TRANSFORMING

THE COMOX VALLEY

HOMELESS SERVING SYSTEM

Our System, its Capacity and our Assets and Strengths in Moving Forward.

Scoping Report prepared for the

CVCCIC: Building Community Capacity Project in the Comox Valley

Compiled by:

Amanda Ridgway - IGNITE Consultancy

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Abbreviations

ACT	Assertive Community Treatment
AGM	Annual General Meeting
AHERO	Ad-Hoc Emergency Resources Organisation
ASTAT	Adult Short Term Assessment & Treatment
AVI	AIDS Vancouver Island
CEAS	Creative Employment Access Society
CHF	Calgary Homelessness Foundation
CLBC	Community Living British Columbia
CV	Comox Valley
CVCCIC	Comox Valley Community Capacity Initiative Collective
CVMHAS	Comox Valley Mental Health & Addiction Services
CVRC	Comox Valley Recovery Center
CVTS	Comox Valley Transition Society
CWO	Cold Weather Outreach
D2D	Dawn-to Dawn Action on Homelessness Society
ED	Executive Director
EWP	Emergency Weather Protocol
FOI	Freedom of Information Act
FTE	Full Time Equivalent
GP	General Practitioner
HepC	Hepatitis C
HIV/AIDS	Human immunodeficiency virus infection / acquired immunodeficiency syndrome
HOP	Homeless Outreach Program
JHS	John Howard Society
MCFD	Ministry Children & Family Development
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MSD	Ministry Social Development
N/A	Not applicable
NGO	Non-government organisation
NIMBY	Not In My Back Yard
PWD	Persons with Disabilities Benefit
RFP	Request for proposal
VIHA	Vancouver Island Health Authority

EXECUTIVE SUMMARY

Building capacity in service responses to homelessness.

Homelessness is a considerable concern for Comox Valley community. Findings of previous investigations prompted local services to collaborate on a building capacity project for service providers. The Comox Valley Community Capacity Initiative Collective (CVCCIC) aims to strengthening the capacity of current services and its workforce to deliver services more effectively and comprehensively.

To achieve this the CVCCIC intends to create a workable model of integrated service delivery across the agencies incorporating best practices and the mechanism, tools and professional development required for its implementation.

Delivering integrated service responses to homelessness requires locally grown solutions focused on best practice essentials. A review of leading communities determined:-

- Themes in best practices offer valuable insight and act as touchstones to guide implementation and sustainability.
- Responses to homelessness at various levels is required
- Factors are evident that significantly affect both the likelihood of success and sustainability of progress.

Investigating the Comox Valley Homeless Serving System

To determine the best way forward, this scoping report examined the Comox Valley context with a community capacity building lens with best practices findings in mind to provide the necessary information to guide and implement project recommendations.

An investigation was conducting using key informant interviews, community mapping activities, a service review of the partner agencies and service user consultation activities.

A system of care approach examined what is the current structure of the system, how a client current moves through the system and what capacity exists within the system currently and for improvements if necessary.

System elements identified and investigated:-

Components

- Prevention
- Homeless Specific Outreach
- Specialist Housing Services
- Housing, Housing Practices
- Supportive and specialist services not specific to housing

Processes

- Access
- Intake, triage and assessment
- Case management
- Human resources
- Professional development
- Information
- Integration & coordination
- Funding.

Implementation and sustainability factors

- Consumer engagement & participation
- Partnership opportunities
- Challenges external to but affecting the system.

The state of The Comox Valley Homeless Serving System.

The Comox Valley's current homeless serving system is a variable and stretched system of care operating in an under resourced context with barriers and limitations likely a forced adaption to structurally imposed barriers, a result of isolation or a reaction to scarcity.

Service users experience the system as complex, disjointed and competitive. Capacity challenges, gaps in services and practices that hinder progress are readily identified by clients with the lack of housing stressed as the top priority.

Critical housing is missing. The inability to suitably house clients and provide choice increases the burden on both service providers and housing providers, significantly impacts client's health and well-being, and places considerable pressure on system functioning.

Essential service components such as prevention, outreach, housing specialist services and support services are in place however function primarily in isolation within a competitive funding environment, are of unknown scope or effectiveness. The network of services operate without the designated coordinating organisations and roles considered necessary to ensure a seamless, client centered and responsive approach consistently across the community.

Absent evidence based processes include coordinated intake, evidence based prioritization and comprehensive community-wide case management of vulnerable individuals and families. Practices vary considerable through the system as compared to reviewed best practices with limited attention, motivation or resources available for sharing good practices throughout the community.

Significant deficits exist in information and information management in addition to monitoring and evaluation systems. Extracting meaningful data is difficult and the lack of shared accurate information as legally and clinically appropriate creates communication challenges and restricts the ability to deliver informed practice.

The ***continuity of care and responsiveness*** are lacking and inefficiencies are evident. In the absence of data, the effectiveness and efficiency of the system to produce desired outcomes for clients in addition to the costs of the systems are undetermined making accountability impossible.

The system exhibits ***dependence on personnel*** and their working relationships for collaboration and good practice, that whilst acts as a strength, is unsustainable. This is a common observation in rural communities and communities not yet acting together to ending homelessness.

The capacity of the system

Programs and services available through the CVCCIC and their community partners offer a broad range of the activities necessary for responding to homelessness. The large number of support services in community and the positive working relationships, competencies and motivation of service staff are assets which provide considerable advantage for community. Service users deeply value staff, respectfulness, and service provider's efforts to connect with them.

Significant capacity challenges exist and in many cases results in undesirable restrictions and barriers imposed on access and service to protect the limited resources as organisations attempt to manage the difficult situation. As a result, the health and well-being of the clients are negatively impacted.

Little improvement was found in financial and human resources since a review in 2010 (Bazink & Butler). Roles specifically attending to homelessness have been cut and the critical housing inventory appears to have decreased since. Most service needs outlined in 2011 remain unfulfilled. Feedback from service users offer insights to help prioritize how these needs may be addressed.

Mitigating the true impact of this situation, organisations and staff work hard to provide access and deliver services within their own mandates. Some valued collaboration exists, however operating in a difficult competitive atmosphere, services and practitioners are forced to focus on short term gains and respond primarily to crises and emergencies. As a result important activities including strategic development, collaborative initiatives, professional development and quality improvement initiatives are sacrificed to the detriment of staff and their clients.

Organisational and institutional capacity is marginal. Key government service providers are engaged and interested in pursuing collaborative efforts however without the necessary resources and the persistent advocacy, institutions remain focussed on their core business. There is an absence of an overarching strategic multi-stakeholder plan, a coordinating entity or the political consensus needed to achieve community wide initiatives, strategically directed funding allocations and major housing developments. Recent moves to reorganise the governance structure shows promise as do awareness raising efforts in the public forum which presents opportunities to leverage community activism and augment positive outcomes.

Finding capacity in integrated solutions.

Enhancements and expansion across the system are required to create and improve the necessary components and processes of the homeless serving system. Transitioning from the current state to an more effective system would require additional capacity and significant cross-sectorial collaboration.

Increasing capacity across the housing continuum would reduce the excessive demands placed on the existing housing inventory, on providers and decisively on clients likely accelerating the transition to evidence based practices across the community.

Stabilizing the system is necessary to reduce demands and pressures on the system at the service level by reinforcing providers, promoting the necessary scaling up of better practices, improve coordination across the system and ensure information is available for evidence based decisions.

Streamlining access and pursuing centralised intakes and agreed upon prioritization across organisations would assist in joining up services in informed practices whilst providing a clear path for clients, maximising resources, and reducing demands on practitioners. These processes would assist in creating the desired seamlessness in the system.

Sharing the expertise of staff within the CVCCIC, its partners and the community offers a collaborative opportunity to improve the consistency of evidence based practice across services and therefore the effectiveness and efficiency of system.

Collaboration and integration offers service providers the best opportunity to maximise available resources for the greatest impact within the current capacity. Collaborating in projects, interagency professional development, joining up service provision, sharing personnel and material resources and coordinating delivery across the community would strengthen the system considerably.

Partnerships are needed to deliver the necessary prevention and early identification components, anti-poverty and income generation interventions, speciality health and medical services and the social programs essential to

complement housing and housing specialist services. Involving service users in planning and evaluation should be included in partnership development.

Information collection, reporting and analysis throughout the system must be prioritised at all levels. Community wide communication and coordination supported by formalised protocols and processes could strengthen the appropriate sharing of client information across services and foster informed practice thereby enhancing capacity immediately. In addition this would provide the necessary information for community planning and future funding requests.

Sustaining improvements

The ***necessary system level modifications*** will be difficult to implement and sustain whilst the dependency on the already stretched resources of the service providers continues and the lack of available housing remains. Maximising current capacity will only go part way to achieving an integrated and effective homeless service system.

Additional resources will be required for critical enhancements including a complete housing continuum, designated coordination, community-wide case management services and effective information management systems all offered as essentials in ending homelessness.

Ending homelessness must be prioritised across the community by all service groups and organisations as a shared responsibility. With a system focused on ending homelessness, emergency prevention, systems prevention and income are also part of the solution.

Community efforts should focus on clarifying this vision, determine a collaborative action plan to achieve it and introduce shared accountability for the community with the necessary functions to monitor its implementation and continually improve it.

Attending to these community wide initiatives, increasing the necessary housing and implementing an integrated homeless serving system would place the community in a powerful position to end homelessness in Comox Valley.

With a comprehensive critique of Comox Valley's homeless serving system identifying areas for improvement and the assets and strengths available in transitioning to a more efficient and effective system, organisations can confidently prioritize action in moving forward. With the community's strengths and commitment, much can be done within the current capacity to improve services and create an integrated system of care aimed at ending homelessness, however investments into its success will be required. As the World Health Organisation recognizes "Integration can lead to more economical use of resources, but it isn't a cure for inadequate resources" (WHO; 2008).

Section 1 - INTRODUCTION

1.1 The Project

The Comox Valley Community Capacity Initiative Collective (CVCCIC) has commenced a project to build the capacity of services to respond to local homelessness by identifying, implementing, strengthening and sustaining collective efforts to improve services. AIDS Vancouver Island, Comox Valley Transition Society, Dawn to Dawn and the Wachiay Friendship Centre have joined together in efforts to improve outcomes for community members. They are among the social organizations and agencies in the Comox Valley that are working to provide housing and support services to persons who may require some assistance to live with dignity and contribute to the community.

The Building Community Capacity Project (the Project) focuses on improving service delivery acknowledging that homelessness relates to three key deficits or factors, housing, income and support. Project partners aim to create a workable model of integrated service delivery across the agencies and the mechanisms, tools and professional development required for its implementation.

The CVCCIC Mission:

Collaboratively implement an integrated approach and better practices & tools, enhancing our capacity to deliver a cohesive, effective and sustainable support service response to people needing just, healthy and stable housing or facing homelessness in the Comox Valley.

1.2 The Report

This report provides information to facilitate project partners and key collaborators in determining options for the implementation of a sustainable integrated service delivery model and the processes, mechanism and tools to support the model.

It is intended to be used in conjunction with first report of the project, *Delivering Integrated Service Responses to Homelessness; A Best Practice Review of Leading Communities for the Building Community Capacity Project in the Comox Valley, Vancouver Island BC*.

1.2.1 Aim

Engage community and stakeholders and collate information in determining current scope of service delivery in responding to homelessness and explore capacity within the community to implement a sustainable service delivery model aimed at incorporating more evidence based practices as defined by the completed best practice review.

1.2.2 Objectives

1. Summarise interagency coordinated response presently against an evidenced based homeless system framework.
2. Confirm previous services gaps and barriers reported by Butler and Bazink Consulting (2011).
3. Explore current capacity of partner agencies and community within this framework.
4. Identify strategic position of resources within the community to implement and sustain improvements.

1.2.3 Approach

Community capacity building is the key approach of this project with proactive engagement emphasized throughout the scoping activities.

The project's best practice review report, *Delivering Integrated Service Responses to Homelessness*, and its references formed the starting point of determining the topics of interest for scoping activities. Aimed at developing an integrated service delivery model incorporating best practices, the following reports provided additional direction focussed on achieving Housing First with supports.

- ☐ At Home/Chez Soi Interim Report. Mental Health Commission of Canada, 2012.
- ☐ Calgary Homeless System of Care System Planning Framework. Calgary Homeless Foundation, 2012.
- ☐ Evidence for Improving Access to Homelessness Services. Christine Black & Hellene Gronda. AHURI Research Synthesis Service, 2011.
- ☐ Organisational Change: Adopting a Housing First Approach. National Alliance to End Homelessness, 2009.
- ☐ Strategies for improving homeless people's access to mainstream benefits and services. US Department of Housing and Urban Development, Burt et.al, 2010.

