referral sources and opportunities for collaboration. It would also support CCH Leads to report on referrals as part of performance measurement and evaluation.
- **Assessment list:** a list of individuals who have not yet completed an assessment who are eligible for CCH services. Such a list would not be needed for pathways in which the assessment is part of the referral process. This list would support CCH service providers to manage individuals requiring follow-up for an assessment.
- **Prioritization list:** a list of all individuals that have been assessed and are eligible for CCH services. This list is organized according to priority. This list is what is

traditionally considered the 'waitlist' of individuals waiting for vacancies and an offer of matching to a new home.

- **Active client list:** a list of all individuals actively receiving CCH services. This list could include information on an individual's housing unit, which may shift over time. This list would support CCH service providers in tracking the number of active clients and managing individuals as they transition between housing settings.

CCH Leads are encouraged to work with their partners to establish the appropriate list(s) that best supports CCH service providers in managing referrals. Not all of these lists will be relevant or appropriate for each community.

MINIMUM REQUIREMENT(S):

1. **CCH service providers must maintain list(s) to manage referrals, prioritization, and active clients.**
   - List management does not require elaborate databases. During this initial phase of CCH, the list(s) may be managed and maintained manually as a secure excel file.
   - In communities where there are existing processes to access health and housing, the list(s) could be maintained using another electronic system.
2. **The list(s) must contain all information necessary to prioritize individuals for matching to services, or the information required for prioritization must be otherwise accessible to the team responsible for prioritizing individuals for CCH services.**
   - If available housing has specific restrictions (age, gender, mobility, etc.), ensure that this information is captured.
3. **CCH service providers must regularly review the list(s) at least every six months to assess whether people still require services (consulting with referring organizations where appropriate).**
   - CCH service providers may review the list more frequently, but this is not a requirement.

7.0 Matching

Matching is the process by which individuals become formally attached to health services or housing units based on the prioritization method adopted for the CCH Access pathway. Broadly, individuals can be matched to services when there is capacity for the CCH provider to take on new clients. Individuals can be matched to housing units when a unit becomes available (e.g. when new units are constructed, vacated, or available to rent in the private market).

MINIMUM REQUIREMENT(S):

1. **Matching to CCH services and housing units must be based on the prioritization method adopted by the CCH service providers and implementation partners.**
   - Ensure that matching is guided by the established prioritization method(s). This will enhance the consistency of access in the region.

2. **Individuals must be involved in matching decisions.**
   - A central principle of the Draft CCH Strategic Framework is respecting individual agency. For CCH access, this means giving individuals meaningful choices in their placements through CCH.
   - If there are limited options, CCH service providers should work with individuals to identify the next best option, as this is preferred to remaining homeless or in unstable housing.

3. **If matching individuals to housing units within a BC Housing site, the CCH Lead will ensure a joint decision-making process is in place. For supportive housing, this would include BC Housing and its contracted operator.**
   - Some regions may have well-established joint decision-making processes already in place. In others, implementation partners should use MOUs or other agreements to set clear expectations around roles and responsibilities.

4. **For unsuccessful matches (e.g. people decline service, available housing site is not appropriate for the individual), individuals must remain in their spot on the priority waitlist for the next available service/unit. If an individual's needs change, they should be reprioritized appropriately.**
   - CCH service providers should be open to housing all clients in need of CCH services but should also carefully consider the individual and the impact they may have on others living or working on site.

5. **CCH Leads must track the number of vacancies (if any) available for every project.**
   - Real-time information on vacancies is essential to support list management and the matching process.

8.0 Process Review and Disputes/Appeals

The initial phase of CCH implementation will involve a range of projects that use different service delivery and housing models. Implementation is expected to be an iterative process, with CCH Leads closely monitoring whether the CCH Access pathway is successful at bringing eligible clients into CCH services. CCH Leads must implement a regular review of their CCH Access process to ensure it is working effectively for service providers and individuals receiving CCH.

In addition, individuals may wish to dispute or appeal any stage of the CCH Access process, including assessment of eligibility, how they are prioritized, or which services/units are offered during the matching phase. CCH Leads and their implementation partners must ensure that processes and protocols are in place for resolving disputes or appeals.

MINIMUM REQUIREMENT(S):

1. **CCH Leads must regularly review the CCH Access process to ensure that eligible individuals are able to access CCH services and housing.**

2. **CCH Leads must ensure that there is a process for individuals to dispute or appeal any stage of the CCH Access process and that there are transparent protocols for how these disputes/appeals will be resolved.**
   - This could include a Patient Care Quality Office or other established dispute resolution process.

CCH Access Flow Diagram(s)

Figure 1 shows each stage of the CCH Access process, not including movement to transition or respite spaces. The **yellow** boxes include descriptions of each stage, and the **blue** box provides an example of an individual's journey along the pathway.

Figure 2 shows how individuals may access transition and respite spaces, whether coming from an existing CCH service or another community service.

Figure 1: CCH Access System Pathway

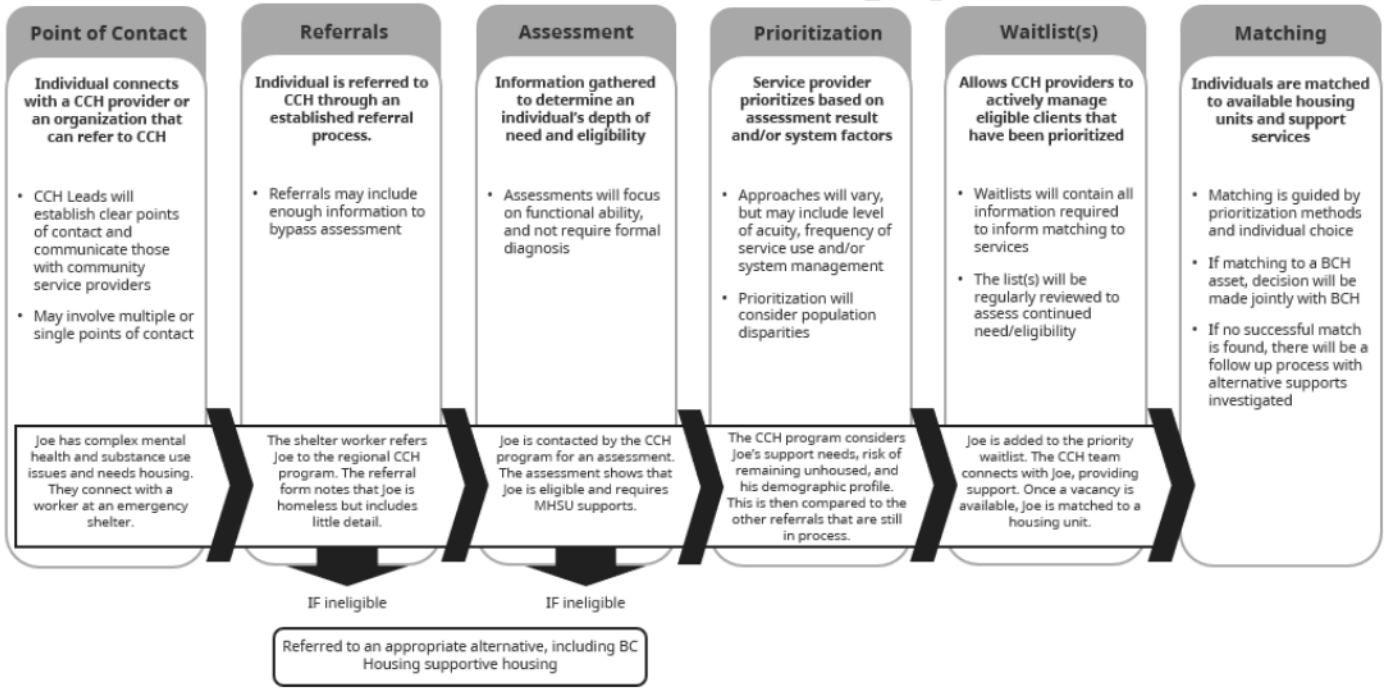
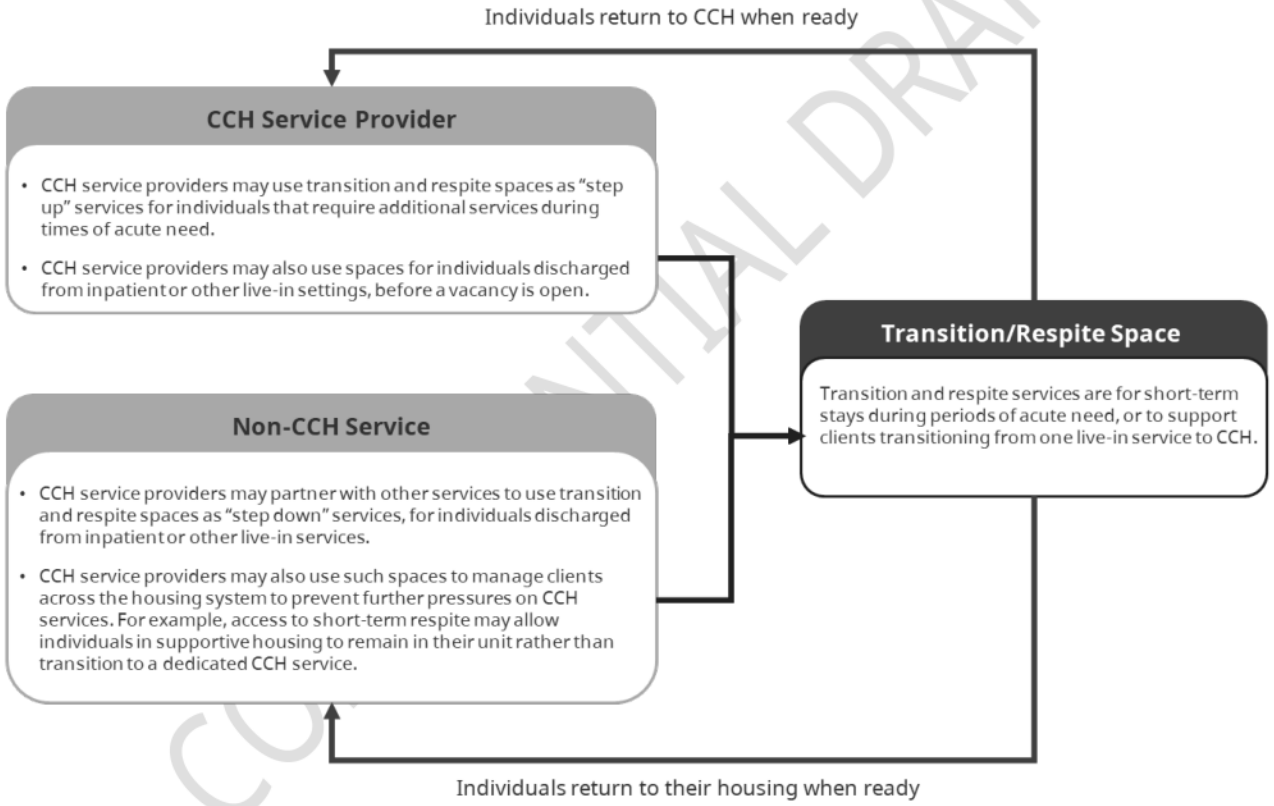


Figure 2: Transition or Respite Service Pathway



Appendix A – Principles Definitions

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.[2] 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.

[2] 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.[3]

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.

[3] 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 peoples.

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".[4] The ethical principle of fairness is an assessment of the distribution of goods in society,[5] 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.

[4] 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

[5] 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[6] 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.