1.2.4 Topics of investigation

Investigations and reporting focussed on the following topics derived from this research:-

1. **Components of the system.** The essential core programs, services and housing that are necessary to serve and house clients and define the structure of the homeless serving system.

   - ☐ Prevention
   - ☐ Homeless Specific Outreach
   - ☐ Specialist Housing Services
   - ☐ Housing
   - ☐ Housing Practices
   - ☐ Supportive and specialist services not-specific to housing and homelessness.

2. **Processes of the system.** A series of actions or steps taken to achieve an end or result. Integrated care processes include activities as they relate to care or clinical pathways and protocols. Included are information systems and activities designed to create interconnectivity between components and processes aimed at integrating the system.

   - ☐ Access
   - ☐ Intake, triage and assessment
   - ☐ Case management
   - ☐ Human resources
   - ☐ Professional development and self-care
   - ☐ Information collection & sharing
   - ☐ Integration & coordination mechanisms
   - ☐ Funding

3. **Implementation and sustainability**. Key supports and partners not specific to the homeless serving system that help implement and sustain the system over time. Success factors which have been demonstrated to facilitate or act as barriers to providing effective service delivery in responding to homelessness.

   - ☐ Consumer engagement & participation
   - ☐ Partnership opportunities
   - ☐ Challenges including funding, lack of housing both affordable and supported, lack of income generating opportunities or inadequate ministry assistance, political climate & leadership.

1.2.5 Methodology

With a focus on engagement and capacity building, a package of scoping activities was used as listed below. The list of key informants, materials used and resources accessed for these scoping activities are available in appendix A, B and C respectively.

Key informant interviews	61 interviews conducted primarily in person were completed with 32 organisations.
Community Mapping	Attendance Frontline meetings x 3 Attendance AHERO meetings x 2 Attendance BC Housing Homeless Outreach Program Regional Meeting AHERO Organisation Asset Mapping Inventory Sheet Community Capacity Questionnaire Attendance Care-A-Van Presentation to City of Courtenay Council.
Service Review	Trawl of Organisational Documentation Practitioner and Service Manager Interviews Practitioners Capacity Questionnaire Attendance on a Cold Weather Outreach with AIDS Vancouver Island
Service user consultation	Resource Fair participant feedback activity Comox Valley Transition Society drop-ins x 2 AIDS Vancouver Island drop-in x1 21 Service user surveys 4 Service user personal interviews

1.2.6 Limitations

Access to clinical and client data was not available for the report. Practitioners were not observed directly in practice with clients.

Activities were designed to provide information to guide the decision making processes of the project and are not intended as a scientific enquiry.

Observations and comments from practitioners are presented regarding specific types of housing needed currently for each vulnerable groups however confirming theses needs with evidence is beyond the scope of this project.

1.2.7 Report Structure

The scoping report is structured as shown below:

- Section 1 is this Introduction
- Section 2 describes Conclusions
- Section 3 details the Findings of scoping activities
- Section 4 identifies Implementation and Sustainability considerations
- Section 5 provides Appendices

Section 2 – CONCLUSIONS

2.1 Summary

The objectives of this report were to describe the current state of the system, confirm previously reported gaps, identify the current capacity of partner agencies and community and the strengths and assets within a best practice framework that focusses on evolving to a healthier, more integrated system based on evidence based practices.

Leading communities follow a developmental journey or stages of growth that, with focussed and persistent effort to end homelessness, demonstrate success. Many communities began their journey with the acknowledgement that increases in poverty and homeless and unhelpful governmental policies have forced adjustments across the nation in order for services and organisations to manage a growing crisis.

2.1.1 The state of the system.

This adaption is evident in the Comox Valley and, like leading communities before them, local organisations are now playing catch-up in response to recent advances in research. Like other rural or regional communities, Comox Valley is characterised by lower comparative funding allocations, suffers from reduced availability of critical and support services, endures transport challenges and likely comprises a significant proportion of hidden homelessness population.

Overall the system currently is fragmented and lacks the continuity of care needed frustrating service users and providers alike. Inefficiencies across the system are evident, the workforce is stretched and some critical processes are missing. Without the necessary information, it is not possible to ascertain the effectiveness and efficiency of the system and its success at prevention, managing or transitioning people to permanent housing.

Housing infrastructure, an essential component of the system and critical to deliver a Housing First philosophy, is severely limited. The absence of the continuum of housing has wide spread impact and contributes to community member's entry into homelessness and prohibits movement out of the homeless serving system.

Most other essential components are present however are of unknown efficiency or effectiveness. Some prevention appears to be occurring however institutional discharges appear limited and the scope of prevention in mainstream services is unknown. Outreach and in-reach is occurring. Housing specialist services are provided and a diverse range of support services are available however streamlining is necessary and competition amongst providers for limited housing is evident.

Collaborative planning, joint case consultation, information exchange and coordination of services are limited.

Initial access to the system through outreach appears to be functioning however systemic barriers are common. Processes described as best practices including centralised intake, prioritisation of the most vulnerable and community wide case management are not currently occurring affecting the system's ability to operate at its most optimum performance. Bottle-necking, wait-lists, and exclusions occur with service providers and users readily describing their negative impact.

Practices and language are inconsistent across the network and the community and there is a lack of clarity around roles and responsibilities of individuals and organisations causing considerable challenges throughout the system.

Client centered and proactive approaches are practiced to some degree within organisations however are frequently interrupted or lost when client moves through the system. Key approaches of the Housing First philosophy, harm reduction and low barrier programs and housing, are not consistently utilised however expertise exists within the partnership to expand this. Choice and flexibility is impossible to provide with current limited resources. Service users confirm positive experiences of best practices when they are present and express hopes for more improvements.

A dependence on personnel and their positive working relationships for good practice and collaboration is apparent however without formalised protocols and procedures, service often changes with staff turn-over.

Purposeful, accurate and beneficial information sharing is significantly absent with service directories, organisational & practice information, client information and monitoring evaluation all demonstrated deficits in information collection and sharing. Improved information collection and management as appropriate could significantly assist in improving client outcomes, alleviating present challenges in communication, determining the effectiveness of responses and assist with securing funding.

Many organisations in the Comox Valley recognise the need to transition to a more successful system and recognize the community's current position given the historical context and its current stage of development in ending homelessness and its lack of resources.

2.1.2 Service Gaps

Most service gaps identified in previous research were reconfirmed by respondents including medical and health services, transport and a drop-in center among others. Coordination of services and case management aimed at continuity of care were confirmed in feedback.

Determining if gaps are real or perceived would be valuable. Lack of knowledge, access barriers, limiting eligibility criteria or lack of coordination between services may result in the perception of gaps in service provision for example.

Service user feedback highlighted discrepancies that offer helpful planning direction and may need further investigation. Service user participation is currently underutilised.

To prioritize action additional information and analysis of the needs of the vulnerable individuals and families, current service utilization, and how services may or may not be meeting these needs presently would be helpful for more accurate conclusions.

2.1.3 The capacity of the system.

Comox Valley has an array of services and organisations working with the community's vulnerable population that have proven themselves flexible and adaptable.

There are clear and significant capacity limitations however and in response dedicated, compassionate staff are going beyond their work hours and job requirements to manage the best they can to serve the community and scrape together housing where possible.

Lack of affordable and supportive housing is a primary contributor to the capacity issues and presents significant challenges to service delivery. Practitioners continue to help clients attend to housing issues in addition to manage the continuation of the social and health concerns that cannot be addressed whilst housing insecurity exists.

Capacity challenges have a direct influence on the barriers services and organisations and preclude their ability to deliver to best practices and there has been little improvement over the previous two years. The heavy reliance on soothing mechanisms has likely contributed to the current challenges and therefore changing and expanding mechanisms offer opportunities for innovation and should be the focus of future improvements.

Community-wide initiatives beyond the scope of any one service provider and considered necessary to deliver a seamless homeless serving system are absent, exacerbating capacity challenges.

Lack on information and the mechanisms to collect and analysis it significantly impact on the capacity of professionals to operate in the system and significant reduces the ability of the system to operate effectively.

2.1.4 Assets and strengths

Staff members, their commitment to their work and employers, and their competencies and expressed desire to continually improve are valuable assets that should be recognised and strengthened. The knowledge and expertise among staff is a significant asset and sharing of the experience of best practices would dramatically improve capacity across the community.

The personal relationships between professionals are considerable strengths and most often the underlying factor for good practice and effective integration. Service users are valuable contributors to solutions and their involvement helps ensure that interventions and actions directly reflect live experiences increasing likelihood of success.

The cooperation and collaboration between services at a practitioner level and through mechanism such as AHERO and Frontline Worker Meetings may offer the best opportunity for innovation given the current capacity. Experience and familiarity with absent elements of the systems such as community wide and enhanced case management experience is also available in the service provider community.

Partnerships are available to improve coordination of services, join up services and resources in efforts to maximise capacity with current resources and realise efficiencies while improving service delivery. Opportunities to share expertise through interagency professional development, pursue system wide improvements, streamline access and processes and develop mechanisms to collect and collate useful data would be helpful first steps. Strengthening partnerships would assist in re-establishing a culture of collaboration, informed practice and of innovation.

The public are an asset for the community however education, awareness raising and a community vision would likely assist in aligning public opinion to evidence based approaches and generate the support to assist in pursing improvements including the much needed development of housing.

2.2 Key Observations

Components

2.2.1 Prevention

CVCCIC organisations through their current activities attend in part to targeting known vulnerable populations. Other services in the community are also conducting prevention activities. Previously recommended prevention plan has not be created.

Primary prevention activities focussed on individuals and families not yet known to the services and systemic prevention including proactive discharge policies in institutions appears limited.

More information is required to determine the scope of prevention activities and their effectiveness. Collating and analysing available data across all services may provide inferences about the numbers and portions of vulnerable sub-populations present in services helpful for planning and focussed capacity building.

2.2.2 Outreach

Outreach activities are present however not consistently available. In-reach; making practitioners available in service buildings and facilities in the community appears well attended and increasing. The opportunity to connect with services in this way is valued by service users.

Coordination of street outreach and emergency provisions and increasing the capacity of outreach targeting vulnerable people is likely warranted.

More comprehensive data identifying potential service users including likely hidden homeless individuals and families and comparing needs to services provided would be valuable.

2.2.3 Housing specialist services

The partnership group with community partners are provided services essential in the homeless serving system. The scope and effectiveness of these services is undetermined.

Specialisms evident within the partnership and the community including experiences, services and staff, are important assets and could be shared in a consistent and structured way to strengthen the system.

Duplication of effort and provision is apparent in housing searches and likely in a number of housing services such as housing applications and landlord cultivation and recruitment. Identifying clients who are receiving these services from several agencies would be valuable in streamlining access to housing.

2.2.4 Housing

All respondents consistently listed the lack of appropriate and affordable housing as the top priority for improvement.

A brief investigation of current housing inventory indicates a decrease in units available and gaps in the housing continuum as identified by Bazink & Butler (2011) remain. Additional information would be required to indicate if demands for the housing have increased since the last analysis.

Identifying the housing needs of the community must take into account the likely

significant population of 'hidden' homeless individuals and families.

The lack of affordable and supported housing in the Comox Valley continues to act as a barrier for community members seeking permanent shelter. Staff described specific instances of individuals returning to unsafe and unhealthy situations because of a lack of appropriate housing.

The limited housing stock has a negative impact on the ability of services to perform their objectives in attending to the needs of community members. The lack of available units contributes to a competitive environment for limited resources and likely affects client outcomes and staff morale.

Housing providers describing consistently operating at or beyond capacity. Continued pressure and challenges for private housing providers is likely to result in further reduced access for vulnerable people to the limited stock available.

2.2.5 Housing practices

Housing providers expressed a range of practices that acted as barriers to housing including within their own organisations. Stay periods, exclusion periods, abstinence expectations, banning of harm reduction paraphernalia, limits to off premise overnight stays, participation expectations for service or continued housing, and rules related to gender matching, pets, smoking etc. were all offered as challenges.

The range of practices described indicates there is opportunity to move closer towards evidence based practices and improvements could be explored within current capacity. Sharing the best practices currently in place would be beneficial.

2.2.6 Support & specialist services

There is a breadth of interventions and services available in the community indicating a healthy inventory is present however perceived gaps remain.

Gaps including medial & dental services, transport and a place to go during the day were reiterated.

Life skill related activities, addictions support and treatment, and case management activities including referral & linking and coordination of supports were listed as provided and also offered as needs or gaps suggesting only some clients may be eligible for these services.

Income generation opportunities & programs were also listed.

Processes

2.2.7 Access

Access to the system via outreach and in-reach and soothing mechanisms are in place to attend to some structural and contextual barrier related to access.

Accurate information is needed to provide critical data on access to the system, movement and responsiveness of the system, the nature of service users needs and its effectiveness of facilitating positive outcomes.

Practices denying or limiting access, denying or limiting choice are evident contrary to identified best practices and are likely the result of lack of education, lack of information

and capacity challenges within the housing continuum and services.

2.2.8	Intake, Triage & Assessment	Intakes and assessments are occurring separately in organisations however are of an undetermined effectiveness for the purposes require and are likely repetitive for clients. Prioritizing agreed groups, vulnerable individuals and families and triaging accordingly is only occurring on a practitioner-client level. Documentation of triage decisions is limited making it difficult to monitor consistency and outcomes. There is no standardised assessment currently being used which includes measuring acuity. Intake information and referrals not connected to outcomes or followed up and response time not recorded. Information collected from these processes would contribute significantly to understanding the needs of population.
2.2.9	Case management	Twenty organisations indicate case management activities are provided however there is not community wide case management of vulnerable community members. 'Enhanced' case management delivering a more intensive proactive service, specifically targeting homeless individuals or families across the community is not occurring in any formal way and there is no organisation currently funded for this responsibility. This, in part, contributes to the interruptions and breaks in continuity of care and contributes to the described fragmentation of service for clients. That case management activities are already occurring suggests a possible reallocation of resources in the community could attend to this need.
2.2.10	Human Resources	CVCCIC staff members are knowledgeable, experienced and a compassionate team working beyond capacity to provide client-centered, flexible, proactive services as deeply as their individual and organisational capacity allows. Lack of resources and capacity were stressed as problematic during the majority of interviews, by each organisation at all levels and from service users. Varying degrees of evidence based practices are described. Obstacles and opportunities from the perspective of the frontline staff provide valuable direction on where to focus efforts.
2.2.11	Professional development	Training needs related to best practices are evident and appropriate professional development is inadequate for some organisation given the nature of the work and the needs of a homeless service system managing under the current capacity. Professional supervision and support for isolated roles would benefit from immediate enhancing. Monitoring & quality assurance activities are more advanced in larger organisations and act as an asset for the partnership however these organisational strengths are not currently shared across the system. Service and housing providers outside the partnership would benefit from additional

training and housing providers in particular support for working with challenging presentations with clients.

2.2.12 Integration & coordination

Coordination of the entire system to ensure continuity of care, optimize resources and maximise success is absent.

Connections, networks and structures are present and promote varying degrees of integration and collaboration. The strongest assets are the working relationships between practitioners and the AHERO forum.

Many existing linkages rely on personal working relationships as opposed to formalised agreements, protocols or service structures.

2.2.13 Information

The lack of information available through and across the system has a significant and wide spread negative impact on the functioning of the system and on the professionals and people in it.

Necessary and appropriate case consultation and appropriate and legal sharing of client information is lacking, likely wasting resources and affecting client outcomes negatively. Situations such as women experiencing or leaving violence, that warrant a higher level of security should be included in any developments.

Open, constructive communication across services is deficient causing significant strain on the system, its staff and the people it serves. The lack of factual information and open communication between services contributed to conflict and difficult working relationships at times.

2.2.14 Funding

Lack of funding is consistently offered as a challenge to providing integrated services and achieving the best outcomes for clients.

Partnerships have successful secured funds and delivered results however government partnerships and leveraging on partnership funding arrangements are limited and larger funding applications that would fulfil a greater volume community needs and ease capacity strains have not been successful.

Implementation & Sustainability

2.2.15 Housing

With severe affordable housing shortages and an incomplete continuum of housing needed to maintain flow and offer choice, it is likely service providers will continue to be challenged with capacity and finding the balance between being client centered and providing services and housing that meets everyone's needs. As a result service users will continue to experience additional demands on them they are unable to meet and staff experience stress and reduced job satisfaction.

2.2.16 Partnerships

Government and mainstream partners essential in creating a comprehensive and integrated homeless serving system, and ensuring significant impact are engaged in the project and interested in the opportunities it presents.

These partnerships will be necessary in providing components of the system that are not directly related to housing but help end homelessness including prevention, early intervention, income generation and the speciality health services to assist clients

		recovery.
2.2.17	Consumer engagement & participation	Service users describe positive trusting relationships with CVCCIC staff however there are few structured opportunities to adequately participate in and inform service planning and delivery reducing the success of improvements. Service users provide valuable input that is currently underutilised.
2.2.18	Information	To understand the extent of homelessness locally, determine efficacy of responses, encourage responsiveness, and make informed decisions additional data is required. Some of this date would be available other community partners. Monitoring and evaluation systems to encourage efficient use of resources, observable outcomes and ongoing improvements are lacking.
2.2.19	Challenges	Funding, lack of affordable and supported housing, lack of income generating opportunities or inadequate Ministry assistance, unhelpful political climate & leadership and public engagement limitations and lack of knowledge were offered as challenges outside of service provider's control that have an impact on building capacity and sustain improvements.

Section 3 - FINDINGS

The following section details available data and information discovered during scoping activities. It is presented in the following format for each topic of interest:-

- Introduction & rationale
- Data available
- Observations

3.1 COMPONENTS OF THE SYSTEM

3.1.1 Prevention

Prevention is an essential response to homelessness. It includes primary, secondary and tertiary prevention activities working to prevent first episodes of homelessness, stabilize people in their current housing or find permanent housing and to help mitigate the impact of episodic homelessness.

Creating more effective tools, processes and resources, having affordable housing, integration and establishing easy access to programs and services are also considered prevention and are addressed separately in this report.

PREVENTION ACTIVITIES	
Housing Advice	All partner agencies, Salvation Army, Legal Advocate, John Howard Society (JHS), BC Housing.
Rental Assistance	HOP, D2D, CVMHAS
Additional Monetary Assistance	HOP, D2D, CLBC, CVMHAS
Tenant Education	HOP Pamphlet- Tenant's rights information
Tenancy Support	All partner agencies + Nursing Center, Coastline, CVMHAS, MSD, CLBC, Legal Advocate, JHS.
Tenant Landlord Mediation	HOP, D2D, AVI, Coastline, Legal Advocate, MCFD.
Landlord Support	AVI, D2D, HOP, Legal Advocate and CLBC
Family Mediation	Comox Valley Family Services

Strategies & Plans

The Homeless! report (City of Courtenay, 2008) provides a recommended action plan that addresses preventions p. 46. A prevention team, emergency prevention fund, early intervention strategies have not been activated at this time. There is some activity attending to youth homelessness and the current project aims to assist with achieving increased access.

AHERO offers an opportunity to discuss prevention matters and appropriate actions at a community-wide level.

Targeting vulnerable populations

There is a broad coverage of HOP in-reach currently, delivering out and in-reach at various locations.

CVMHAS intake information, MSD, BC Housing, and information from the Food Bank may provide information that would assist in determine target population and the means to connect with

individuals & families in need not yet accessing CVCCIC partners.

Opportunities to increase income

MSFD income assistance application process was commonly described as a challenge. There is no fast-tracking program as described in other communities. MSD includes an appointment time for the HOP worker.

The processes of working with AVI and the Nursing Center to complete PWD applications and help GPs is highly regarded.

CEAS staff acknowledged their mandate and lack of funding is a constraint in meeting the needs of the homeless population with requirements for attendance but not the resources to proactively follow up with individuals limited.

Social enterprise is offered through CVTS.

Institutional discharge planning

St Joseph's Hospital

- ☐ No permanent discharge policy in place.
- ☐ EWP - policy of no discharge to street.
- ☐ Staff have indicated a strong interest in pursuing best practice policy
- ☐ Social work staff refer primarily to HOP and a good working relationship is described.
- ☐ The psychiatric ward discharges to Pidcock House shelter.
- ☐ CVTS-LH has discharge discussions with the hospital.
- ☐ Nursing staff level of confidence in discharging to Pidcock House shelter increased with recent changes to shelter hours however staff stated this is not ideal.

Corrections

- ☐ Institutions offer services to inmates who are leaving including assistance with housing. However there is no known discharge policy.
- ☐ Community corrections staff most often suggest the Pidcock House shelter if housing is required and will work with clients specifically on housing if challenges in accommodations are related to risk of offending behaviour.

John Howard Society

- ☐ Significant gap for young people leaving care and moving into adult services.
- ☐ Enhanced case management and intensive support young people receive ceases often at 19 and young people are placed at significant risk.
- ☐ Lenient criteria for 19-24 year olds to try and continue some service provision but are bound by funding requirements.

Ministry of Children and Family Development

- ☐ The challenges of clients' transitions to adult services are acknowledged by staff. Some mechanisms including youth agreements and transition conferences are available however capacity challenges are present.
- ☐ Housing with supports is considered best practice.
- ☐ Gaps in service exist and the lack of available housing, income opportunities and resources presents challenges for many young people moving to adulthood.
- ☐ Recent action to determine the housing needs of young people will assist and is well regarded.

CV Recovery Center

- ☐ Care planning with the referring agencies and supports clients with housing searches.
- ☐ Bees Nest is a referring partner.

	Salvation Army Pidcock Emergency Shelter ☐ Case manager conducts case planning for planned departures. ☐ Service refusals or unplanned discharges are recommended to go to shelters in neighbouring towns.
Upcoming opportunities	Ready To Rent, a private organisation is currently in communication with CVTS staff to initiate a tenant education program in the community. Rent banks have been proposed by VIHA staff during AHERO meetings as a possible initiative.

Critical Observations

Preventions activities specific to housing are available and discussions are underway to increase the options.

Diverse in-reach is occurring and likely targeting some vulnerable populations.

Coordination between prevention activities amongst organisation does not appear to be occurring. A perceived unfairness at resource allocation was expressed during interviews described as service users 'shopping around'.

Tenant support services may be a duplication of effort by service providers and identifying needs of the community would confirm this.

Information is lacking on efficiency and effectiveness of prevention activities making it difficult to assess if activities are reaching target groups. Given the likely population of hidden homeless, it is difficult to assess if populations who are not currently involved with services know where to go to for assistance.

Systemic prevention appears limited in the organisations contacted. Education on homelessness with mainstream services or advocacy for prevention is not known to be occurring in any structured or regular form. Previously recommended prevention plan is not in place.

3.1.2 Homeless Specific Outreach

Outreach is a key item in planning to end homelessness. Outreach offers flexibility to meet people where they are at, proactively engaging and connecting hard to reach individuals to services.

Street/ outdoor outreach

AVI-WFC Cold Weather Outreach was to operate during Nov –Mar, 3 days a week, Tuesday, Thursday & Sunday conducting regular route stops with hot drinks, food, harm reduction supplies and some clothing. On Jan 10 2013, agreement was terminated on the basis of a conflict around the provision of resources. Presently AVI is continuing to providing the same schedule and provide resources through operating budgets planned for other activities.

Care-A-Van operates a fixed schedule 12 months/year offering access to health and dental services. During the winter months the services alternate their days with AVI-WFC Cold Weather Outreach to provide 6 day coverage.

AVI outreach workers described more coordination to proactively direct the most helpful in-kind contribution donations from the community would assist service provision.

In-Reach/ Drop-in

The HOP worker attends locations including AIDS Vancouver Island, Comox Valley Transition Society Offices, Lilli House, the Sonshine Lunch program and St-Joseph's Hospital. HOP stats provided: 41 Clients housed April – October 2012; 81.08% remained housed.

AVI operates a regular morning drop-in between 9 – 12 Noon.

CVTS offers a drop-in to women of any age Tuesday mornings 11.30-2pm.

Nursing Center operates as One Stop Drop one Friday per month. Recorded contacts including 10x10x10, and soup kitchen in-reach provided March 8, 2013:

2011-12	278 contacts; 22 group sessions
2012-Nov 2013	166 contacts; 11 group sessions.
Increase of 23 additional contacts over two years (10 months of comparative data)	

Drop in Center

Practitioners and service user consultation re-confirmed that there is a need for a drop-in center. Reports indicate that homeless individuals move about between AVI, 'friendly' cafes, the library, soup kitchen and the Pidcock House shelter . Service user feedback however indicates health & medical services and transport are more pressing needs currently.

Critical Observations

Information detailing outreaching contacts and outcomes for most organisations was not available.

During winter Comox Valley has 6 days of outreach coverage working with the CVCCIC partners and Care-A-Van. Summer months leave only the Care-A-Van operating 3 days.