[6] 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.

BRITISH COLUMBIA | Ministry of Mental Health and Addictions

Complex Care Housing: Draft Strategic Framework

February 2022

Introduction

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. Complex Care Housing is a component of the provincial Homelessness Strategy, which is under development.

The Complex Care Housing Framework (the Framework) provides strategic direction to the health, housing and social sector on enhanced services for a key population in British Columbia (BC) that is currently underserved. It details the core elements of what we are looking to attain with this new service model, and aims to provide direction to guide service consistency and quality, while allowing for flexibility to react to local and regional contexts.

This document is not an operational guide – work is ongoing to bring this strategy to life and implement Complex Care Housing. This operational work includes establishing funding models, legislative oversight, 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 for staff. Effective operationalization and implementation of Complex Care Housing will require cross-sectoral collaboration and partnership.

The Framework brings together the recommendations developed in collaboration with health, housing and municipal partners, Indigenous partners, people with lived experience, community service providers and experts over the spring and summer of 2021. In order to finalize the Framework, 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 experiencing 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. Some of the major challenges 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 current model of supportive housing.
- Inadequate health and housing support for Indigenous people, who are impacted by generations of colonization, trauma, systemic racism and discrimination1, 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

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.

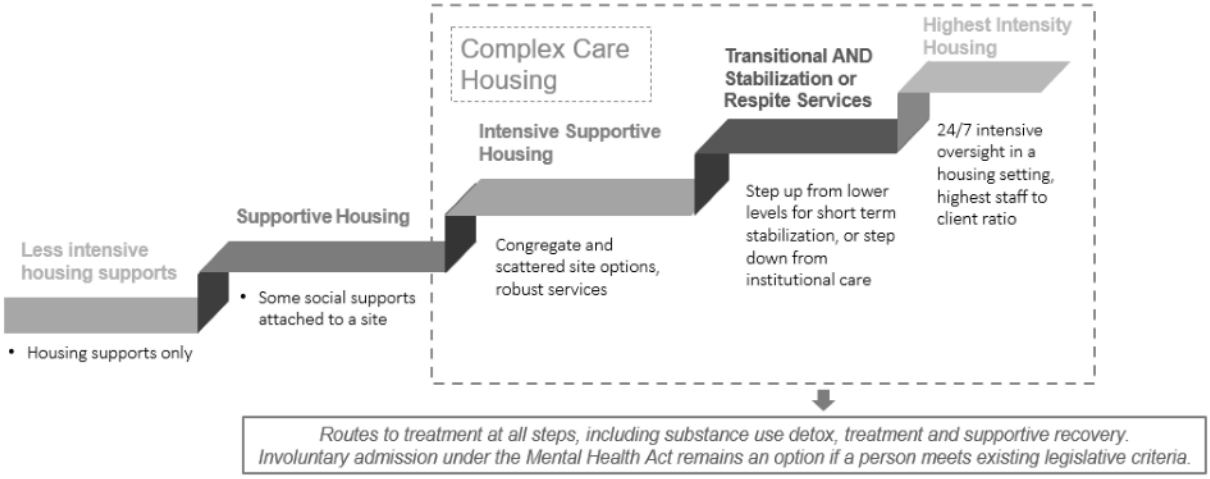
- Histories of poverty, unstable housing, enforcement, stigma, discrimination, racism, marginalization, criminalization has contributed to significant trauma and mistrust.
- The lack of a robust system of mental health care can result in people experiencing severe, persistent symptoms of mental illness 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.

Complex Care Housing – 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. 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 services - part of a System of Care



The existing services on the left meet the needs of many people experiencing housing precarity or homelessness. 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
- Transitional and Stabilization/Respite Services
- Highest Intensity Housing

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.

Intensive Supportive Housing

The first new step, 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.

Services are not time-limited, and ideally services are attached to people (as opposed to specific settings). Wherever possible (i.e. where there is adequate supply in the community) clients are supported to choose where and in what kind of setting they will live. Types of sites in Intensive Supportive Housing may include:

Rural and Remote Communities
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.

Scattered sites where individuals reside in private market residences with rent supplements. This would include robust in-reach services to support client needs.[2]

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.

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.

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

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.

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.

Transitional and Stabilization or Respite Services

The second step includes two types of services, both meant to be time-limited and shorter duration.

Transitional or "step down" services provide housing and care during transitions – for example, bridging people discharged from acute care, other health or addictions treatment settings, correctional facilities or forensic services. These services promote engagement and successful return to long-term housing in the community.

Stabilization or respite services are essential for supporting individuals to maintain their housing by providing a short-term level of higher intensity supports during periods of temporary escalation of needs or other acute challenges. This immediate response can prevent break down in tenancy relationships and evictions, and provide respite for the individual to reconnect to supports and services.

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. Settings may 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 distinct area is dedicated to this service. 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.

Highest Intensity Housing

The third step, Highest Intensity Housing, is the most intensive tier of care in the Complex Care Housing model, for the smallest subset of the population who may benefit from

more focused care and supports over a longer term in a home-like setting. Key elements at this level are low client to staff ratios, very small numbers of clients in one setting, access to specialized services (if desired), and oversight by staff to identify opportunities for care and prevent escalation of needs.

Eviction prevention and rapid rehousing
Part of putting this strategic framework into operations is establishing policies and procedures that support the principles of this new service. Two of these policies will include:

Eviction prevention policies to provide ways to manage challenges, de-escalate situations and create paths that are alternatives to eviction.

Rapid rehousing plans, so that if a client does need to move, they won't 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.

Transitions out of this level of care are supported if it aligns with the client's 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.

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 – Integrated Supports

In Complex Care Housing, all clients are reached with the full spectrum of services in the *Integrated Support Framework* with the intensity required to match their needs.

The Integrated Support Framework identifies the right supports for someone at risk of or experiencing homelessness and will improve wellness, stability and community integration for those transitioning out of homelessness or those who have exited homelessness and require more intensive supports. These wraparound support building blocks can be tailored to the needs and choices of the clients. Services will be delivered through partnerships that will support people to achieve their best quality of life across different settings, including Complex Care Housing, using different modalities.

Homelessness Strategy and Integrated Supports

The Homelessness Strategy, which is under development, is the Province's first comprehensive response and plan to address complex needs, social inclusion, prevent and respond to homelessness. Central to a new approach to addressing homelessness, is building and implementing the **Integrated Support Framework** – an integrated and coordinated service delivery model, connecting wrap-around supports. This is a new system of supports for a population that is currently underserved. Both the Integrated Support Framework and Complex Care Housing are part of the Homelessness Strategy.

Integrated Support Framework – Building Blocks		
• Coordinated Case Management & System Navigation • Indigenous Cultural Supports	• Physical Health, Mental Wellness and Substance Use Supports • Housing Supports • Food Security Supports	• Social, Emotional & Community • Personal Care & Living Supports

Within the services included in the draft 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.
- Indigenous cultural supports such as traditional teachings and knowledge, and connection to the land and ways of knowing.
- Supports that are accessible where people are at, culturally safe, gender- and trauma-informed, meet unique and intersecting needs and provide peer supports opportunities.
- Personal care and living supports including medication management, life skills, and home care.

In addition to the Integrated Support Framework, there are specific service considerations at different steps of the model.

In *Transitional and Stabilization/Respite Care*, transition planning is a key aspect of the services provided. 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.

In *Highest Intensity Housing*, additional services should be considered based on clinical need and individual goals.

SERVICES – KEY CONCEPTS

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 may 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.

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.

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

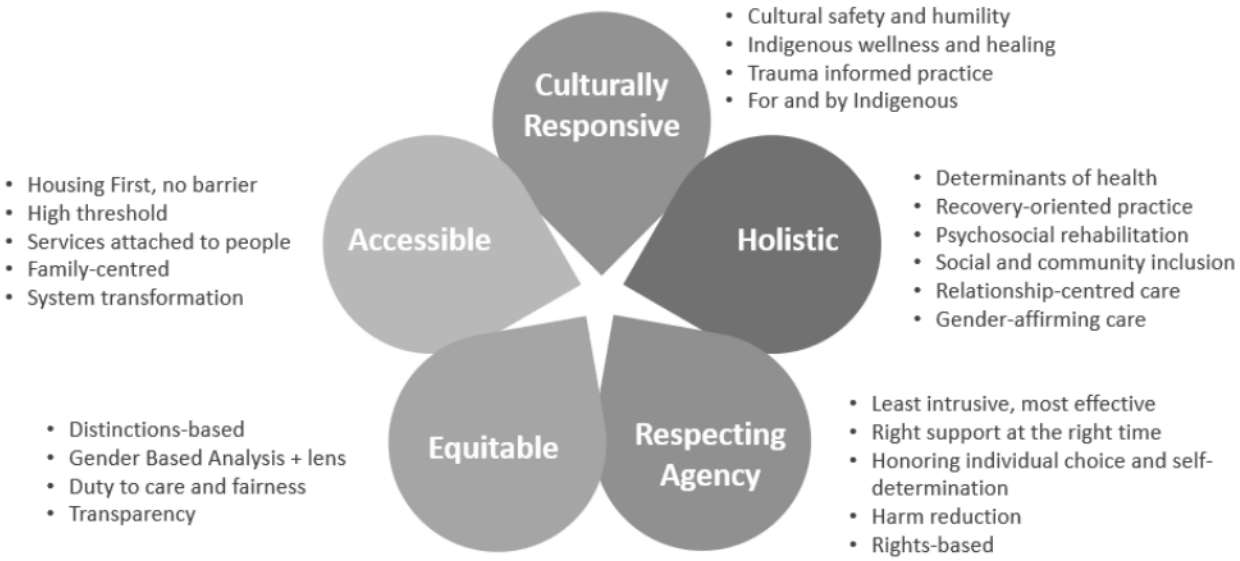
Further work will be undertaken to identify and create competency-based training and standards for all staff who are delivering Complex Care Housing services. This includes training that brings to life the principles of Complex Care Housing, with a focus on building skills in relationship-driven care, 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.

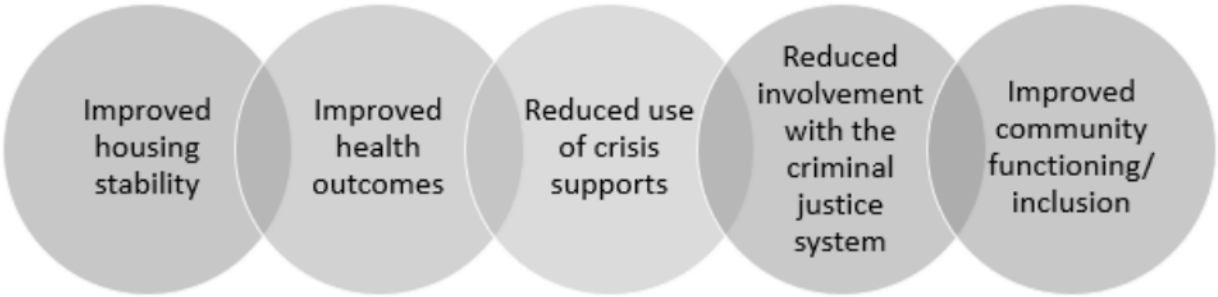
Principles

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.



Intended Outcomes

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 to identify ways to measure success, but also to understand and describe what success looks like to Indigenous communities, and to people who are receiving services.