Increasing capacity to all year coverage may be warranted. It was noted that increasing the mix of outreach workers to provider diversity may be beneficial.

An eight-year old AVI-WFC partnering agreement to jointly provide outreaching services was terminated requiring AVI to find additional resources to ensure continuation of outreach services.

3.1.3 Specialist Housing Services

Activities directed as finding and acquiring housing and support services connected to housing are essential components of any homeless serving system. (see also Support and Specialist Services)

SPECIALIST HOUSING SERVICES	
Housing Needs & Resources Assessment	HOP, D2D, Salvation Army
Housing Search	HOP, CVTS-CF, CVTS-LH, Salvation Army
Housing Applications	D2D, HOP, CVTS-CF, CVTS-LH, Salvation Army
Placement	D2D, HOP, Salvation Army, MCFD.
Landlord Cultivation & Recruitment	D2D, HOP, Salvation Army, Coastline.
Leasing	D2D
Moving Assistance	D2D, HOP

Critical Observations

The CVCCIC partners together with The Salvation Army are well recognised as performing the majority of housing specialist services for the community. Information necessary to make an informed assessment on the provision of these services and their efficacy was not available.

Some practitioners within community services continue to conduct housing searches despite, or instead of referral to housing specialist services. Some searches related to clients requiring specialized support within internal and contracted housing inventories such as with Coastline and CLBC. The 'Housing registry' as a centralised bank of housing options offered as a way forward in Homeless! has not been implemented.

Practitioners are accessing the same sources of information on available housing indicating duplication of effort. Practitioners have disclosed keeping vacancies private to provide for clients attached to their services indicating competition for scarce resources.

The mapping exercise and interviews indicates HOP is referred to by many organisations including key partners VIHA services, St Joseph's staff and MSD. Detailed information tracking frequency and outcomes of these referrals is not available.

3.1.4 Housing

Housing is cited as the number one pathway out of homelessness.

Below is current capacity information provided by the CVCCIC partnership and housing providers contacted directly through this project.

HOUSING PROVIDERS CAPACITY STATUS (2012)		
Emergency		
Pidcock House Emergency Shelter	Beds for 14 men 6 women During EWR additional 10 mats.	237 individuals; 4199 bed nights (an increase of 17% over 2011) October 51 individuals, 14 turn-aways; November 54 individuals, 9 turn-aways, December 37 individuals; 3 turn-aways. *Data does not include EWR stats.
Lilli House Emergency Shelter	For women fleeing abuse and their children	Statistics for emergency shelter included in transitional data below.
Transitional		
Lilli House - Women fleeing abuse and their children	30 days stay with some leniency as long as client actively working what they need to do get housing.	152 women and 56 children (19 or under) 2595 bed nights (up 32% from 2011) 181 days the house was full (up 65% from 2011)
Lilli House - A&D detox bed & Supportive Recovery bed.	One bed + floating bed. Referral is required from Substance Abuse Intervention Nurse or from CV MHAS.	Detox - 48 women; 454 bed nights. Supportive Recovery – 24 women; 324 beds.
Dawn-to-Dawn Residential Housing Program	18 units	21 clients (11 men, 6 women, 4 children).

The most recent Affordable and Supportive Housing Inventory is available through the CVRD here http://www.comoxvalleyrd.ca/uploadedFiles/Regional_District_Board/Homelessness/20110329_CVRD_Housing_Inventory_March2011.pdf. The CV Housing Task Force indicate this inventory will be updated in the near future.

The following changes in units were reported:

- Habitat for Humanity's build of three-duplex for six local families is almost complete.
- 11 supportive transitional housing units managed by CV Understanding Men are no longer operating.
- Washington Inn no longer has units contracted to VIHA.
- L'Arche has bought some land and is hoping to build another center with 5 apartments for their clients.

Service Provider's Feedback

The lack of supportive and affordable safe, clean housing was repeatedly offered and significantly stressed across the community as a gap and a certain barrier to clients getting housed, healthy and producing an income. Many providers offered Housing First as a best practice model, clear that their work is impeded significantly as an individual or a family focuses on obtaining shelter.

Throughout the community there was recognition of the excellence and the positive outcomes for clients and programs with the acknowledgement of the lack of resources and capacity.

Pidcock House shelter staff offered that with the incomplete continuum of housing, the shelter no longer operating as an 'emergency' shelter, rather a temporary or transitional shelter. Staff note there are 'big expectations of the shelter to fix problems' but the shelter is still part of the housing continuum.

The Pidcock House shelter cannot accommodate children or couples who wish to remain together, pets or people with active addictions. A portion of respondents stated the shelter is unsafe for some because of client's own challenges, the nature of the facility and/or because of other resident's behaviours including theft, drug use and abusive behaviours.

Gaps in housing offered (in no order)

- ☐ Assisted living units.
- ☐ Secondary stage housing
- ☐ Transitional housing with zero or low barriers
- ☐ Specific populations housing units
- ☐ Single low income earners who cannot share.
- ☐ Seniors functioning but homebound.
- ☐ Low barrier shelter
- ☐ 'Wet' housing program
- ☐ Housing that accepts pets and smoking

Service User's feedback

Of 19 service users interviewed, 15% of their days spent in the listed housing situations was unsheltered; living on the streets or in cars, places not considered fit for human habitation. 7% of their housing days were spent in the shelter, 24% in provisional accommodation including transitional housing and with friends.

In order of frequency of the most common homeless situation experienced:-

Living with friends
Time at the shelter
Sleeping on the streets
Living in a hotel room

In exploring average time spent in each situation, living with friends is heavily relied upon. When the data of 2 people who indicated they had lived in shelter settings for over a 1.5 years which were outliers in the data, the average stay at shelters reduced to 24 days.

Time in days spend in forms of homelessness

	No. of respondents	Max (days)	Max (yrs)	Average (days)	Average (mths)
The Emergency Shelter	11	547	1.5	119	4.0
Living with friends	14	730	2	331	11.1
Living out of a vehicle	6	365	1	151	5.0
Sleeping on the street	9	730	2	303	10.1
Transitional Housing	6	180	0.5	125	4.2
Permanent supported housing	4	2555	7	927	30.9
Living in a motel room	9	850	2.33	191	6.4
Other (describe) Foster Care.	1	1460	4	1460	48.7

Housing provider's feedback

Housing providers engaged to varying levels on invitation to participate.

'Honesty in housing' was requested. Key themes emerged in the interviews; accurate and timely information on vacancies, accurate information in referring potential tenants and consistent rules and practices in accepting and managing tenants. Whilst providers accepted capacity issues and 'big hearts' may be the intent behind inaccurate or incomplete information provided, it was clear many professionals and housing managers are frustrated with this approach. One provider indicated it was likely they will no longer accept referrals from some housing programs because information provided by referrers that the provider considered maliciously provided.

Housing providers noted the lack of low income and supported housing as a continued gaps in the community.

Some providers expressed perceived inequalities with who was accessing assistance questioning whether their level of need warranted free resources. Tighter control mechanisms and restrictions were offered as a solution.

Describing service provision in the community one respondent offered "many of the organisations, they are only doing their own business" and offering the benefits of working better together.

Many described the negative attitudes shown in the community towards people who are homeless or as one provider stated generosity seen at times towards others "only if they behave the way we think they should".

Some providers were open and accepted the invitation to further involvement in future project activities and some proactively work to raise awareness in the community.

Critical Observations

The lack of available housing both market and supported was consistently raised as the most significant challenge for the community and on the ability of service and housing providers to delivery best practices.

The increase in Pidcock House shelter use and in the use of the women's transitional facility is suggestive of a growing but not clearly defined need. Information may be available to clarify the numbers of shelter users who use the Pidcock House

shelter and Lilli House as a limited emergency response as opposed to community members using the shelter repeatedly because this is not other suitable alternative. This information was not available for this report.

The Pidcock House shelter is seeing added pressure because of the lack of permanent and supported housing. It is acknowledged through the community that as an emergency shelter it is not designed or intended to be permanent housing. It is recognised by Pidcock House shelter staff and professionals that the current facility is inadequate for families and, for varying reasons, for many individuals experiencing multiple barriers and challenges that keep them homeless.

Feedback from service users confirms that there is likely a significant population of 'hidden homeless' as suggested in research.

Respondent's feedback reiterated varies types of supportive housing as a continued gap.

Private housing providers are working to manage tenants with high needs and multiple challenges without the knowledge, experience, and support of health and social professionals.

3.1.5 Housing Practices

Housing providers policies and practices directly impact access to housing and client's interactions with the homeless serving system and outcomes.

Exclusionary practices

Withdrawal of, or limiting service based on personalities, personal relationships and presenting behaviours or known behavioural, substance use or criminal history were described by practitioners.

'Blacklisting' of clients by services and doctors 'firing' patients and other doctors being informed of this and subsequently refusing to take these clients on. GPs have not been consulted in this process to confirm or deny however this practice has been described in other communities.

Pidcock House shelter staff indicated that there are 3 people on permanent restrictions stating that due to mental health concerns these individuals require supported housing and a level of care the Shelter is not in a position to offer.

Stay periods

CVTS Lilli House

- ☐ 30 day stay policy however practice is that women actively working to get housing can stay. The perceived 'overstaying' of individuals adding to capacity and resulting in the turn away of others was raised as a barrier by referrers.
- ☐ Policy of allowing only one overnight in two weeks staff perceive as a barrier to clients accessing their social support networks and their reintegration back to the community.
- ☐ Concerns were raised about open door policy accepting women without prior knowledge of history or presenting behaviours.

Pidcock House

- ☐ 5 days regularly maximum stay.
- ☐ Up to 30 days stay with discussions with the Case Worker however guests must then leave for a period of 30 days before accessing the shelter again.
- ☐ Referred to Campbell River or Nanaimo shelters as alternatives. It is acknowledged this is difficult for many due to lack of transport, the duration of the bus trip particularly as people are often unwell when presenting to the Shelter.

Alcohol & Drugs	CVTS Lilli House ☐ Zero tolerance of substances use or possession in house. ☐ Intoxication is managed as a client's behaviour affects the household however recent use or current inebriation is not a reason for denying access or exclusion. ☐ Violence is strictly unacceptable. ☐ Sharing of the house with addictions beds is necessary due to lack of resources but is 'not ideal' according to Addictions and hospital staff D2D units ☐ With limited resources, it is preferred clients are maintaining sobriety and do not have active addictions. ☐ Landlord restrictions written into leasing agreements include no drug use. ☐ Property managers are pleased with D2D's management of the leased units acknowledging improvements over the course of the program and noting that they have not had any complaints in over a year. ☐ Shared housing arrangements have been a challenge for some clients. Pidcock House Shelter ☐ High barrier program with restrictions on clients who have active addictions or 'high risk' of addictions. ☐ Individuals presenting inebriated are asked to for a walk and come back unless there are concerns for their safety in doing so. ☐ No paraphernalia are allowed on site including those provided through harm minimisation programs. ☐ High barrier programming presents challenges for clients and staff.
Service User feedback	☐ Refusals of service were indicated as an experience of service users during interviews. ☐ Drugs, intoxication and previous aggressive behaviours were noted in addition to the statement that mental health issues and crying in a clinic were also reasons for service refusal. ☐ Negative assumptions and expectations about use were including in service users votes for what service providers should cease.

Critical Observations

Many providers and practitioners acknowledge the challenges in policies and practices and the value of alternative evidence-based approaches. Due to the limited options however they describe making decisions with the knowledge, experience they have and the resources available that best fits the majority of people.

Housing practices were the subject of many negative statements by professionals and confirmed by service users feedback as unhelpful and damaging at times.

Without access to reliable client data and organisational records it is not possible to quantify the extent of exclusionary practices.

3.1.6 Supportive and Specialist Services

A broad range of services are required to provide for the needs of community members including those experiencing housing and homelessness concerns. Health, employment services, financial support, recreation, safety services etc. are necessary to complement housing specific services in the systems of care.

A brief mapping exercise together with interviews provides basic information however qualifying the scope and nature of services outside of the CVCCIC partnership is outside the scope of this project.

Support services & activities

A basic services audit conducted through AHERO provides a rudimentary analysis of available services and information to assist confirming perceived gaps. Details of results can be found in Appendix E.

Case management activities are listed as occurring in 7-20 organisations.

Specific Activity	Number of organisations
Intake	16
Triaging/matching	12
Assessment	16
Planning	14
Referral and Linking	20
Advocacy	18
Monitoring and evaluation	17
Transition	13
Discharge	11
Coordination of Supports	17
Key-working of Services	7

Number of organisations listed as providing outreaching and assertive engagement:

Housing specific outreach	
Outreach/assertive engagement	8
In-Reach/Drop-in	10
General outreach	
Street Outreach	11
Home outreach	12
Community outreach	18

Ten services are listed as providing tenant support.

Interventions such as mental health, addictions treatment, supportive counselling, recreation activities and social inclusion activities are offered by 11 – 16 organisations.

The majority of services continue to operate on Monday-Friday, 9-5. Public Health, AVI, Coastline, CVMHAS, Legal Aid, CLBC, CVTS and the Salvation Army were listed as providing afterhours or 24 hour access to services.

One organisation is listed as conducting consumer engagement.

Eight services identified they transport clients and four organisations indicated they have vehicles to transport clients with organisations listed as being able to provide assistance with bus or taxi.

Service user feedback

Service users participated in activities to examine if previously identified needs and gaps in support services continue. Summary of results can be found in Appendix F.

Place to go during the day or when time runs out at shelter, helping to connect to medical/dental/health, services coordination and system managing/on-line access continue to be perceived as gaps.

Disparity between services needed but not being available highlighted these gaps and confirmed that transport and affordable housing are also perceived gaps.

The highest need overall was medical & dental services.

A place to go during the day or when time runs out at the shelter was ranked highest as a gap in the community however did not present high on service needs when compared to other needs.

Transportation was also significant need and listed as a gap and demonstrated the greatest discrepancy.

Outreach worker/advocate was also a high need however was also listed as a service that is currently used and therefore would not be considered a gap.

Housing provider's feedback.

Supports and needs of the clients in housing providers experience were:

- ☐ Day programs
- ☐ Job programs
- ☐ Life skill programs
- ☐ Drop in center
- ☐ Addictions services
- ☐ Support groups
- ☐ Transport
- ☐ Continuity of care with case management
- ☐ Frustrations from family members attempting to access senior units due to wait lists

Critical Observations

A variety of support services are present in the community.

A significant number of services are currently conducting case management activities however continuity of care is services coordination is listed as a gap.

Whilst perceived gaps may be ranked more common, service user feedback demonstrates it is important to gather information to determine of services listed as gaps which should be prioritised because they are considered of higher need.

3. 2 PROCESSES OF THE SYSTEM

3.2.1 Access

Access to the system including housing services, support and specialist services and mainstream services should be clear, easy and efficient moving people quickly to help and support they require. Service models, eligibility criteria, participation requirements all affect a community members access to services. Common barriers are addressed in the following section 3.2.2.

Limited data is currently available to detail access to the system. More information may be available through sources such as The Salvation Army, HOP program as provided to BC Housing and from Care-A-Van and VIHA.

Referrals to Partners

	SOURCES	*INCOMING*	*RESPONSE TIME*	*OUTCOMES/NOTES*
AVI	AVI drop in, Harm Reduction Services & Cold Weather Outreach	10+ people/mth consistently have housing issues.	Information not available.	Referrals to HOP, Lilli House, SA Shelter, Dawn to Dawn, provide emergency supplies (i.e. tents, sleeping bags)
CVTS CF	Internal CVTS Drop in	4 women/ mth consistently have housing issues.	Information not available.	Safety assessments, goal setting & planning and referrals. Stats not separated from non-housing clients.
CVTS Lilli House	HOP, AVI, Mental health Legal Aid Duty counsel	1440 calls Word of mouth. 76 women contacted but not admitted. 36 cases - the facility was full. 5 cases MH or A&D issues were present. 2 cases homelessness was the primary concern. 30 did not show.	Information not available.	Follow up phone calls with women asked by CVTS but not always safe to do so.
WFC HOP	Partner agencies Nursing center, St Joseph's SW team, MH, Addictions		Information not available.	Housed 41 clients April– October 2012, with 81.08% remaining housed.
D2D	AVI & CVTS referrals, word of mouth with clients and practitioners advised.	23 clients currently.	Information not available.	Referrals to counselling services, rehabilitation, training and other social and health services.

Practitioner feedback

Referrals not accepted to their own service:

- Don't meet funder determined program requirements e.g. Financial, health diagnosis.
- Safety issues, sexual advances, escalating potential violent behaviour
- Lack of sobriety
- No space available in units

Service user feedback

16 of 19 interview respondents indicated referrals had been made in their care including between partner agencies and a range of community partners.

Mental health referrals were most common.

Referrals were mostly satisfactory with an average score of just over 7 out of 10 with comments on the positive side indicating ease, communication, speed and helpfulness to the client.

Expressed negative experiences:

- Lack of communication
- Transportation difficulties
- Confidentiality challenges
- Paperwork getting lost
- Making decisions without the client.

Top three most common access challenges:

- Wait times
- Complexity of application process
- The way staff treat clients

8 of 19 respondents had been refused service for one (5 respondents) or more reasons (3 respondents). The number one reason was not qualifying for the service. One comment was of staff making personal judgements about service eligibility.

Community Partners

CVMHAS staff describes significant capacity issues and gave the example of 30 new referrals in the 4 days prior to the meeting. Contacts are triaged with the intake team and information about housing services including HOP and Salvation Army provided if appropriate. If an intake appointment is considered appropriate, the approximate wait is 3 weeks currently. Staff estimated 80% are referred to addictions or seen in less than 5 sessions.

CVMHAS intake team approximated that a significant number of people present initially to their service experiencing stress due to social indicators including housing rather than significant and eligible mental health concerns that general support services would be more appropriate for. Due to limited resources in the community however they are referred by other services to CVMHAS.

Confirming the extent of this and its impact on clients and services would be helpful and require additional data analysis.

CVMHAS staff acknowledges there are community members who are homeless or in precarious housing situations that likely fit their mandate of severe and persistent mental health illness but who would not wish to see VIHA staff for a range of reasons including the stigma of attendance and the institutional building.

MSD was unable to provide any data presently however opportunities to expand data collection exist and staff expressed openness to explore this.

Critical Observations

Accurate counts of people accessing the system and movement or referrals between components of the system are difficult without documentation and tracking of unique individuals across the system and accurate service utilization data.

The partner agencies are well known and appear well utilised within the community according to network mapping and conversations. However the collection of meaningful contact data is limited. Connections are not made between presenting issues and referrals out decreasing the meaningfulness of the data. This is a well-documented experience of communities usually attributed to funder requirements focusing on output collection not outcomes.

Response time is not currently being accurately recorded by any partner. Documenting time from first contact to outcomes enables accurate measure of the efficiency in the system and a measure of success for access to services and rapid rehousing.

Bottle necking of clients with housing concerns may be occurring at CVMHAS intake and should be further investigated.

3.2.2 Systemic barriers & overcoming mechanisms

Systemic barriers in accessing homelessness services can occur in three main categories as defined below. Overcoming barriers is a frequent strategy in ending homelessness. Practitioners and services use a number of mechanisms in attempts to overcome barriers (Burt et al. 2010).

- **Structural barriers -** system interactions between services, identification and documentation requirements, transportation, discrimination. **Smoothing mechanisms** reduce structural barriers and address problems at the street level.
- **Capacity barriers** include insufficient supply to meet demand for services, insufficient value of benefits and services and delayed availability. **Expanding mechanisms** address capacity barriers.
- **Eligibility barriers** such as meeting program eligibility or participation criteria are often additional challenges faced due to lack of stable housing and complex needs. **Changing mechanisms** alter eligibility but not overall capacity

Below is a list of key systemic barriers presently in the Comox Valley and the mechanisms used to efforts to overcome them.

Structural barriers

The application process to complete PWD. People have to 'jump through a million hurdles'. Online accessibility offers multiple access points, however staff acknowledge this is challenging for some. Changes to staff and changes such as intakes going through the Duncan office creates delays.

It is acknowledged by respondents that the look, feel and perceptions of mainstream health and social service buildings do act as barriers as does the social stigma to attending these services. Mental health offices were offered numerous times as an example.

Site based services only such as mental health present a challenge for some clients.

Smoothing mechanisms include:

- AVI Outreach service & drop-ins
- One Stop Shop
- Meal programs
- Co-locating services

- CVTS drop in
- HOP slot with MSD
- Providing taxi-chits, bus vouchers.

Capacity barriers

HOP role is heavily referred to as indicated by interviews and network mapping exercise. An analysis of referrals in, presenting needs and appropriateness may reveal this role has become a catch-all intake for housing queries.

Concerns about meeting needs have led to a few respondents choosing not to make resources publically known, "If more people knew and referred, then we'd have to disappoint people".

Staff cannot leave offices to attend professional development or networking meetings.

Care-A-Van coordinator Helen Boyd states the shortage of physicians in the Valley is a barrier to accessing health services.

Shortage of detox and supportive recovery for women.

Waitlists for mental health and addictions services.

Expanding mechanisms include:

- Extending the hours of Pidcock House shelter
- Awarding D2D VIHA grant

Eligibility barriers

Services trying to 'fit marginalised (people) into systems that are locked down by rules and policies' and people 'can spin wheels for a long time because of all the rules'

D2D mandatory qualification criteria and same gender roommates condition has been offered as excluded women more often because most clients are men. D2D units do not allow pets.

High barrier programming and exclusionary criteria at the Pidcock House shelter.

CVMHAS severe and persistent mental illness criteria.

Personal barriers such as references to get into housing

Client's reputation preceding them, "Everybody knows everybody's business"

Mental health does have housing rehab but the strict eligibility requirements were described by a number of practitioners as a barrier.

Changing mechanisms include:

- Previously a MSD staff member was available who understood processes and the needs of client enabling more efficient and effective responses. This was highly regarded by D2D and VIHA intake team.
- MSD includes a homeless self-identifier which if marked by the application and results in a high priority rating on the application.

Critical Observations

Barriers are present within the Comox Valley that require attention to improve client outcomes.

Practitioners expressed a great deal of frustration observing clients experiences of barriers and it appears to affect job satisfaction and morale.

The service provider community has responded primarily with smoothing mechanisms in attempts to attend to these barriers.

Changing and expanding mechanisms have not be well utilised.

3.2.3 Intake, triage and assessment activities

A consistent and effective way to move clients through the system is essential. Agreement on processes such as screening, referral prioritization and intake to assist services in operating as an integrated collective system of care rather than individual entities is recommended.

Without direct observation and access to clinical files, observations are based only on written documentation and explanations by practitioners.

Intake

Each partner agency conducts its own intake and assessment processes using own tools. There are common elements across the tools such as personal details, status on a range of matters including health, housing, income etc.

AVI records contacts during activities and an intake is conducted for the Positive Wellness Program. The form includes housing as a listed topic that can be discussed.

CVTS are currently in the process of updating intake and assessment procedures for Lilli House in response to an organisational shift to address recent research on the systemic barriers to housing for women leaving violent relationships. Currently CVTS-LH staff conducts a phone intake checklist and proceed to an intake if participant is to be housed at the house. The separation of the intake forms provides useful information on turn-aways.
CVTS-CF uses a brief intake form primarily with contact information and the topics information, support or referrals relate to.

D2D has a 'Prospective Candidate Referral Form' intake and assessment. The form performs several functions providing information, listing conditions of referral and expectations of referring agents support, getting consent for criminal records check, in addition to assessment.

HOP uses the BC Housing Case Planning tools and consent forms as required under contract.

FOI and privacy information forms and consents are discussed during intake and assessment stages.

Triage	Triage is the process of prioritizing resources for clients or matching clients to programs. Practitioners describe triage decisions happen on an individual, case by case basis and recorded in case files if kept. There are no documented protocols. Caseload management primarily occurs on the basis of capacity of practitioner or of the programs. CVTS-CF has consultations with the program manager about case load capacity.
Assessment	AVI – Housing matters are discussed however no formal housing needs assessment is conducted. CVTS-CF - Housing is discussed however formal housing needs assessment is not conducted. CVTS-LH – An intake package, currently under review is comprised of two parts with immediate information gathered followed by the second part within 2-3days. Ms Leadbitter, Transition House Coordinator, did note the process is somewhat dependent on the staff member completing the assessment. D2D - Clients assessments conducted with each referred client. In two bedroom units, sit-down assessment with roommate in the unit offers an opportunity to assess and match between potential roommates. Support needs are included in the referral form along with information that assists in matching clients to the appropriate housing unit. HOP worker uses the BC case management tools including Personal Goal Setting – Enhanced both as an assessment proforma and a documentation tool that is inputted into the BC Housing HMIS.
Community partners	The Salvation Army - BC Housing tools together with a resident screening tool determining what issues a guest would like support with and assistance they may need during their stay. MSD - If citizen self identifies as homeless in their application, this is listed as an immediate need and is prioritised. However there is no fast track system currently utilised except in the case of citizens fleeing abuse which is considered critical and the ministry is in touch within 24 hours. Staff acknowledge limitations to self-identified housing status. CVMHAS - If a client is not accepted to VIHA, intake staff indicate they provide information on HOP or the Pidcock House shelter or phone services. If a client is eligible for VIHA services and move to the ASTAT, safety in the housing situation is assessed, housing options are provided. This procedure is not formalised in writing.