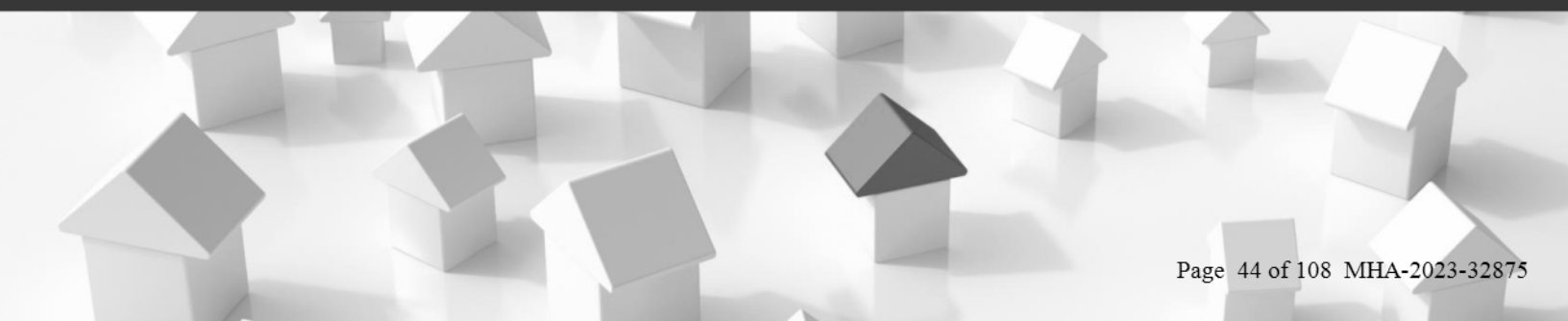


Conclusion and Next Steps

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 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.

COMPLEX CARE HOUSING: DRAFT STRATEGIC FRAMEWORK AUGUST 30, 2021

BRITISH COLUMBIA | Ministry of Mental Health and Addictions



Contents

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:

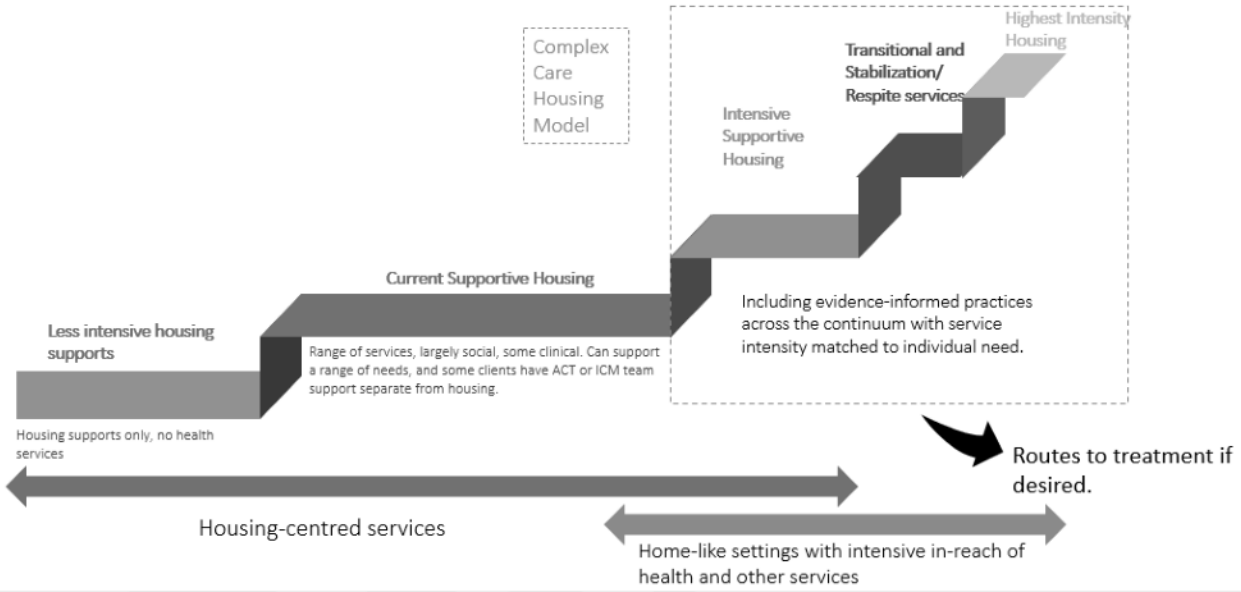
- Gaps in services for people with concurrent mental health and substance use challenges.
- Gaps in treatment for people with mental health and substance use challenges alongside things like developmental disability, acquired brain injury and/or history of violent behaviour.
- Challenges for people who 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.

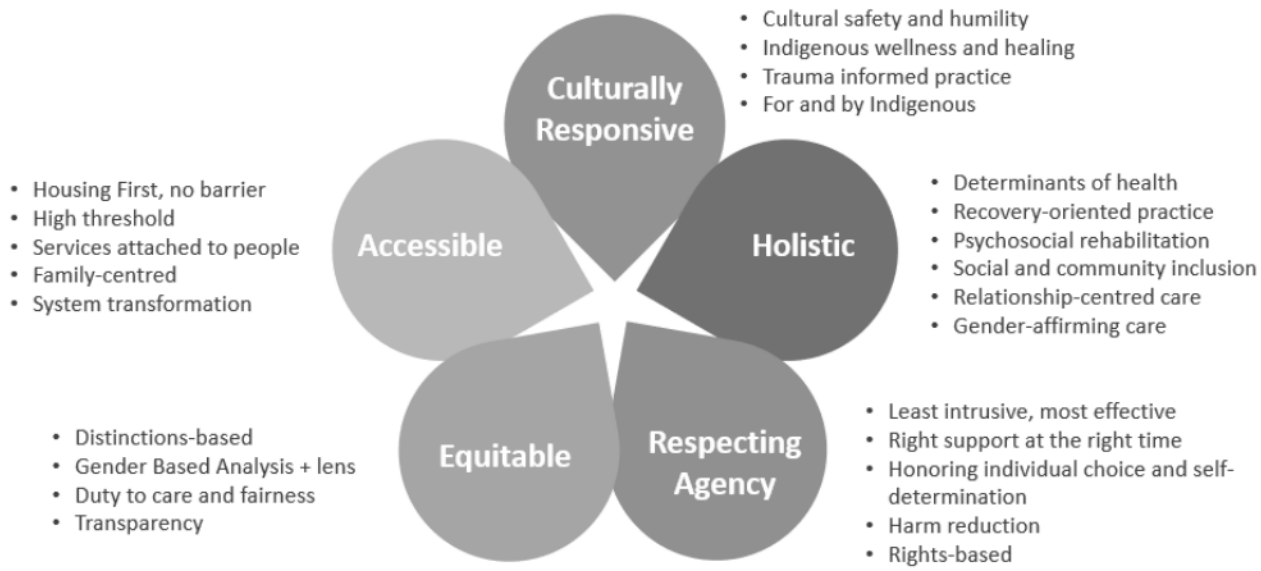
- Histories of poverty, unstable housing, enforcement, stigma, discrimination, racism, marginalization, criminalization has contributed to significant trauma and mistrust.
- The lack of a robust system of mental health care can result in people experiencing severe, persistent symptoms of mental illness 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 - Enhanced Health Services

Referral Screening Committee Terms of Reference

1.0 Objective

The Screening Committee is responsible for providing a consistent screening process, as per the Ministry of Mental Health and Addiction Access Framework and admission criteria, for referrals to Enhanced Health Services complex care housing sites. The committee will be grounded in principles of client centred, trauma-informed, culturally safe care.

2.0 Functions

- Screen referrals that are received by Fraser Health Mental Health and Substance use Referral Coordination Service
- Provide a disposition for the referral
- Provide a forum for identification of clinical issues for potential residents.
- Maintain processes to ensure timely and full utilization of beds.
- Identify and collaboratively problem solve barriers to admission
- Provide recommendations when a referral is declined
- Address any requests to appeal referral decisions

2.1 General Criteria – Complex care housing

Candidates will be:

- 19 years or older.
- People must be eligible for BC Housing Supportive Housing (low-income adult, experiencing or at risk of homelessness) – BC Housing Supportive housing referral must be submitted to BC Housing.
- s.13
- People will be agreeable to accessing eligible supports.
- People are impacted by mental health and or substance use conditions that may not be formally diagnosed.
- Living in or have a connection to the community where the complex care site is located

And/or (have):

- Developmental disability
- Brain injury
- Past or current engagement with forensic and/or corrections system
- Significant experiences of trauma

A person may be selected to move into an Enhanced Health Services program as a Program Participant if the person meets all of the above criteria as well as the following criteria:

- s.13
- Requires Enhanced Health Services to support housing stability and/or discharge from an institution such as hospital or correctional facility
- Exhibit behaviours that preclude them from supportive housing or have resulted in evictions from supportive housing.
- Behaviour preventing stable housing, including recent or relevant history of violence or aggression that can be mitigated through enhanced care program services and supports not placing anyone in the supportive housing complex at risk of harm.

- s.13
-

  - Is able to make decisions on their own behalf in relation to key areas of function.

The key areas of function for a person who is able to make decisions on their own behalf include the ability to:

(a) voluntarily agree to a referral;
(b) initiate activities to the extent necessary to function safely for the periods they are alone in their unit;
(c) willingness to develop and strengthen life skills;
(d) recognize the consequences of decisions or actions and that some actions may result in injury or harm to themselves or others;
(e) recognize an emergency and summon help or follow directions;
(f) find their way back to the supported living residence independently;
(g) participate in regular reviews of their Individual Wellness Plan, and respond to questions about needs and services offered, and
(h) make a complaint about something happening at the residence.

2.2 Foxglove specific criteria

- People who mobilize via wheelchair need to be able to safely transfer independently (where there are wheelchair accessible units on site).

2.3 Red Lion specific criteria

- People must be able to navigate stairs on their own.

3.0 Process

- Referrals will be received by Referral Coordination Services (RCS).
- Initial screening will be completed by RCS.
- Priority will be given to high-risk populations:
  - Indigenous Peoples, including First Nations, Métis and Inuit
  - People who identify as BIPOC
  - Young adults (19-26), particularly those that meet the eligibility criteria and are transitioning from government care to independence
  - Women
  - 2SLGBTQ+
  - Seniors (65+)

All referrals will be brought forward to this committee for further review, collaboration, confirmation of suitability, and identification and coordination of any necessary clinical services and supports.

- All referral outcomes will be communicated to the referral agent in writing
- For eligible referrals that are declined, alternate recommendations will be suggested by the Screening Committee.
- A person referred or referral agent may appeal a decision within 5 days following the current appeal process.

4.0 Membership

- CCH Congregate site Housing Service Provider Representative
- BC Housing Representative
- Fraser Health Referral Coordination Services (RCS) Clinical Specialist
- Fraser Health Public Health Vulnerable Population Housing consultant
- Fraser Health Clinical Operations Manager, Home Health
- Fraser Health Clinical Operations Manager, Enhanced Health services or delegate
- Fraser Health Acquired Brain Injury Coordinator (1 rep)
- Fraser Health Enhanced Health Team Coordinator
- Physician Lead: Dr. Hussain
- Referral agent
- Ad hoc member: Director Clinical Operations MHSU, CCH Congregate sites
- Ad hoc member: Referral Coordination Services Coordinator/Manager

4.1 Chair and Reporting

- RCS Clinical Specialist will track all referrals received with current MH tracker
- RCS Clinical Specialist will be responsible for engaging with:
    - Referral agent - clarifying information, reviewing client updates, sending correspondence regarding referral status and disposition.
- RCS will set up a screening committee meeting within seven calendar days of receiving a complete referral.
- RCS will send the referral package to committee members prior to screening committee meetings.
- RCS Clinical Specialist to Chair.
- RCS to take minutes that will be shared with screening committee.

4.2 Decision making

- The committee will strive to reach consensus decision making on referrals presented for eligibility for enhanced health services.
- If consensus can not be reached amongst committee members, and there is no reasonable request for additional information, a majority based decision (50% of members) will be made.
- s.13

- RCS will share decision outcomes in writing with all committee members within three calendar days of meeting.

5.0 Meeting Frequency

- The committee shall meet as needed when referrals are received.
- When there are vacancies, the screening committee will be called within seven calendar days of receiving a complete referral.

Withheld pursuant to/removed as

s.13

Complex Care Housing: Eligibility Criteria

The following criteria are to be used by CCH service providers when considering referrals and assessments for those individuals "in greatest need" of CCH services.

As regional partners begin implementation, they may consider additional criteria should it ensure those that would most benefit from CCH are able to access services.

Adults (19 and over) living with serious mental health and/or substance use challenges and other health issues that severely impact function and ability to maintain housing.

Formal diagnoses of mental health disorder, substance use disorder, acquired brain injury and other conditions are **not** required.

AND

Individuals whose needs are not met by existing supportive housing that are homeless (unsheltered or sheltered) or are precariously housed, which may include:

- Those who have had frequent stays in institutional health care settings (e.g. acute or tertiary care, forensics);
- Those with no fixed address who may have been evicted or discharged from supportive or transitional housing;
- Those with no fixed address who have been prioritized based on vulnerability or functional capacity - but are beyond level of care for existing supportive housing;
- Those residing in in-patient or transition services that are likely to be discharged to homelessness or housing that lacks appropriate supports;
- Those living in or recently discharged from the corrections system; and
- Those with unstable tenancy/residency in market or subsidized housing.

AND

Individuals that would benefit from (too broad) access to round-the-clock, 24/7 mental health or substance use services and/or functional supports. Other supports have not been successful, a history of eviction or discharge in supportive housing, or beyond level of care for supportive or transitional housing.

In some ways, eligibility for CCH will be defined by which services are available in the region. For example, if low-barrier housing services are in place that support individuals with complex challenges, CCH service providers may instead seek to engage individuals that remain unhoused. In other regions where services are limited, such as rural communities, eligibility criteria may need to be adjusted to ensure individuals most in need can access services.

Similarly, many Indigenous communities may have their own understanding and meaning for what is considered "complex". The eligibility criteria above can be considered a starting point when Indigenous communities or organizations plan and define pathways into CCH.

Provincial Context

In addition, CCH service providers should consider the following when applying eligibility criteria for their projects:

- CCH was initiated at a provincial level to better support people with persistent and complex mental health and substance use challenges to access and maintain stable housing. When planning and implementing CCH services, consider the local community context and what "complexity" looks like in your community.
- Wherever possible, **functional need** should be the focus of referral and assessment rather than confirmed diagnosis. There are persistent gaps or delays for services that can provide a formal diagnosis. Reliance on formal diagnosis can disproportionately exclude people who are the most disengaged from care and who experience systemic barriers to services.
- The model has been designed to meet the needs of people who disproportionately experience mental health issues, substance use and homelessness. This includes Indigenous people and others who have faced systemic racism and discrimination and multiple barriers to services, as well as other populations that have faced compounded structural challenges. This necessitates special consideration at each point of the pathway into CCH, from points of contact to matching.

Priority Populations for CCH

- First Nations, Métis, and Inuit people
- People who identify as BIPOC
- Young adults (19-26), particularly those that meet the eligibility criteria and are transitioning from government care to independence
- Women,
- 2SLGBTQ+
- Seniors *(55+)*

- Implementation partners should carefully consider how to ensure that engagement and prioritization approaches are working. Should individuals requiring CCH continue to experience barriers in accessing CCH, consider shifting criteria or the access process to improve engagement.
- Consider how to develop and map CCH Access processes to engage people with one or more of the following challenges and complexities:
    - Developmental disability
    - Brain injury
    - Other functional impairment or significant physical health challenges
    - Past or current engagement with forensic and/or corrections system
    - Significant experiences of trauma
    - living with serious mental health and/or substance use challenges and other health issues that severely impact function and ability to maintain housing
    - Persons who meet eligibility for CCH but are unwilling or unable to engage with health teams or health services
    - Frequent evictions from supportive housing/long term homelessness

Violent and aggressive behaviours

Violent/aggressive behaviour does not preclude an individual from accessing CCH. However, it warrants a comprehensive assessment to ensure people are matched to appropriate housing and services. Appropriate protections and procedures must be in place for both the individual accessing CCH services, as well as the staff providing the services and supports.

Individuals with active or recent violent/aggressive behaviour may not be appropriate to place in congregate housing settings, particularly when alongside others who may be highly vulnerable or susceptible to victimization.

For individuals where aggressive/violent behaviour may escalate, a care plan will identify appropriate responses, which may include access to transition/respite spaces or even tertiary care. Individuals assessed as high risk may require skilled observation so that they can receive support early if they start to decompensate.

It is important to note that violent behaviour is often a result of trauma the individual has experienced, and all the CCH supports are to be offered via a trauma-informed approach.

Complex Care Housing

Draft Eligibility Criteria

Feb 2023

Adults (19 and over) living with serious mental health and/or substance use challenges who may have health issues that severely impact function and ability to maintain housing. Formal diagnoses of mental health disorder, substance use disorder, acquired brain injury and other conditions are **not** required.

AND

Whose needs are not met by existing supportive housing that are homeless (unsheltered or sheltered) or are precariously housed, including:

- Those with unstable tenancy/residency in market or subsidized housing
- Those with no fixed address
- Those living in in-patient or transition services that are likely to be discharged to homelessness or housing that lacks appropriate supports
- Those living in or recently discharged from the corrections system
- Those who have had frequent stays in institutional health care settings (e.g. acute or tertiary care, forensics)

AND

That would benefit from access to round-the-clock, 24/7 mental health or substance use services and/or functional supports

Complex Care Housing

Functional Program Planning Guide

Date: Click or tap here to enter text.

Organization: Click or tap here to enter text.

Title of Project: Click or tap here to enter text.

Project Contact: Click or tap here to enter text.

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

Amelia Moretti (Amelia.Moretti@gov.bc.ca)

Purpose

The purpose of the Functional Program Planning Guide ("Guide") is to support project partners to collaboratively develop the **functional program*** for selected CCH Phase II projects. The first section of the Guide outlines provincial parameters for Phase II such as the guiding principles, regulatory framework, intended population, service delivery model, staffing cohort and budget. The second section seeks detailed project partner input on the program and built design requirements to ensure the physical spaces and operations can support service delivery and meet resident needs.

A secondary purpose of this Guide is to document partners' planning process. The information captured will be reviewed and collated by Ministry of Mental Health and Addictions (MMHA) staff for the purposes of developing provincial Built Design Guidelines for future Complex Care Housing. Partners are asked to complete and submit the second section to MMHA prior to proceeding to construction.

***Functional program** refers to "a detailed, multi-purpose document that serves as an interface between a physical space and the activities, programs and services the space will support... [to] reduce risks of scope creep"[1] and capture the final state. In other words, a detailed description of what happens on the day-to-day and what space is needed to enable those daily practices.

[1] Why is Functional Programming Important in... | Colliers Project Leaders

Contents

CCH Phase II: Provincial Parameters

Guiding Principles

Complex Care Housing provides a range of health, social and cultural supports and services to people who have significant mental health, substance use and/or functional needs to support their attainment of stable housing and well-being.

The development of Phase II new builds is guided by the Draft Strategic Framework[2] that sets out a series of principles:

a) **Accessible:** Minimal barrier housing that can support persons with diverse abilities.
b) **Culturally Responsive:** Trauma-informed, culturally safe settings and practices.
c) **Holistic:** Wraparound care and services that address social determinants of health
d) **Respecting Agency:** Rights-based approaches that honour individual choice.
e) **Equitable:** Intersectional and fair provision of services to persons with diverse identities.

Regulatory Framework

Phase II builds are expected to fall under the **Assisted Living Regulation (ALR).** Project partners are advised to consult with the relevant statutory decision maker to confirm a project meets the applicable definition of an "assisted living residence" and can comply with regulatory requirements. The consultation should occur once the population, services and staff have been determined and prior to the completion of schematics for the building.

Community Care and Assisted Living Act (CCALA) – *Assisted Living Registration*

The CCALA is the legislation that covers Assisted Living Residences and Community Care Facilities[3]. The Assisted Living Regulation (ALR) further specifies the requirements for Assisted Living Residences, which accommodate and provide assisted living services to seniors and persons with disabilities, persons with mental health disorders, or persons with substance use concerns, depending on the class. In order to reside in an Assisted Living Residence, a person must not contravene the restrictions set out in s.26.1(1). The Ministry of Health is responsible for registering and monitoring Assisted Living Residences through the Assisted Living Registrar.

Population

The intended population for Phase II CCH is limited to individuals at risk of or experiencing homelessness whose mental health or substance use-related health needs exceed their current level of service attachment and who would benefit from access to 24/7 on-site supports.

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[2] The Draft Strategic Framework is currently under review. Some components may be out-date. Prior to the circulation of an updated version, please refer to this Guide for information on Phase II CCH.
[3] Please consult MMHA if the Registrar assesses the project to be unsuitable for registration and advises further consultation with the licensing office at the regional health authority.

Significant mental health and/or substance use needs
Residents have significant mental health (MH), substance use (SU), or concurrent MHSU needs that impair their ability to maintain housing and function in community settings. Priority is given to residents whose unmet needs have the potential to lead to chronic disabilities and who would benefit from long-term, on-site supports; however, recognizing the barriers that exist to accessing MHSU care, no formal diagnosis or previous connection to health services is required.

Residents' MHSU needs create **one or more** of the following conditions, which indicate unmet or continuous high-service needs:

- Frequent use of in-patient psychiatric services, tertiary care, or crisis services such as police, ambulance, and emergency departments.
- Difficulty consistently meeting basic survival needs, residence at substandard housing, at risk of or experiencing homelessness
- Difficulty effectively utilizing traditional office-based out-patient services.
- Prior experience of service bans from out-patient, hospital, or tertiary level services.
- Difficulty establishing relationships with community service providers.

Functional needs
Residents' health-related challenges such as acquired brain injury, chronic illness, and/or physical, intellectual or developmental disabilities may impact their cognition, mobility, capacity for self-care, social skills and economic participation.

Residents' functional needs are evident by the difficulty they may experience:

- Performing activities of daily living such as personal hygiene, meal preparation, household tasks, managing money, socialization, employment, and/or participation in their community.
- Maintaining a safe living situation without supports, which may include a history of evictions.

Do not regularly require unscheduled access to professional health services
CCH residents are supported with activities of daily living (ADLs) and benefit from access to health services but are *not* dependent on a caregiver [CCALA, s.1(c)(ii)] and do *not* require unscheduled professional health services[4] on a regular basis [CCALA, s.26.1(1)(d)]. In this instance, "unscheduled" does not entail residents must be able to keep scheduled appointments. CCH sites may have licensed nurse practitioners, care-aids and/or healthcare assistants on-site 24/7 to support with ADLs and treatment of minor injuries and illness. Residents are encouraged to access these health services when needed to reduce escalation of health symptoms and use of emergency services.