Critical Observations

CVCCIC tools are available to streamline however program specific assessments are still required. All forms have room for improvements including presentation, streamlining and efficiency. Strengths could be shared across the organisations. For example, the question “who else is involved in your care” necessary to explore collaborative case management was not readily observed in the majority of forms with the exception of the Lilli House intake. Practitioners may ask in person.

The BC Housing forms offer the most consistent and specific housing/homelessness data. They are statistics focussed and the practitioner's assessment process would be vital in establishing the necessary therapeutic rapport and relationship.

BC Housing data available on request may offer some insight otherwise case file reviews would be required.

There is no standardised assessment currently being used which includes measuring acuity. Self-reporting, subjective assessment and narratives are heavily relied upon.

Duplication of effort is likely occurring for clients moving between agencies and clients confirm they are required to retell details and stories increasing risk of re-traumatization.

Conversations and the mapping exercise indicate that organisations understand some terms differently.

3.2.4 Case management

The best practice review offers case management has both an essential component and process of the homeless-servicing system. Case management activities once a client is accepted into the system are difficult to assess without permissions to complete case file reviews or direct of observations of practice. [See also Professional Development].

Without access to clinical files it is difficult to make an accurate assessment as to the depth of case management provided and to its sufficiency.

Case Planning	AVI – no formal case planning however there are policies referring to case management activities. Record keeping occurs through case files based on practitioner's decisions on the relevance of information included. Contact with professionals, advocacy, arbitrations with residential tenancy board, legal matters and health matters are documented. CVTS-CF – role does not include ongoing case management however monthly reports indicate case management activities are conducted including assessments, planning and goal setting, case consultation and referrals. CVTS-LH – case planning is conducted utilising BC Housing guidelines. D2D - 'Living With a Room Mate Guidelines' and a 'Independence Work Plan' according to their policies. "The Residential Program Worker will establish with each new Resident, within 60 days of moving in, a personalized Independence Program that will assist each as they move towards their own level of independence." A tracking sheet was reported as utilised to document activities with clients. HOP - utilises BC Case Planning tools. All HOP funded programs are required to follow-up with clients at six months after a client is housed. After this period, follow-up is generally left up to the client who can maintain contact with the outreach program as long as necessary either by phone or in person.
Partnership	Varying activities and processes of case management occur at all partner organisations. It is clear that practitioners are sharing clients however consents would be required to determine scope and nature of this practice and the implications on case management process and use of partner resources. Numerous practitioners offered "there's no follow-up" providing a range of case examples including

	highlighting the limitations and restrictions of services, the cessation of contact or efforts to engage or contact clients despite client's known physical or psychological challenges or barriers, and limited or no communication between services. There is no written protocol on referral follow up. Staff advise follow up does occur at times based on capacity and colleague relationships. It was observed that practitioners expressed some hesitation of how 'assertive' to be with clients for fear of being perceived as coercive.
Community partners	The AHERO Service Audit determined that between 11-16 organisations are conducting case management activities with varying levels and intensity of case management described by practitioners. Breaks or gaps in continuity of care in community organisations were offered as challenging and unhelpful experiences. CVMHAS's general approach was described as 'The door is always open' however client's make the choice to stay actively involved for the most part without proactive outreach if client's withdraw contact. Assertive engagement in the community settings or when a client disengages from services is not provided. VIHA have an IT case management system, Cerner, which assists case management across VIHA services. Input into the system by staff is still required and psychiatric notes for example must be sent to Victoria for inputting delaying the availability of some information. MSD have moved to a model of sharing case management responsibilities across teams. The 'Integrated Case Management' is a new computer system that was established to assist with this. Staff have recognised it is currently presenting some challenges. Integrated Case Management was also a program in the youth sector that required a 'structured' approach among service providers; including joint decision-making, development and implementation and monitoring of a 'single' service plan. It was developed for complex and longer term cases. The program is no longer funded however some staff at CV Family Services are trained in the approach. Numerous respondents expressed the need for an ACT team as a solution for the current state of system for homeless clients. ACT teams criteria include individuals with severe and persistent mental illness only. Communities with ACT teams have expressed varying responses to how well ACT teams collaborate with the NGO service providers in the community. John Fitzgerald indicated that Comox Valley is high, if not next, on the list for an ACT team and it is most likely to happen before or with the completion of the new hospital 2017.
Case consultations	Case consultation meetings have been suggested, conducted or attempted in past. Practitioners have described successes previously working together across agencies. Personnel changes appear to be the primary reason meetings cease. Practitioners do have clinical conversations with each other when consented. In addition they regularly speak in generalities about clients without using names if opportunities are taken or present. All practitioners are indicated conducting case consultations is helpful and provides the opportunity to "collaborate between organisation and support an outcome" for clients and results in "less work for us and more success for the clients".
Discharges	Discharge summaries are completed by HOP, D2D and CVTS-LH.

Critical Observations

An accurate assessment of practice and effectiveness of case management planning, interventions and discharges is not possible at this time due to limited information.

Some case planning across organisations is occurring on a case-by-case basis dependent on the practitioners. Written protocols are limited.

Practitioners are challenged by perceived privacy limitations when sharing information outside of their agency. Opportunities for consented, regular and effective case consultation are appear inadequate given the nature of the work conducted.

'Enhanced' case management specifically targeting homeless individuals or families across the community is not occurring in any formal way and there is no organisation currently funded for this responsibility. An ACT team may be some years away and will attend only to engaged community members eligible for the ACT service criteria.

Models of enhanced case management exist and key partners in the community have expertise and systems to learn from and to explore integration that may assist in achieving a comprehensive community-wide case management of vulnerable individuals and families.

3.2.5 Human Resources

Experienced, diverse, client centred staff at varying levels of clinical expertise is essential as determined by Best practice review.

Structures	AVI and CVTS roles sit within team structures with direct supervision on a daily basis through a defined organisational management structure. HOP and D2D are sole practitioners reporting to ED and a Board Director respectively and mostly function as isolated workers with irregular contact with supervisors described.

Full time equivalents

	ROLE	FTE	% HLN	TASKS	LOCATED
AVI	Program Wellness coordinator Harm Reduction worker Community Outreach worker	1 0.5 0.25	25% 25% 100%	Assessment, support, harm minimisation, needle exchange, information, advocacy, Referrals. Housing search, outreach.	AVI office & street outreach.
CVTS-CF	Community Facilitator	1	0-25%	Intake, safety assessment, goal setting, referrals, counselling, information, advocacy, drop-in, accompaniment.	CVTS office
CVTS-LH	Coordinator, House Staff	8 9 casual staff.	100	Intake, safety assessment, orientation, goal setting, referrals, tenant mediation, program delivery, information, advocacy,	CVTS Lilli House
WFC HOP	Homeless Outreach Program Worker	1	100	Outreach, Housing advice, housing searches, tenant education, Futures Committee, hosting Front Line Workers group	WFC office
D2D	Residential Program Worker	.75	100	Landlord recruitment, tenant education, support, recreational & social inclusion, life skills, referrals, advocacy.	Home office

Competencies

Partnership staff have broad range of skills related to housing, social and general supports with varying documentation of job requirements and expectations noted across the partnership.

Competencies are unable to be assessed without direct observation or access to client files or measured outcomes.

Formal qualifications include counselling & social work degrees. Important soft skills including active communication skills, lived experience, capacity to relate to clients, street-wise respect, compassion, hope and the desire for continued learning were clearly offered.

Self-reported underutilised skills and experiences currently included counselling skills, training and group facilitation skills.

Staff perceptions

Lack of staff capacity was strongly emphasised throughout scoping activities. Two practitioners offered areas where enough resources were available presently; support from management and running fixed harm reduction services.

Inadequate capacity impacts practitioners in a variety of way. Practitioners described scenarios of going beyond the expectations of their roles and the resources available resulting in volunteering their time, after hours work, overtime, negative perceptions of their availability and/or job performance, and requests and pressure to compromise their professional and ethical boundaries.

Best recent changes in organisations:

- ☐ Increasing capacity
- ☐ Providing stability at the governance level and
- ☐ Working with other agencies to review collaboration and make improvements

Improvements suggested:

- ☐ Increasing capacity
- ☐ Improved referral process,
- ☐ Clarity around services provided and
- ☐ Improving understanding of working where clients are at with their level of engagement, participation and preferences.

Critical Observations

Capacity issues were evident and described in each organisation. Resources, time, additional staff, additional hours and extended programing were specifically listed. Negative impacts were disclosed, observed and also identified by practitioners from community organisations.

Elements of evidence based practices are described to varying degrees across the partners including client-centered approaches, harm reduction, low barrier, emphasizing choice, proactivity, and connecting where people are at.

Staff appear proud of their organisations' accomplishments, understand capacity challenges and suggested improvements were very relevant and aligned with best practices.

3.2.6 Professional Development & Self Care

Involvement, recruitment, training and retention through incentives, professional support and development to ensure skilled, diverse, supported and listened-to staff are often listed as critical by leading communities.

Performance Management

Varying processes are in place for monitoring and evaluation of job performance with larger organisations have more formal and regular activities including orientations, staged and annual reviews.

Training

Training is irregular and varies considerably across the partners. No formal training plans, budgets or completed needs assessments were available. WFC, AVI and CVTS have increased accessed to training opportunities through provincial programs, team structures and conferences.

Helpful prior training

- ☐ Motivational interviewing
- ☐ Chronic illness
- ☐ Poverty
- ☐ Drug use
- ☐ Violence against women
- ☐ Advocacy
- ☐ Law & legislation
- ☐ HIV, AIDS/HepC
- ☐ Women leadership
- ☐ Self-Care
- ☐ MSD applications and programs

Beneficial additional training

- ☐ Residential tenancy advocacy skills
- ☐ Community based harm reduction housing training
- ☐ Relapse prevention
- ☐ Suicide prevention
- ☐ At team of support for the agencies who work with homeless clients
- ☐ External advisory to team for interagency case conferences

Training for broader community

For homelessness and housing information, staff in community services rely on the HOP role and written material, on the job experiences and peer discussions.

Housing providers expressed the desire for additional information and support for attended to their residents.

Formal opportunities such as workshops, teleconference and annual conferences were noted for other non-housing information. Informal opportunities for learning occur through practitioner contact and at forums including AHERO and the Frontline Workers meetings and workshops held by various organisations.

Suggested training for community by CVCCIC practitioners

- ☐ Harm reduction housing education
- ☐ Motivational interviewing
- ☐ Joining medical and enforcement agencies together with front line service staff for up-skilling and planning
- ☐ Education in referral processes and service provision
- ☐ Law and legislation including Residential Tenancy Act
- ☐ Understanding about presenting behaviours
- ☐ Challenges of people with cognitive impairments and the barriers they present

Professional Supervision

Professional supervision is available at varying regularity through both team meeting structures and on a one-to-one basis. General peer supervision occurs at CVTS and AVI through the team and management structures. AVI policy encourages peer support.

Informal peer consultation occurs on an as-needed basis as determined by practitioners. Case consultation either for active or presenting cases may occur on an ad-hoc basis however there is no formal structure or consistency.

Self-care	Symptoms of cumulative stress (burn out) were observed in a number of practitioners and organisations during investigations and expressed directly by staff. Pressures are observable, disclosed by practitioners as creating strained relationships and diminished job satisfaction and have been expressed by other practitioners.

Critical Observations

Training needs are well described by practitioners and access to training specific to homelessness and current best practice housing practices is inconsistent. Isolated roles described as needed more direct support and assessed as requiring more professional supervision.

Given the current state of the system, described experiences, winter deaths and practitioners working beyond capacity it is highly probable that practitioners are suffering from burn out, compassion fatigue and vicarious traumatization.

Homeless serving practitioners provided a comprehensive list of information and training needs for the community. There is a wealth of experience within the partnership group and the wider community to act as assets in up-skilling practitioners and the community.

3.2.7 Information Collection & Sharing

Information is essential in strategic planning, integration, monitoring and evaluation and in the provision of evidence based practices. Information management systems and sharing protocols for client information and outcomes are critical.

Gathering information to understand the client base, service use and the effectiveness of programs and interventions was very challenging during the course of this investigation.