Capacity for independence
CCH residents have a capacity for independence with adequate supports and skills training. In the event of an emergency, they can recognize the seriousness of the situation and take steps to protect themselves and/or follow directions [CCALA, s.26.1(1)(b)]. They can make, on their own behalf, decisions that are necessary to live safely [CCALA, s.26.1(a)]. The ability to live safely means residents have the

[4] *Professional Health Services are defined in the CCALA as services provided by a person registered as a member of a college under the Health Professions Act or the Social Workers Act.*

capability to make decisions that minimize their exposure to risk or harm. Residents may not always exercise this ability, but they understand when they are making safer or riskier choices. Their ability to live safely may be enhanced and further developed by CCH supports. The ability of a CCH resident to live safely is not negated by their ongoing, active decision to use substances.

Risk of violence is managed with supports
A resident's risk of violence towards their self and others can be managed with the supports available. Any history of violent behaviours should be considered within context and not taken to dictate current risk. With supports, residents do not "behave in a manner that jeopardizes the health or safety of others" [CCALA, s.26.1(1)(c)].

Persons of diverse identities are actively included
CCH must actively include and support persons of diverse identities related to race, gender, family status and age. Cultural safety must be intentionally woven into all CCH programming and the built design. Functional programs may be designed and managed to support a particular priority group and be tailored to their needs.

Service Delivery Model

Housing Ecosystem
Phase II of CCH is intended to be part of a Housing Ecosystem, with a focus on expanding options within communities to fill existing gaps and support resident autonomy and choice, rather than a component of a continuum premised on progression within or out of a system. Housing placements are intended to be permanent or not time limited.

Service Delivery Environments
The service delivery models of Phase I projects varied and included both congregate settings with co-located services and in-reach supports to scattered sites. In contrast, Phase II projects will largely be Intensive Supportive Housing, with congregate buildings and on-site service delivery. Phase II CCH units may be part of a larger supportive housing building or a dedicated standalone site.

For Phase II, there are two environments for Intensive Supportive Housing that could be separated by buildings or floors: 1) low barrier and 2) managed-to-low substance use. Project partners can select which type is most suitable for their site based on current service gaps and unmet needs amongst the intended population.

Low Barrier Environment
In a Low Barrier environment, residents may be engaged in active substance use. The building is ideally located in the downtown core or area of a municipality with the highest concentration of low-barrier, community-based SU services to prevent individuals from having to chose between their community and a home. Buildings are equipped with a safe consumption site and outdoor inhalation site. Services honour resident choice and meet them where they are at. Residents are offered connection to treatment and recovery services if and when they choose.

Managed-to-Low SU Environment

In a managed-to-low substance use environment, residents have expressed desire to live in a community with a lower level of substance use. The building is ideally located outside of the downtown core or municipal area with the highest concentration of low-barrier, community-based SU services to reduce proximity to environmental triggers and best support resident's self-identified goals.

Residents may have:

- recently exited detox/treatment and are ready for permanent housing with supports.
- a goal of lessening or eliminating their use of substances.
- a treatment plan that includes safe supply such as Opioid Agonist Therapy (OAT)
- a mental health condition and functional impairments and not previously used substances.

Importantly, in this environment, CCH continues to retain a high threshold for eviction. Residents are *not* evicted for initiating or re-initiating substance use. In instances where this does occur, operators are expected to take steps to support the resident to manage their substance use, balance considerations around the health and safety of other residents, and when necessary, transition a resident to a more suitable housing placement better aligned with their choices.

Respite Units

Respite services support existing CCH residents to maintain their housing[5]. All Phase II buildings will have a minimum of one respite unit per building, with a maximum ratio of **1 respite unit** for every 10 CCH units. For existing CCH residents, respite units provide stabilization or health services during a period of temporary decompensation and prevent break down in tenancy relationships and evictions. The units will have on-site or on-call 24/7 health professionals to attend to emergent situations and reduce use of emergency services.

Highest Intensity Housing[6]

Highest intensity housing (HIH) represents a smaller building, with higher staff-to-resident ratio. Residents in HIH present with a higher level of functional need and require more supports and supervision to live safely. Regardless, HIH should promote independence and agency (wherever possible) and centre resident choice. A home-like and non-institutional environment is prioritized.

Residents of HIH may include:

- persons who actively use substances and are experiencing degenerative health conditions related to histories of chronic substance use,
- persons who have severe acquired brain injury,
- persons who have concurrent intellectual or developmental disabilities, with or without attachment to CLBC services.

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[5] ***Transitional Units*** *are under consideration to support new residents transitioning into CCH and differ from Respite Units. Transitional units provide a period of increased support for people transitioning to CCH from acute care, other health or addictions treatment settings, correctional facilities or forensic services. These services also promote engagement and/or return to community.*

[6] *There is a higher likelihood that HIH will require licensing under the CCALA. Please consult MMHA should you select this model for a Phase II project.*

Staffing Cohort

In addition to what is provided in traditional supportive housing settings, the CCH staffing model includes five staff categories:

1. Primary care and nursing
2. Specialized MHSU care
3. Social and cultural supports
4. Peer supports and programming
5. Activities of daily living/care aids

Some examples of staff roles within each category are listed in *Appendix I*. Each building will have a minimum of 2 tenant support workers on-site 24/7, one seven-day-per-week cook, and one position from each staff category. The CCH staffing ratio will consist of roughly 14 staff per 20 residents. Staffing plans and hiring practices should be developed with reference to Division 2 of the Assisted Living Regulation, which sets out employee requirements for assisted living residences.[7]

Budget

There are two operational funding components for Phase II projects:

- Clinical services operating funding
- Non-clinical services operating funding

Both funding components were costed based on the model of a single building with 20 residents. Sites with fewer than 20 residents will have a reduced economy of scale. In planning a Phase II project, the regional health authority can collaborate with BC Housing to identify which non-clinical services and clinical services are required to support program operations. Each project does not need to use the maximum available budget.

Non-clinical services operating funding

Each 20-unit allotment has a non-clinical services operating budget of up to **$1,272,000.00**. This funding will flow from BC Housing to a non-profit operator selected through a Request for Proposals (RFP). The non-profit operator will provide on-site, non-clinical services, including hospitality and one or more assisted living services as defined in the *CCALA*.[8] The minimum staff cohort is 2 tenant support workers on-site 24/7, one seven-day-per-week cook and one or more position to meet the ALR requirements. Table 1 provides a breakdown of this costing:

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[7] MMHA recognizes that adhering to employee requirements in the ALR may have implications for peer employment at CCH sites. Peer employment and supports remain a core part of the model and MMHA will continue work to assess the impact.

[8] Per the Act, "hospitality services" means meal services, housekeeping services, laundry services, social and recreational opportunities and a 24-hour emergency response system (such as having staff on site or access to a phone). "Assisted living services" means one or more of the services defined in the Act that provide assistance with activities of daily living, managing medications, safekeeping of money and other personal property, managing therapeutic diets or behaviour management, and/or psychosocial supports.

Table 1 – Annual CCH Non-Clinical Operating Budget (BC Housing)

Item	FTEs	Total Cost
Tenant Rent		-$90,000.00
Vacancy Loss @ 2%		$1,800.00
Salary and Labor (including relief positions)		
Building & Maintenance Staff	2.50	$263,000.00
Tenant Support Worker	8.50	$682,100.00
Other Supports (cook 7 days per week, etc.)	2.50	$180,080.00
Building Maintenance		$30,000.00
Utilities		$50,000.00
Operating		$80,500.00
Office and Overhead		$79,500.00
Total	**13.50**	**1,277,180.00**

Clinical services operating funding

Each 20-unit allotment has a clinical service operating budget of **up to $2,300,000.00**. This funding will flow from the MMHA to regional health authorities for the provision of on-site clinical services. Each health authority must develop a functional program within this budget. When developing the specific clinical service budget for a site, health authorities will allocate funding to each of the following:

- Staffing costs, including any physician compensation
- Program costs, including any supplies, ongoing IMIT expenses, honoraria, etc.
- Evaluation costs, including any costs related to program data requested by the Province.

MMHA must approve all clinical operating budgets. Please see *Appendix II* for a sample budget.

Therapeutic Design

Above all, CCH is intended to be a home for residents. The building should emulate a home-like atmosphere wherever possible, rather than an institutional setting.

Some key characteristics include:

- Clear sightlines and visibility into communal spaces, hallways, and stairwells.
- Access to nature and/or land-based healing opportunities such as an outdoor garden and ample natural lighting.
- Opportunities for resident personalization and control of spaces, with resident rooms spacious enough to allow for décor, personal items, and ample storage.
- Avoidance of institutional appearances such as stark white rooms, materials associated with hospital settings, fluorescent lighting, or ceiling panels.
- Low stimuli including noise dampening, dimmable lighting, and options for residents to control the temperature and lighting within their units.

Built Design Questionnaire

Purpose:
The purpose of this section is to collect information on the functional program to inform built requirements for specific CCH Phase II projects and future CCH Built Design Guidelines. The proposed approaches are informed by the previous consultations on built design (see *Appendix III)*, a review of Supportive Housing and Health Facility Built Design Guidelines, and partner feedback to date.

Part 1: Clinical Program

Population

Please describe the population you intend to serve and any special service considerations.
Click or tap here to enter text.

Partners

Please describe the partners for this project and their respective roles.
Click or tap here to enter text.

CCH Units

How many CCH units (permanent and respite) are planned for this project?
Click or tap here to enter text.

Building Type

Please select which building type:
☐ Intensive Supportive Housing – Low Barrier (CCH co-located with SH)
☐ Intensive Supportive Housing – Low Barrier (standalone CCH)
☐ Intensive Supportive Housing – Managed to Low Substance Use (standalone CCH)
☐ Highest Intensity Housing (standalone CCH)

Zoning

What is the zoning of the site currently? Will rezoning be required for the co-location of health services?
Click or tap here to enter text.

Staffing Model

Provide details on the planned staff positions, who employs each position, planned FTEs and rotations:

Position Title	Position Employed by	Planned FTEs	Rotations

Please provide any additional details on the proposed staff model, including:

- *the number of staff persons who will be on-site at any given time (day vs overnight)*
- *the ratio of staff to CCH residents.*

Click or tap here to enter text.

Part 2: Space Requirements

Staff Spaces

Each new building should have a **minimum** of one of the following STAFF SPACES:

1. **Front office/reception area**
2. **Staff offices/desks:** including 'drop in' desks for in-reach staff to do admin-related tasks.
3. **Staff meeting room:** with soundproofing for confidential discussions.
4. **Staff breakroom:** including kitchen and eating area.
5. **Staff washrooms**
6. **Staff laundry:** with industrial machines for the purposes of housekeeping.

Staff spaces should be able to accommodate the presence, at a minimum, of the approximate number of support staff on-site at any time per the rotations outlined above.

Please indicate any proposed revisions to the list above or any specifications or added details for any of these staff spaces (e.g., number of staff office spaces/desks, size of meeting room).

Click or tap here to enter text.

Clinical Spaces

Each new building will have a **minimum** of one of the following CLINICAL SPACES:

1. **Physician/nurse clinic room:** equipped with examination table that can raise/lower and all equipment (including IMIT) required for clinical service delivery.
2. **Medication room:** secure location for medication storage equipped with a fridge and sink.
3. **Private meeting room:** comfortable, homelike space for 1:1 appointments that necessitate privacy and confidentiality.
4. **Meeting/appointment flex space:** technology-equipped space to support in-reach appointments, appointments with specialists, virtual care, and other meetings.

Intensive Supportive Housing that maintains a Low Barrier Environment will also have:

5. **Safe consumption space:** a space with access to clean drug use equipment and safe disposal, support staff or peer witnessing, or drug checking services.
6. **Outdoor inhalation space:** designated space for smoking (such as covered gazebo).

Do these proposed spaces align with your program planning?

- ☐ Yes
- ☐ No

If not, what additional spaces are necessary for successfully delivering the program?

Click or tap here to enter text.

Do you require additional medical rooms on each floor with CCH residents for minor treatments?

- ☐ Yes
- ☐ No

What types of care will be provided on-site and where?
(e.g., counselling, physical clinical assessments, and wound care.)

Service Type	**Space**

Please provide detailed information on the clinical spaces, on each floor and within CCH units.

a) *Approximately what size does each of these spaces need to be?*
b) *What equipment is required for each space?*

Space (per above list)	**Equipment**	**Size (sq. ft.)**

In addition to care provided in clinical spaces, will care be provided in some or all residents' units?

- ☐ Yes, all
- ☐ Yes, some
- ☐ No

If yes, how many units?

Click or tap here to enter text.

If yes, what are the space requirements for resident units and/or medical equipment required?

Click or tap here to enter text.

Amenities and Common Areas

Building amenities

The following amenities may be available for the building depending on the overall capital costs for development. Finalization of available amenities will be determined in partnership with an architect.

Please check off which of these building amenities are desired:
☐ Commercial kitchen
☐ Cultural room (outfitted with HVAC to support smudging)
☐ Outdoor scooter storage with charging capability
☐ Bike locker
☐ Garden with medicinal plants and herbs
☐ Heat treatment/bed bug room
☐ Storage room(s) for resident use

In co-located buildings, will CCH amenities and common areas be shared with SH residents?

Click or tap here to enter text.

Common areas

Please check off which common areas are preferred:
☐ Communal dining room
☐ Large common room on main floor for building use (accessible by both CCH and SH residents in co-located buildings)
☐ Small common rooms on each CCH floor for floor residents to use

For common rooms, what features or amenities are important?

Click or tap here to enter text.

Resident Units

Each new building will have a **minimum** of one of the following features for RESIDENT UNITS:

- 25% of units are fully accessible
- All units have private bathroom and kitchen
- Simple intercom system for rooms to communicate with front desk (i.e., phone)
- Dimmable lighting and blackout blinds
- Resident controls over heating/cooling of room
- Rooms have sufficient outlets to support medical equipment, if needed

Resident units within Intensive Supportive Housing – Low Barrier buildings will also have:

- Technology for substance use and/or overdose detection, such as silent alarms
- HVAC system and airflow to clear smoke and allow staff to enter during an emergency

Please share any suggested specifications, additions, or deletions to this list:
Click or tap here to enter text.

For this project, should all CCH units be single resident occupancy?

☐ Yes
☐ No

If not, what is the suggested breakdown for single vs double vs family units?
Click or tap here to enter text.

Should all resident units have a cooking stove?

☐ Yes
☐ No

Respite Units

Each new building will have a **minimum** of one respite unit with one of the following features:

- Sufficient space for motorized wheelchairs, a hospital bed, and additional medical equipment
- A walk/roll-in shower with a handheld showerhead and adequate space to accommodate the presence of a support person
- A location close to staff spaces for ease of support and supervision

What additional features and equipment are needed for the respite unit(s)?
Click or tap here to enter text.

Accessible Units

Each new building will have a **minimum** of one of the following features for ACCESSIBLE UNITS:

- Sufficient size for motorized wheelchairs
- A walk/roll-in shower with a handheld showerhead and adequate space to accommodate the presence of a support person

What types of disabilities will accessible units be built to accommodate?
(i.e., people with mobility, vision, hearing impairments?)
Click or tap here to enter text.

What accessible features and equipment are needed for these units?
Click or tap here to enter text.

Part 3: Building Layout and Features

Please check off the desired building features:
☐ Minimum of 2 elevators that have space to accommodate motorized wheelchairs and a medical bed (only for buildings that consist of 2 or more floors).
☐ Key fob access for each floor to allow separations based on different resident groups e.g., different SU/MH environments, women-identifying floors, etc.
☐ A backup generator to support elevators, security, access, and medical equipment.
☐ Adequate fire suppression allowing oxygen tanks to be used and stored on-site.

Please feel free to provide more detail on any of the features above (e.g., length of time for backup generator support), or any additional features you feel are missing.
Click or tap here to enter text.

Which features are important for tamper-proofing and building upkeep?
☐ Tempered glass
☐ Universal fixtures for easy replacement rather than custom.
☐ Floor drains anywhere there are sinks
☐ Strong plumbing
☐ Windows/glass panels are also universal sizes/easy to replace

Are there any other considerations for tamper-proofing/ease of building upkeep?
Click or tap here to enter text.

What are the data, Cable TV, and Wi-Fi/internet requirements for the building?
(i.e., does it differ from a traditional supportive housing building)
Click or tap here to enter text.

Safety Features

Each new building will have a **minimum** of the following features for SAFETY:

- CCTV cameras
- Panic buttons
- Double egress in treatment spaces
- Windows on ground floor do not open to prevent unwanted guests from accessing building.

Beyond this, are there additional safety and security requirements? (i.e., silent alarm on doors)
Click or tap here to enter text.

Parking

What is the minimum number of staff that should be able to park onsite at any one time?

Click or tap here to enter text.

Are there special parking requirements such as ambulance parking, deliveries, or resident off-loading?

Click or tap here to enter text.

Additional Input

What has been missed here or needs to be included?

Click or tap here to enter text.

Appendix I: Staffing Model

The CCH staffing cohort includes five staff categories. Below is a sampling of staff roles that fall under each category. This list is not meant to be exhaustive or exclusive, but rather provide an idea of possible staff roles aligned with the CCH model. Project partners are encouraged to select and design a staffing model to meet residents' needs and can decide which organization employs which position to ensure consistency and quality of care. Some regulatory restrictions may apply.

Primary care

- Physician, General Practitioner
- Nurse Practitioner
- Registered Nurse (RN)
- Licensed Practical Nurse (LPN)
- Dietician
- Clinical Coordinator
- Team Lead/Clinical Lead

Specialized MHSU Services

- Clinical Counsellor
- Social Worker
- Case Manager
- Concurrent Disorder Clinician
- Behavioural Interventionist
- MHSU Clinician
- Psychologist
- Physician, Addictions Medicine
- Physician, Psychiatry
- Occupational Therapist

Social and cultural supports

- Vocational Worker
- Recreational Therapist
- Cultural Support Worker
- Indigenous Liaison
- Indigenous Wellness Worker/Indigenous Client Navigator
- Elder
- Community Support Worker
- Rehabilitation Worker/Assistant
- Addictions Recovery Worker/Outreach Worker

Peer supports and programming

- Peer Support Worker
- Harm Reduction Worker

Activities of daily living/care aids

- Healthcare Assistant
- Care Aid
- Mental Health Care Aid
- Personal Care Worker

Project Leadership and Support

- Team Leadership
    - Managers,
    - Directors,
    - Team Lead,
    - Non-Clinical Coordinators,
    - Project Managers,
    - Project Coordinators.
- Administration Support,
- Medical Office Assistants (MOAs),
- Program Support Workers,
- Nursing Unit Assistants
- Data Analyst, Evaluation Specialist, Research

Appendix II: Sample Operating Budget

Note: Costing is for 20 unit dedicated building.

Health Budget

	Position/Expense	FTE	Cost/Salary	Notes
Health Staff	Team Lead/Coordinator	1.0	$130,000.00	1 team lead, 8 hours per day, 5 days per week
	Nurse Practitioner	0.6	$130,000.00	8 hours per day, 3 days per week
	Nurse Educator	0.6	$102,000.00	1 nurse educator, 8 hours per day, 3 days per week
	Registered Nurses	3.0	$400,000.00	1 registered nurse, 10 hours per day, five days per week; 1 registered nurse, 10 hours per day, 7 days per week
	Case Manager (BSW)	1.0	$124,000.00	1 case manager, 8 hours per day, 5 days per week
	Clinical Counsellor/Psychologist	1.0	$140,000.00	1 clinical counsellor, 8 hours per day, 5 days per week
	Psychologist/Behavioural Specialist	0.2	$28,000.00	16 hours per week; would also support staff training/education
	Peer Support Workers	2.8	$193,200.00	2 peer workers, 8 hours per day, 7 days per week
	Occupational Therapy	0.8	$120,000.00	1 occupational therapist, 8 hours per day, 4 days per week
	Admin/MOA	0.6	$42,000.00	8 hours per day, 3 days per week
	Home Support/Care Aid	3.2	$268,800.00	3 home support workers or care aids, 8 hours per day, 7 days per week
	Cultural Support Worker	1.0	$85,000.00	8 hours per day, 5 days per week (may be BSW or BA level position)
	Dietitian	0.2	$30,000.00	8 hours per week
	Regional Staffing/Project Management	0.4	$40,000.00	
	Case Manager (BSW)	1.0	$124,000.00	1 case manager, 8 hours per day, 5 days per week
	Clinical Counsellor/Psychologist	1.0	$140,000.00	1 clinical counsellor, 8 hours per day, 5 days per week
	Health Staff Total	**16.4**	**$1,833,000.00**	
Physician Compensation	Primary Care		$70,000.00	Approximately 130 sessions; 8.75 hours per week
	Addictions Medicine		$70,000.00	Approximately 130 sessions; 8.75 hours per week
	Psychiatry		$85,000.00	Approximately 130 sessions; 8.75 hours per week

	Physician Compensation Total		**$225,000.00**	
Program Costs	Program specific costs		$80,000.00	(e.g., medical supplies, equipment, etc.)
	Staff Training/Orientation		$10,000.00	
	MAP - Alcohol		$10,000.00	5 clients
	Office supplies		$10,000.00	
	Travel		$20,000.00	
	IMIT and set up		$50,000.00	
	Honoraria (peer work)		$15,000.00	
	Elder honoraria		$20,000.00	
	Recreational/cultural activities		$15,000.00	
	Program Costs Total		**$230,000.00**	
Evaluation	Program Evaluator	0.2	$16,000.00	
	Evaluation supplies		$2,000.00	
	Evaluation Total	**0.2**	**$18,000.00**	
Health Budget Project Total		**16.6**	**$2,306,000.00**	

BC Housing – Operating Budget

	Position/Expense	FTE	Cost/Salary	Notes
Rent and Vacancy	Tenant Rent		-$90,000.00	
	Vacancy Loss at 2%		$1,800.00	
Salary and Labour	Building & Maintenance Staff	2.5	$263,200.00	
	Tenant Support Worker	8.5	$682,100.00	Assumes 2 FTEs x 24/7
	Other Supports	2.5	$180,080.00	Includes 1 cook 7 days and other support, e.g., Case Planner, Program Coordinator, or other
Other Costs	Building Maintenance		$30,000.00	
	Utilities		$50,000.00	
	Operating		$80,500.00	
	Office and Overhead		$79,500.00	
BCH Operating Budget Total		**13.5**	**$1,277,180.00**	

Appendix III: Feedback from Built Design Consultations

The following is a summary of feedback from the Built Design Consultations that took place with CCH Leads, Health Authorities, housing operators, and government partners as well as findings from research on Therapeutic Environments.