Collection Tools and Systems

	SYSTEM	*INFORMATION TYPE*	*REPORTING FREQUENCY*	*PUBLIC*
AVI	Paper	Stats, contacts & length, referrals, A&D, MH, Health-care; new diagnosis); Office, Drop-in numbers, needle exchange, numbers of materials, referrals, client files, program evaluations.	1/4ly to VIHA Monthly to board, 1/4ly - Annual reports to funders.	Annual reports
CVTS CF	Paper	Stats and trends	Monthly	Annual
CVTS LH	BC Housing + internal	Comprehensive – client info, activities and outcomes.	Monthly	Annual- AGM
HOP	BC Housing + internal	Comprehensive – client info, activities and outcomes.	Monthly	Info can be requested.
D2D	Paper	Tracking sheet	Monthly	Public AGM

Community partners

Shelter, the Food Bank, Care-A-Van, Community Nurse, JHS Youth Outreach, CV MHAS, MSD, and MCFD all collect data through varying mechanisms that could contribute to defining the numbers and needs of members of the CV community.

A homeless count indicator listed in the CVRD sustainability plan and the completion of the Quality of life report are opportunities to assist in forming a data collection system to contribute in the development of a community wide information system. Additionally, BC Housing and VIHA have well-resourced information systems. Victoria and Nanaimo communities use these statistics in reporting with additional data collected locally to complement it.

Service Directories

There are 6 resource directories available in various formats.

- Comox Valley Community Services Directory
- Vancouver Island Crisis Line Online Community Resource Database
- HealthLink BC
- Comox Valley Resource Guide
- Valley Links
- Comox Valley Drug and Alcohol Services Directory

The Comox Valley Resource Guide is the most used print directory. Valley Links, and the VIHA web-based system HealthLink BC, are well used with some limitations and navigational challenges noted by practitioners. The monthly CV Resource Guide is widely and well referenced by clients.

Client information

All services have policies and consent forms. Some partners additional have information sheets about client's rights, confidentiality and the FOI Act. Consent for release of information forms are of varying quality.

There is no community wide information sharing system. All agencies collect data to varying depths, through various means and at varying reporting frequencies.

Most practitioners expressed the desire for increasing information sharing. Numerous examples were offered when the perceived inability to share information put clients or staff at risk or lead to diminished outcomes for the client. Information and the status of clients considered 'dangerous' has not been shared in the past and practitioners have felt this has put their safety at risk.

Services offer varying need in sharing information. CVTS maintains stricter limits on sharing information due to the security risks of the clientele.

Discrepancies in how staff in various agencies are interpreting and practicing under the privacy legislation were apparent and expressed as a source of frustration among some service providers. Resources such as VIHA and The Division of Family Practice are available in the community to access to clarify the parameters of information sharing and on helpful protocols and practices.

Organisational & practice information

Several staff members and housing providers expressed frustration at what they perceived as dishonest communication.

Reliance on third party accounts was observed and offered as the source of unnecessary conflict and recognised as poor practice. Practitioners and housing providers appreciated when other professionals contacted them directly to follow up on any concerns or questions.

	A number of service users described instances where the disconnect in communication between services is used by clients to access what others perceive as inequitable resources.
Monitoring & Evaluation	Partner agencies vary in how they collect and report program and service outcomes. Those programs attached to BC Housing have the most extensive collection. BC Housing do not produce local specific analyses of results except through specific requests. Limitations to BC Housing data are documented by leading communities who are using local systems to complement the data collection. The United Way are moving to outcome-based reporting and is currently conducting training in new methods for organisations who receive these funds.
Community knowledge	2008 was the last homeless population count in Comox Valley as reported in Homeless! Many practitioners in the community had not seen the previous reports completed on homelessness and housing. There is not an organisation or coordinating body currently responsible for recording the impact of homelessness to our community members or responding to new information such as population changes, changing characteristics and deaths. Services share information occasionally at the AHERO forum. There is not a Safer Communities Committee and the Community Drug Strategy Committee currently focuses on producing a directory, annual presentations and prevention activities with schools. BC Housing information related to the community is available through the local programs or by request.

Critical Observations

Most partners are collecting information, appear comfortable with using information collection systems and understand the need for it. Systems are based on funders requirements yielding some helpful information however improvements would be essential to delivery data to achieve evidence-based responsiveness.

Valid concerns about the sharing of information and the use of cross-agency case management for women considered at high risk of violence should be attended to and accounted for in the development of any information sharing processes particularly given the smaller population of the community.

Reliance on paper as oppose to digital information systems impedes evidence based planning and practice and significantly impedes the responsiveness of the system if aiming to move people as quickly as possible from homelessness to housing.

The lack of sharing of client information was the source of significant expressions of frustration during interviews. Practitioners are clear on its usefulness. However without appropriate information sharing mechanisms in place and varying comprehension of the scope of the privacy laws, practitioners lack confidence and behave cautiously. This is causing inefficiencies and challenges in delivering effective interventions across services.

In organisational related information, there is a lack of clarity around roles, responsibilities, mandates and practices to varying degrees across the community. This appeared in part to be an effect of changing funding requirements for services and roles. The heavy reliance of client's accounts of service provision is a barrier and source of frustration with a possible impact on service provision.

3.2.8 Integration & Coordination

Integration at all levels and in between all levels is vital to maximise synergies & economies of scale, attend to structural barriers, gaps, confusion and provide continuity of care.

Networking Forums	AHERO is well attended and commended as an information sharing forum with attendance from providers across organisational levels. During a meeting, attendees listed 57 organisations/services considered AHERO partners. Improvement offered included reducing the experience of a 'regurgitation' of information that could be accessed in a different format and that the time more often could be spent discussing more pressing matters. Admin Network is a group of executive directors from a variety of services which offers peer support. Strategic operational and contractual arrangements are discussed and included is a sub-committee focused on shared resources. Frontline workers meetings are highly value. Improvements offered including having more time, meeting more frequently, discussing self-care, and having consent to discuss clients would add value to the meetings. Some staff attending the meeting indicated they do so as part of their lunch break as they organisation will not support the hour.
Working relationships	Most practitioners described good working relationships they value highly and frequently commenting on how hard staff are working across the community. During a mapping exercise, AHERO attendees described the presence and relative strengths of their current working relationships. A clear theme emerged that relationships with all levels of government, municipal, provincial and federal and relationships with housing providers, developers and philanthropists were considered absent and the most desired. Capacity pressures, lack of communication, misinformation and different organisational philosophies, priorities and practices are reported and observed as sources of tension. Disagreements between practitioners and service providers have been described as impacting on communications about clients and service provision.
Case consultation	Case consultation between services occurs between agencies to a limited degree. There are no written protocols established however practitioners make arrangements on a case-by-case basis. It was expressed and observed that practitioner do feel limited by privacy legislations and more opportunities to discuss client matters were preferred with the recognition that this would serve the clients better.
Coordination	Lack of coordination between services was repeatedly stressed and was related to the provision of both services and resources, in addition to the competitive environment presently. A structure to oversee and coordinate service provision across the community was offered as a solution. "Leadership that is separate from any one agency", someone to "take care of the messy parts of all of this that practitioners have to do right now' offering care and consistency of work, ownership of clients and joint funding proposals as some suggested starting initiatives. Recommendation of a housing registry from the Homeless! report has not be activated as yet.

Co-working, co-location & joint training.

Practitioners sharing responsibility for clients in either a team or joint project capacity does not appear to occurring in any regularity.

One Stop Friday are highly regarded. Six organisations indicated they are co-located with others through the AHERO services audit. The Resource Fair provides the opportunity to co-work on non-case related activities.

Drop in center continues to be a stated gap in the community by service providers, housing providers and service users.

Some practitioners do share information with each other about training opportunities through working relationships and have attended sessions together.

Critical Observations

Coordination happens between individual practitioners and on a service to service level to varying degrees.

Coordination between services and across the community is lacking as evidenced by duplication of effort and services, cessation of services without collaborative planning, reports of 'double dipping', expressed surprise at media release or information presented. This is causing interruptions in care and likely affecting client outcomes.

The advantages of the smaller rural community are evident with practitioners utilising personal relationships and direct communications most frequently in achieving positive outcomes.

Networking and direct connections between practitioners appear to offer the best opportunities to strengthen integration. Integration through formalised co-working, co-location and service structures are currently the weakest. Success of one-stop, resource fair, AHERO and positive working relationships offer experiences and opportunities to build on.

Conversely the dependency on personnel in the absence of protocol was evident. Changes in agency staff resulted in changes to depth of communication, attendance at in-reach opportunities and practice and hindered practitioner's ability to attend to client's needs.

3.2.9 Funding

Funding allocation is strategic, predictable, transparent, accountable and encourages cooperation.

Project partners

	FUNDER	*$ Value*	*REGULARITY*	*RENEWAL*
AVI	VIHA, Health Canada, Private donations.	$1000 – outreach.	Multi- year	
CVTS CF	Thrift store.	1FTE	Multi-year	
CVTS Lilli House	BC Housing	500000	Multi-year	
HOP	BC Housing		Multi-year	2014
D2D	VIHA, Private donations	190000	Yearly	

Competition	Competitive funding environment was evident and described by many respondents, A provider described 'territorialism' with another stating this led to 'hoarding' of clients, not making referrals or not sharing information for fear of losing clients' as it 'affects the count'. Limited collaborative dialoguing or decision making is occurring with projects, funding proposals and media communication are more often presented by solo organisations without warning or dialogue and as a result surprising others. A small number of respondents described concerns of inequitable access to services with current clients of services receiving preferential access to additional services, to PWD application processes and to new resources becoming available.
Capacity	Throughout scoping activities capacity was consistently described as a primary challenge of service provision. Practitioners describe there is no time to be strategic with responses to emergencies taking priority over the opportunity to be plan ahead including get funding in time to pre-empt future challenges. CVMHAS staff noted the challenges of inconsistent funding. Staff describing having resources available for temporary rental subsidies for clients and then having to withdraw them due to funding cuts. Similarly the lack of 'flow through' funding was challenging with the suggestion that VIHA funds and BC Housing funds be joined up to deliver consistent support to clients based on their needs not the limits of service responsibilities.
Partnerships & Leveraging	It is understood that partnerships and organisations providing letters of support have been successful in past funding applications for example acquiring the BC Housing HOP role. AVI currently isolates funds for their outreach roles from the organisations general funding. Private donations including financial and supplies such as tents and blankets are variable. Historical funding partnership information or failed application information have not been provided for assessment. Housing specialist services appear primarily based on single sources of funding rather than leveraging. Homeless Partnering Strategy has not been made available in the community. CVRD holds a fund for housing and homelessness however has no mechanism to disperse the funds presently.

Critical Observations

Capacity challenges are evident across service providers. More information on the needs of the community would be required to determine what volume of funding would be required to meet all needs.

AVI currently operates outreach and drop-in services without any funding specific to homelessness.

Coordinated and transparent funding allocations were offered as a need. The competitive funding culture is described frequently by service providers and listed as the cause of the lack of trust within the non-government service provider community.

Strategic planning over the longer term across the community is absent and leveraging partnership dollars and utilising economies of scale with cooperative efforts between organisation appears limited.

Section 4 – IMPLEMENTATION & SUSTAINABILITY

The best practice review identified factors which leading communities have offered may facilitate or act as barriers to providing effective service delivery in responding to homelessness. Presented below is information gathered through the scoping activities related to factors affecting implementation and sustainability of the projects objectives.

4.1 SUSTAINING AND SUPPORTING FACTORS

4.1.1 Consumer engagement and participation

Engagement Activities	Engagement activities with service users specifically focussed at service and program design and development currently occurs in an ad-hoc, one to one basis between service staff and clients. Partners rely primarily on direct suggestions from clients for service improvements. The Pidcock House Emergency Shelter has a guest survey related to determining what services they received and providing the opportunity to make comments and suggestions.
Social Enterprise	Comox Valley Transition Society currently offers opportunities for the service to generate income and support employment opportunities for clients through their Too Good To Be Threw Thrift Shop.
Consumer feedback	Results of the service user engagement activities are detailed in Appendix F. In asking service users for their preferences for formats for engagement, most offered were lunch or dinner with talking stood out followed by meet with us and our workers together. People with lived experiences and using the local services appreciate client-centred, harm reduction and low barrier approaches, the proactivity of access and case management, and streamline processes. Client reports see value in self-care for staff, strategic funding and clarity in roles and responsibilities. Forty service users participated in an engagement exercise to determine that specific actions or activities they desired service providers to keep doing, stop doing and start doing. Most common results reported:- Keep doing? ☐ Working together to advocate when I face barriers ☐ Treat us as individuals ☐ Arranging referrals before we arrive at the referral Stop doing? ☐ Making negative assumptions about me ☐ Expecting us to stop drinking/using to see you ☐ Making us tell our story over and over again ☐ Letting staff burn-out Start doing? ☐ Have a drop-in where we can access all the services ☐ Join your money together to do bigger projects ☐ Be clearer about who does what

4.1.2 Partnerships Opportunities

Key partners consulted have indicated interest in being involved in further discussions in planning more integrated service delivery and identifying opportunities for partnerships in coordination, programming and strategic planning for increasing capacity and housing.