	Design Intent	Evaluation Standard	Source	Comments
Building Structure and Materials	To ensure windows are not a safety hazard for residents or staff	Wherever possible, glass must be tempered and laminated	Design Consult 1 & 3 BCH Design Guidelines	Glass is frequently broken by residents
		Windows on the ground floor should not open	Design Consult Follow-up	Intended to prevent unwanted guests from accessing the building
		Windows on higher floors should open to permit airflow, but not allow a resident to fit through them	Design Consult Follow-up	Airflow is important for temperature regulation and ventilation
	To ensure protection against bedbugs	Metal bed frames and other fixtures should be provided, and use of wood avoided in bed frames	Design Consult 1	
	To avoid custom parts and materials, especially in residences	Universal fixtures and replaceable parts are used wherever possible to lower long-term maintenance costs	Design Consult 1	This applies to the size of the glass panes too, for replacement but also for window coverings.
	To protect fixtures from tampering or damage	All fixtures, electrical systems, fire systems etc. are hardened and tamper-proof	Design Consult 1, 2 & 3	It was suggested that hardened plumbing systems are important and that floor drains are needed anywhere there are sinks. Extra fireproofing and firewalls should be included as well.
Building Layout and Site Specifications	To ensure there are opportunities for	Buildings include multiple, varied common spaces with	Design Consult 1 & 2	The common spaces should be close to staff offices if possible

	resident, staff and community engagement wherever possible	different purposes, some larger and more open, and some smaller.		and have adequate square footage for life-skills programming such as cooking supports. Some projects have found benefit in having separated common spaces for different resident groups.
	To support staff and resident safety and wellbeing through site layout	Respite and transitional spaces should be separated from the rest of the building	Design Consult 2	Respite spaces should be close to main staff spaces.
		Capability to separate floors with fobs in larger shared buildings	Design Consult 2 & 3	Differing perspectives: safety/security and social cohesion benefits but also possibility of stigma/alienation.
	To support resident independence and privacy	Resident units have their own bathrooms	Design consult 1	Handheld showers for persons with mobility needs who require personal care. There may be need for a tub room or shower room to support clients with accessibility needs.
		Resident units have their own cooking facilities	Design consult 3	Some units should not contain cooking facilities due to fire hazards related to the oven and/or stovetop being left on or have ability to turn cooking stove off from outside a unit.
	To provide residents ample space for their belongings	Resident storage in building and client rooms is important	Design Consult 1 & 2	Residents need adequate space to store belongings of sentimental value.
	To ensure safety for residents, especially	Staff office should be at the entrance with a controlled	Design Consult 3 BCH Design Guidelines	CCH residents should have the ability to screen guests

	with respect to uninvited guests	door to restrict access to unwanted guests		
	To ensure respite and ease of movement for staff, including for off-site services and deliveries	A staff-only access hallway that runs through the building, allowing staff to have a home base and place to accept deliveries and off-site services such as maintenance	Design Consult 1 & 2	Example in Foxglove, the hallway runs past deliveries area, kitchen, meeting room, and has staff-only bathrooms.
		Staff-only laundry room separated from client laundry	Design Consult 2 & 3	Staff-only laundry room with industrial laundry machines in case of biohazards; bed bug treatment
		Staff-only spaces with own bathrooms, kitchen, break area	Design Consult 1 & 2	Suggestion of staff patio for staff who smoke.
Therapeutic Environment	To provide access to cultural supports and nature	Residents have access to nature and/or land-based healing opportunities	Design Consult 1 & 3; Therapeutic Design Guidelines	Access to nature can be achieved through access to garden spaces, large windows, natural materials, plants, etc. Recommendation that gardens can be easily maintained/watered to ensure it as a desirable space for residents.
	To ensure the building has a home-like environment	Lights are dimmable; use of blackout curtains and UV-rated window film	Design Consult 1 & 3; Therapeutic Design Guidelines	Dimmable lights can help reduce sensory over-load, especially for clients with ABI and developmental disabilities
		Removal of institutional or medical features within personal and common spaces	Design Consult 1, 2 & 3; Therapeutic Design Guidelines	Home-like environments can be created with attention to materials and décor such as use of wood, carpeting, calm colours

		Residents have sufficient space to personalize their own room	Design Consult 1 Therapeutic Design	Square footage of rooms should be large enough to accommodate client preference for furniture arrangement and personal storage.
		Dampen noise within the building (electronics, HVAC, lighting buzz) and from outside (traffic, voices)	Therapeutic Design	
Clinical Spaces and Supports	To provide adequate spaces for service provision	Clinical practice spaces (medication/nursing) on the same floor as the CCH units	Design Consult 1,2 & 3	Clinical space would need to have all tools required for an appointment to remain fully on-site, which includes space for an exam table and an adjustable medical bed. Medical rooms on same floor as residents that allow for minor treatments like wound care.
		Dedicated room for counselling appointments	Design Consult 1,2 & 3	The space will require sound-proofing and multiple entry points to maintain resident confidentiality. It should be a low-stimulation environment that does not look like a medical room.
		Multiple consultation rooms for in-reach supports or specialists to meet with residents	Design Consult 1, 2 & 3	At least one consultation room should be enabled for virtual appointments.
		Low sensory room to support resident de-escalation and prevent use of emergency response	Design Consult 2	An example: https://www.snoezelen.info/

		Space for medication storage	Design Consult 2	For needs related to safer supply prescribing or medication compliance.
		Safe Inhalation Space	Design Consult 2 & 3	Suggestion of creating safe inhalation space outdoors rather than indoors as indoor space required laboratory-grade ventilation hood. However, outdoor space needs to feel safe to use (designed so people do not exposed/ vulnerable).
		Resident rooms should have enough plugs to accommodate medical equipment if needed.	Design Consult 1	
Accessibility	To ensure access to CCH for individuals with mobility challenges	A significant portion of the units are designed and designated as fully accessible, with accommodation for motorized scooters and wheelchairs	Design Consult 1 & 2	Outdoor charging areas should be included for the motorized scooters to prevent this from becoming a fire hazard
	To prevent service interruptions and facilitate resident movement within the building	More than one elevator for buildings that are over five stories	Design Consult 1	Elevators must be large enough to accommodate motorized wheelchairs/ medical bed.
Security and Safety Features	To support staff ability to track when individuals come and go for resident safety	Silent alarms installed on doors to indicate when they are used	Design Consult 1	
	To ensure safety within residents' personal spaces	Clinical/Office/Common room spaces to have two exits wherever possible	Design Consult 1 & 2 BCH Design Guidelines	

		Technology for substance use and/or overdose detection	Design Consult 3 BCH Design Guidelines	An example is silent alerts residents can use to call for help
		Clear sightlines in/out of entryways, communal spaces and stairs	Therapeutic Design Guidelines; Design Consult 1 BCH Design Guidelines	Use of tamper-proof glass and membranes where appropriate.
	To provide adequate ventilation; especially given that residents are likely to use substances in their rooms	Robust HVAC system that provides ventilation within personal and any secluded common areas	Design Consult 1 & 2	There is need to clear spaces of smoke quickly to allow staff access in the event of an emergency. HVAC must also allow for the cultural practice of smudging.
	To enable communication between desk-staff and residents	Intercoms/telephone systems installed in rooms and common areas; must be tamper-proof	Design Consult 2	Recommendation is for telephones or another form of common technology that cannot be associated with surveillance and are easier to replace if damaged.
	To support building operations in case of power outage	Backup generator for elevators, access, security, and medical devices.	Design Consult 1	

Parking Lot

- Process when Guests damage home.
- Define reasonable cleanliness; define damage
- Damages
- Bed bugs/parasites/rodents – when present, how do we ensure the stability of the tenant while ensuring accountability to the situation?
- Damages framework that doesn't penalize the unwellness of a tenant, maybe a fund for damages?
- Transitions from street to home, mindful of trauma accrued from stigma and punitive housing, acknowledge power imbalance and impacts of paranoia
- Direct Deposit and Social Assistance, Direct Deposit as Harm Reduction approach to reduce risk of being in arrears
- Availability/accessibility for housing retention crisis examples Hot line, housing retention counselor, crisis line for housing retention
- Illegal activities process and procedure
- CCH training for damages – can we offer education on how to fix holes, paint, light construction, basic plumbing, basic electrician, yard maintenance? Life skills, housing service provider.

Housing Retention (formerly Eviction Prevention)

Purpose

All participants in the Interior Health (IH) Complex Care Housing (CCH) initiative will be signing Program Agreements. As such they have the same rights and responsibilities as all tenants in the province of British Columbia. IH CCH initiative acknowledges that there will be situations where behaviour, damages, or arrears would normally result in eviction. In these situations, IH CCH initiative is committed to reducing and eliminating experiences of returning houselessness through developing housing retention processes and approaches.

This framework will support Interior Health and partner agencies as they address the issue of participants and their guests who cause damage to the property where they live including their unit and common elements of the property (common areas, doors, walls, etc.).

This framework will also support process mapping for when participants are in arrears of rent, unable to meet market rent, transitioning from Complex Care Housing to either another stage of supported housing or market, or in need of respite.
Also add in that this will serve as a guide to address issues with parasites/rodents as well as using a harm reduction approach regarding arrears by encourage direct deposit.

Person Centred Decision-making

It is acknowledged that in every situation where eviction would typically be the outcome, a customized response will be required, that takes into account the specifics of the situation including the participant's role, the staff's role, and potentially the concerns of neighbours. For this reason, we will set out an approach for considering each situation and implementing a plan of action. Also included is a feedback loop so that we can learn from past situations.

In making decisions about actions to be taken when there is a housing retention issue, the following principles must be considered:

- Avoiding Evictions: The intent of the CCH initiative is to avoid evictions and help support stable, successful tenancy.
- Trauma Informed Care: realizes the widespread impact of trauma and understands paths for recovery; recognizes the signs and symptoms of trauma in participants, families, and staff; integrates knowledge about trauma into policies, procedures, and practices; and actively avoid (re)traumatization
- Participant accountability: The process must include ensuring that the participant understands and acknowledges their responsibilities and accountability
- Restorative Justice: An approach to justice that seeks to repair harm by providing an opportunity for those harmed and those who take responsibility for the harm to communicate about and address their needs in the aftermath of a situation.
- Staff & Participant Relationship: The mitigation plan must consider the preservation and enhancement of the staff and participant relationship. Need a clinical debrief for both staff and participants to further preserve the relationship. This approach will support participants with concerns about housing retention due to past traumas of evictions.
- Research: Demonstrate the types of issues that arise and effective approaches for resolution.
- Prevention: Preventing future behaviours, damages, arrears, and on learning from incidents.
- Quick Responses: Timeliness, responsiveness, and respectful actions.

- Role Clarity: Clarity in the role of Housing Service Providers in supporting participants to prevent damages, be successful participants, and resolve situations. Add advocacy in the house, and clarify further distinction between clinical and housing supports.
- Efficient and Effective Decision-Making Processes: for example, determine a benchmark for situations that would be considered under the damages protocol vs. those that are minor and can be resolved by the service worker and participant; establish a process for including expert advice in the development of mitigation plans.

Roles
The primary persons involved will include the participant, Housing Service Provider, and Interior Health. Others may include House leads, the most responsible clinician, and one or more advisors with expertise in the situation.

For major situations, the Housing Service Provider and Interior Health will jointly have lead responsibility for the development and implementation of the mitigation plan and may consult with expert advisors. Housing Service Providers will lead on minor incidents and may request support from Interior Health as needed.

Payment of damages or arrears will generally be made by Interior Health (either directly or through reimbursement of payments made by the Housing Service Provider). Repayment plans for the participants may be established on a case-by-case basis.

Damages

CCH Peer Advisory recommendation – post damages, participant should be encouraged to participate in restorative justice education that can include anger management, include community inclusion, and build relationship. Something that is compensated to ensure value of experience – working toward developing accountability and responsibility for actions.

Process for damages
As a general rule of thumb, the more public the damage is, the faster the response needs to be. Public means damages to the exterior of the unit, common areas, and/or impacts on neighbours. Less public is damage within the unit that cannot be seen by others and does not impact others.
We accept that there will be wear and tear and possible damages from moving in and moving out.

Minor Damages
Damages may be minor: matters within the unit, not impacting the neighbours or staff, and low cost. The Housing Service Provider may in these cases work directly with the tenant to fix the problem. For example, poor cleanliness or marks on a wall. The CCH team can identify cleaning supports or clinical supports if related to hoarding or obsessive compulsion.
Principles of CBT for setting goals and boundaries – in the participant care plan.

Major Damages
This framework is concerned with damages that cannot be dealt with directly by the staff and participant, and which if left unaddressed may lead to eviction. Examples:

- Staff identifies damage to a unit during a unit visit or if staff cannot access the unit due to safety or other issues
- Damages are increasingly expensive to address
- Neighbours complain about damages

Please note that damages may occur at the same time that the participant is experiencing instability. Assessment and mitigation may need to be delayed (for example, where a unit has been taken over by guests and it is unsafe for either the participant or staff to enter the unit; the participant is in a crisis situation). In such situations, it is important to communicate with staff and partners, so all parties understand that there is a commitment to mitigate, but that concerns for the safety and well-being of the participant and safety of support would take precedence. Furthermore, work with the participant to prevent future damages may need to be delayed until the instability (crisis) that led to the damages is under control.

Fast Track – Health & Safety
Matters that can affect the health and safety of the participant and/or other participants if left unresolved for more than a day or two must be treated as a priority and responded to immediately to avoid further risk. In such situations, the steps below need not proceed in a linear way where they would impede a necessary critical response. In such a situation, Interior Health and the Housing Service Provider should be in immediate contact and work out a quick, interim response.

Assessment
Where a major damages issue has been identified, staff will investigate and document all allegations of damage to the unit and/or common areas.

Information in the Assessment will include:

- What happened?
- Who's affected?

- How bad is it/expensive?
- Why did it happen/could it be avoided in the future?
- What could be done to resolve it?
- Who is responsible/accountable for the repair and restoration? The assessment will identify responsible party will provide process for getting repairs done. Create a general maintenance manual: Identify different services such as plumber, electrician, etc. Develop decision tree as to severity of damage, does it require a plunger or a plumber, for example.

Assessment Review
This information will be shared between Interior Health and the Housing Service Provider as required, who will review the information to make an initial determination of:

- Responsibility for damages
- Assessed the value of the damages
- Outcome the service is looking to achieve

Mitigation Plan
Interior Health and the Housing Service Provider will jointly lead the development of a mitigation plan that responds to issues raised in the assessment, and the decision principles identified earlier in this document.

The mitigation plan will include:

- The approach for repairing damages
- The approach for paying for work to be done, including (if applicable) the participant's share
- The approach for the staff to address the participant behaviours that led to the damage and towards preventing future incidents
- May include plans for moving, respite, transition

<u>Payments for Damages</u>
If it has been determined that damages are the responsibility of the participant and that it is reasonable to make a payment to cover the damages then the following will be considered as payment options:

- Discussion with the landlord will take place to confirm the amount of the payment for damages and if this will be paid in a lump sum or installment payment plan. In many situations due to the need for quick resolution, IH may pay for the repairs or deductible up-front, and the repayment plan can be determined later.
- Where no funds are available through income support programs, the participant, insurance, or other means IH will authorize payment from contingency funds available in the program.

Participant payback of "loans" from the damage fund would be by way of a financial agreement between the participant and CCH. The "loan payments" may be small (e.g. $10 a month minimum); part of the "loan" may be waived if necessary (*principles for waiving repayment requirements need to be developed*). Principles research to be considered for repayment: ie when damages happen due to mental health decompensation, ie paranoid hallucinations, substance-induced psychosis:
Principles
Person-Centred
Individual

Note: Payment up-front for damages by IH does not mean that IH or the Housing Service Provider have accepted liability. This needs to be made clear in any communications with the landlord.

Arrears/Non-payment of rent

Individuals get into arrears of rent for a variety of reasons such as job loss; other debts; illness; decreased government benefits; and cost of living barriers. We acknowledge that some participants' part of the Complex Care Housing initiative will be living in market or supportive housing situations and may require assistance to maintain and sustain their place of residence.

The primary strategy for housing retention is effective rent collection. Efforts to collect rent and to support participants facing eviction will continue after an order to evict has been issued and up to the point where the unit is being re-rented.

Current housing unaffordability – rents are too high? How do rent supplements work here? Are they stackable, long term? We need to develop a guide to Rent Supplements, how to access, when to access, where to access?

Rent Collection

- Focus on collecting the rent on time
- Provide a range of flexible rent payment options

- Inform participants about steps to take if they are unable to pay rent, and offer to help participants develop plans for staying housed – what happens if the plan is not followed through, what would be the next steps? Option, rather than monetary repayment, what about work program?
- Negotiate reasonable repayment agreements that best fit the participant's circumstances
- Provide access to rent supplements and crisis supports

Rent Supplement and Crisis Supports

Rent Supplement is a means-tested payment for certain people living in private rented accommodation who cannot provide for the cost of their accommodation from their resources. In addition to rent supplements, there are crisis supports accessible through different government agencies and non-profit agencies (i.e., utility relief, basic needs such as food, clothing, medicine, etc.)

Key Rent Supplement elements (Rent Supplement guide needs to be developed that accounts for variability in market housing)

1. Recipients are entitled to XXX amount of benefit depending on household size
    a. For singles: $TBD/month
    b. For families: $TBD/month
2. The benefit is paid directly to landlords/service providers on behalf of the participant and must be applied toward the rent payable.
3. Research different agencies that provide Rent Supports, develop a table to determine amounts each agency supports.

Transitions[1]

Peers who can mentor CCH Participants through transitions (must have a Peer available for transition)
Housing transitions involve more than identifying locations and coordinating moves. Housing transitions are stressful, and may be particularly stressful for individuals who have experienced chronic homelessness and who have experienced a revolving door of treatment and incarceration, and often have co-occurring substance use, psychiatric, and physical health problems that can complicate housing transitions. We anticipate and acknowledge that individuals accessing the CCH initiative will experience transition stress and likely re-traumatization. Additionally, transition stress will likely be present when individuals meet readiness to move onto the next step of the housing continuum which could be supportive housing or market housing. We acknowledge that the experience of chronic houselessness is traumatic and transitions will evoke diverse behaviours and reactions.

Within the housing continuum, there are many kinds of transitions. We will do our best to capture relevant transitions, what to expect, and where possible strategies to reduce stress and (re)traumatization. Transition planning will be necessary where there is the possibility that without appropriate support the individual may not achieve the key factors of:

- Independent living;
- Appropriate housing;
- Employment and financial stability;
- Education and personal development;
- Social inclusion, citizenship and relationships;
- Optimum health and well-being.

Transition Plans

For the purposes of reducing experiences of eviction, the transition plan helps the participant prepare for different housing opportunities such as supportive housing or market rentals. The plan is an evolving and individualized tool. The plan will identify opportunities for progressively increasing the participant's independence and ability to function in diverse housing settings. The plan may consider and address all areas of change including, but not limited to, income support, community inclusion, MHSU & Health services, living arrangements, rent skills training, and supportive employment or voluntary work experience. The transition plan will identify the tasks that need to be completed, the information that must be provided, and the individuals responsible for completing each aspect of planning.

Transitions into CCH initiative

After years of chronic homelessness, which often involves sleeping on the streets as well as overnight stays in ERs, shelters, and sobering centres. Many individuals will experience relief that this is no longer the case. There will be reports of individuals feeling disoriented, wondering where they are when they wake, and a jolt from the previous day-to-day routine of houselessness. At the time of recruitment, many participants will experience compromised cognitive function (e.g., substance-related intoxication, physical/psychiatric disorders). Additionally, participants do not have direct control over what kind of housing unit will be assigned to them, for some participants this will lead to anxiety and speculation.

[1] Transitions are further complicated by supply – there is limited Complex Care Housing spaces, supportive housing and market housing available. Mitigation strategies will have to be implemented to prevent CCH participants from returning to houselessness.

There will be presentations of complex psychological adaptations to chronic houselessness and experiences of trauma. CCH can never create an environment that is completely "trigger-free," but can create trauma-informed programs and practices that minimize triggers as much as possible. Some examples:

Overt example: the residence does not have locks on the bathroom doors, leading to a lack of privacy that makes participants wary of showering/using the bathroom
Covert example: The system/program often determines what the goals should be for the participant, rather than having the participant identify their own goals/needs
Example: Participant uses substances to manage anxiety and flashbacks, staff can understand this as a relapse or lack of commitment to sobriety. No connections will be made by staff or participants to better understand that substance use served as coping and developing strategies to identify different ways to cope. Traditionally, strongly confrontational approaches have been used. These approaches do not respect or support a person's right to go at their own pace with reducing substances and can damage their fragile coping strategies and make them want to abandon their recovery efforts.

It will be important for the CCH team to work from a strengths-based lens. This means:

- Identify the participant's individual strengths
- Identify who is part of the participant's support system
- Identify the participants' hobbies/interests
- Identify participant's strengths in education and employment
- Identify what has been helpful for the participant in the past when faced with challenges
- Identify participant's current coping skills when faced with challenges

Transitions within the Provincial CCH Initiative
CCH is a provincially mandated implementation that is being stewarded by the Ministry of Mental Health & Addictions. Participants will have complex needs that may inform a need to relocate to another area of the province. Where possible, the CCH provincial partners will be consulted for available spots that participants may be able to transition to. This will be done on a case-by-case basis and may not necessarily result in success. Mitigation plans will need to be developed to ensure the Participant does not return to houselessness.

Transitions within the Interior CCH Initiative
Participants have many competing needs and diverse experiences that inform a change in location. Wherever possible we inform participants identified for transition within IH CCH of possible IH CCH homes and communities to transition. We invite the participants to tour other locations and determine for themselves whether the move is the best fit for their wellness journey.

Transitions to Supportive Housing (This transition will benefit from a more formalized and regulated Supportive Housing framework)
Participants have many competing needs and diverse experiences that inform a change in location, this can also include housing readiness and motivation to take a supported approach to achieving independent living. In these situations, through established networks, CCH program staff will support the participant in navigating access to the appropriate supportive housing. CCH program staff in collaboration with the participant will need to make a plan to determine which services the participant will need to continue to access to ensure ongoing stability as they progress in housing readiness.

Transitions to Market Housing
Participants have many competing needs and diverse experiences that inform a change in location, this can also include housing readiness and motivation to transition into market housing. This transition likely will come with a lot of emotions and anxiety and it will be crucial for CCH program staff to provide a high level of support through a well-planned transition that is determined by the participant and well communicated. The plan must include what supports will continue to be available to the participant as the transition into market housing including clinical, social, and financial supports.

Respite

Respite usually refers to caregivers providing a temporary break from their caregiving duties. Respite in the CCH initiative is speaking to Participants who, for complex and diverse reasons, may require a temporary break from their current CCH site. We acknowledge that CCH environments will make every effort to provide calm, safe, supportive spaces and that due to complex needs, this may not always be consistently achieved. In such situations, Participants may require a "time out", temporary break to regain stability to be able to better engage with their CCH care plan.