Funders

- VIHA

VIHA goals include trying to keep and maintain stable housing for the people they serve. VIHA acts as both a funder and provider for services and housing specifically related to the populations they serve. Opportunities to achieve this are always sought and consideration of funding cycles is important.

VIHA has increased funding to Valley each year for the past four years.

In 2008 the VIHA Comox Valley Mental Health and Addictions Services put forward 'Reducing Homelessness: Proposals for Housing and Support Services in the Comox Valley. The report noted "The issue of homelessness is complex and difficult to solve in isolation. It will require the cooperation and partnership of all levels of government, VIHA and other community partners. Our hope is to address this growing trend in a collaborative and creative way" (VIHA, 2008; p. 5).

The proposal describe the priority housing needs of the community and the programs and services required to meet the need at the time considered 250 homeless people and an estimated 500 persons at risk of becoming homeless due to mental illness or addiction issues.

VIHA staff acknowledge current data is out of date and there has been little progress on building specific supported housing facilities. It was offered that whilst there are clinical roles presently available to support such a facility, the absence of a larger well established housing provider such as those present in Victoria, Pacifica Housing and CoolAid with experience to partner with is a challenge.

A minimal or low barrier sobering center attached to a low barrier shelter was considered a need by VIHA staff and an opportunity for economies of scale if practice philosophies were aligned. It was clarified that an ACT team for the Comox Valley is high if not next on the list with the aim of being in place before or when the new regional hospital is built. ACT teams are funding through a Ministry of Health Initiative not VIHA.

- MSD

Staff were strongly encouraged by the collaborative efforts of the current project and interested in exploring their place in delivering a community wide homeless-serving system. Staff indicate collating data using a homeless indicator on file may provide assistance in gathering useful information.

Staff expressed their desire to discuss opportunities further.

- BC Housing

In responding to questions regarding what BC Housing expects from a community in order to receive funding for affordable or supported housing, Ms. Hartman Vancouver Island Representative made note a comprehensive plan looking at the continuum of housing and speaking to this in a proposal. Clear and transparent process as put forward by a society or municipality through an RFP process.

In discussing the concept of 'Speaking with one voice' for the community, Ms. Hartman offered the example in Campbell River and Nanaimo where a society responds to an RFP or the Municipality responded to the request of a MOU and puts forward a piece of land. The province responds with funding for ongoing operation. The RFP process allows for a clear and transparent process. Providers putting forward proposals are evaluated on an individual basis.

Current trends are focused around more transitional and supportive housing and decreasing the number of shelter beds. Shelters are considered short term. Ms. Hartman confirmed Comox Valley's emergency shelter is contracted as high barrier presently.

Ms. Hartman is available to support the community and act as a resource. For example, in Nanaimo she offered she participates in the Nanaimo Community Advisory Board to offer information about framework or programs. "We want to support our communities and the role they take in combating homelessness."

- United Way

A public consultation held in 2009 indicated that the issue of homelessness was pervasive with a very high profile. Suggestions during the event included that United Way act in a leadership role regarding service integration building agency capacity and political action to focus public attention on key community concerns. During the course of this project, United Way staff indicated an interest in discussing raising the profile of United Way in the community and expressed openness to further discussions.

An opportunity exists to explore how the United Way may assist in potential coordination activities or processes to assist in facilitating community development work around homelessness.

People

The Comox Valley community was often described as a generous one. In addition to the 'passionate caring people' of practitioners, the broader public were seen as an asset. Successes to build upon were offered including services surviving on public donation alone, the levels of in-kind contributions services received and on a number of private partnership projects.

Proponents and supporters of the attending to homelessness and affordable housing are present, local advocates in the media and public interest continues on the subject

Previous studies and research is available and can assist in providing baselines, evidence historical need and recommendations to build on.

4. 2 CHALLENGES TO CONSIDER

Successful community development requires that constraints be realistically accounted for when planning improvement. Summarised below are key themes respondents indicated are challenges to the implementation and sustainability of making changes to the homeless serving system.

4.2.1 Funding

Senior service managers and councillors offered it is 'widely recognised' that the Comox Valley is 'grossly underfunded' when compared to some other communities.

As noted earlier, whilst integration and efforts to build capacity with current resources are likely to produce health change, broader service delivery improvements and housing developments will require additional financial resources.

4.2.2 Lack of housing both affordable and supported

The Comox Valley continues to have a severe shortage of affordable and supported housing. This was consistently offered as the number one solution current homelessness in the Valley.

Multiple supportive housing options are required to address the quantity, variety, and combination of needs likely present in the population. Information, strategic planning and strong partnerships will be required to complete the housing continuum.

4.2.3 Lack of income generating opportunities or income assistance

Lack of job opportunities in the Comox Valley was consistently raised as a challenge. Social enterprise efforts were appreciated and in increase in these programs considered desirable.

Inadequate income assistance and inadequate shelter allowance was regularly offered by service providers and service users throughout interviews as challenge.

4.2.4 Political climate & leadership

Respondents offered a challenging experience of the Comox Valley's current political climate and its impact on the ability of service providers to deliver services and help find suitable safe housing for clients.

Respondents stated their doubts in the local leadership and frustrations that some barriers to achieving progress appeared to be directly related to personal attitudes of decision makers. Examples were offered including the sheer lack of housing stock, failure of a number of proposals at the council level, the failure of the municipal jurisdiction to collaborate, recent unsupportive zoning and failure to take into account well researched community responses to housing developments such as NIMBY-ism. A loss of confidence in the political leadership of the valley was evident.

The Housing Task Force is currently in deliberations as to its next course of action as a governance structure.

4.2.5 Public engagement and lack of knowledge

Community engagement and education to encourage acceptance and understanding in the 'polarised' community was considered a need. Lack of information was offered and an ignorance of 'changing face of homelessness'. Examples were offered of experiences of stigma attached to homelessness, to service users and as housing tenants including for those participating in Dawn-to-Dawn.

Observations during the course of this project that NIMBYism is evident in the Valley community as publically expressed in the media.

Public perceptions of service providers were noted as problematic with one respondent describing attitudes as seeing a "community of winers" due to misunderstanding of the service capacity issues in a under serviced community.

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Section 5 – APPENDICES

APPENDIX A – List of Informants

APPENDIX B – Materials used to elicit feedback

APPENDIX C – CVCCIC organisational resources accessed

APPENDIX D – Practitioners Capacity Questionnaire- Summary of Responses

APPENDIX E – AHERO Community Services Audit Results & Contributors

APPENDIX F – Results of Service User Engagement Activities

Appendix A – List of Informants

ORGANISATION	FIRST	LAST NAME	POSITION
AIDS Vancouver Island	Natasha	Benoit	Practicum Student
AIDS Vancouver Island	Del	Grimstad	Harm Reduction Worker
AIDS Vancouver Island	Sarah	Sullivan	Manager
AIDS Vancouver Island	Peter	Quatrale	Harm Reduction Worker
BC Housing	Rebecca	Bell	Coordinator, Homelessness Services
BC Housing	Heidi	Hartman	Non Profit Portfolio Manager
Casa Loma	Laura	Crawford	Assisted Living Manager
City of Courtenay	Gary	Usher	Bylaw Enforcement Officer
City of Courtenay	Ronna Rae	Leonard	Councillor Chair CV Housing Task Force
Coastline	Phil	Mills	Case Manager
Community Living British Columbia	Barbara	Legg	Facilitator
Comox Bay Care Society Care-A-Van	Helen	Boyd	Coordinator
Courtenay/Port Alberni Community Corrections	Dave	Edmonson	Local Manager
Creative Employment Access Society	Andrea	Gilfillan	Resource Technician
CV Brain Injury Society	Cathy	Stotts	Executive Director
CV Family Services Association	Gillian	Normandin	Executive Director
CV Food Bank	Jeff	Hampton	President
CV Food Bank	Susan	Somerset	Manager
CV Nursing Centre	Maggie	St Aubrey	Street Outreach Nurse
CV Recovery Center	Jane	Worth	Administrator
CV Regional District	James	Warren	corporate *legislative* officer
CV Social Planning Society	Bunny	Shannon	President
CV Transition Society	Anne	Davis	Program Manager
CV Transition Society	Glenda	Dawson	Community Facilitator
CV Transition Society	Caroline	Leadbitter	Transition House Coordinator
CV Transition Society	Heather	Ney	Executive Director
Dawn to Dawn	Richard	Clarke	President
Dawn to Dawn	Dan	Jackson	Director
Dawn to Dawn	Grant	Shilling	Residential Support Program Worker
Dawn to Dawn	Rhonda	Smith	Director
Legal Aid Courtenay	Lauri		Legal Aid Worker
Lush Valley	Jean	duGal	Staff
M'akola Housing	Pam	Black	North Island Regional Property Manager
Ministry Child & Family Development	Doug	Hillian	Director of Practice, Central/North Island
Ministry Social Development	Tara	Goodless-Mason	Supervisor
Ministry Social Development	Nancy	Sim	Supervisor
Mount Washington Hostel	John		Manager
RCMP	Cst. Nicole	Hall	Community Policing/ Media Liaison
RCMP Victim Services	Deb	White	Program Manager
Royal LePage	Janice	Elderbroom	Property Management Representative

Royal LePage	Tara	McFee	Property Manager
St Joseph's General Hospital	Cheryl	Christiansen	Psychiatry Social Worker
St Joseph's General Hospital	Jimena	Espinoza	Psychiatry Social Worker
St Joseph's General Hospital	Leesa	Ferguson	Director, Quality & Risk Management
St Joseph's General Hospital	Christine	Knights	Substance Abuse Intervention Program
St Joseph's General Hospital	Natalia	Richardson	Residential Social Worker
St Joseph's General Hospital	Anne	Roberts	Manager Social Work
St Joseph's General Hospital	Vicki	Timmers	Crisis Nurse
The John Howard Society of North Island	Vicki	Luckman	Program Manager
The John Howard Society of North Island	Mirander	Blomquist	Youth Outreach Support Worker
The Salvation Army Comox Valley	Lorrie	Cox	Pidcock House Supervisor
The Salvation Army Comox Valley	Brent	Hogden	Community Ministries Director
The Salvation Army Comox Valley	Alistair	Hunting	Caseworker/Chaplin
The United Way of the Central & Northern Vancouver Island	Brad	Bayly	Community Development Co-ordinator
VIHA Aboriginal Health Services	Laurel	Anderson	Aboriginal Liaison Nurse
VIHA Addictions	Sam	Sommers	Coordinator
VIHA CV MHAS	Petra	Ballantyne	Coordinator ASTAT/ACSS
VIHA CV MHAS	Robert	Bennet	Housing Team/Rehab Worker
VIHA CV MHAS	John	Fitzgerald	Manager
VIHA CV MHAS	Steve	Groupa	Coordinator Rehabilitation and Residential Programs
VIHA CV MHAS	Anna	Leevers	Housing Team/Rehab Worker
Wachiay Friendship Centre	Rhonda	Billie	Homeless Outreach Worker
Wachiay Friendship Centre	Vivienne	Jorringo	Advocacy
Wachiay Friendship Centre	Roger	Kishi	Program Director/Health

Appendix B – Materials used to elicit feedback

AHERO ORGANISATION ASSET MAPPING INVENTORY SHEET

AHERO COMMUNITY CAPACITY MAPPING QUESTIONAIRE

PRACTITIONERS CAPACITY QUESTIONNAIRE - LIST OF QUESTIONS

***SERVICE USER FEEDBACK MATERIALS** including:*

- ***HANDOUT FOR ANONYMOUS FEEDBACK KEEP START STOP ACTIVITY***
- ***HANDOUT FOR ANONYMOUS FEEDBACK CONFIRMING GAPS***
- ***STRUCTURED INTERVIEW SURVEY SHEET***
- ***SERVICE USER FEEDBACK SHEET***

HOUSING PROVIDERS PHONE INTERVIEW SURVEY SHEET

AHERO ORGANISATION ASSET MAPPING INVENTORY SHEET

Organisation: _____ Locations: _____

Name: _____ Primary groups served: _____

Position: _____ _____

Contact: _____ Secondary groups: _____

Housing		**Funding**		**Basic Needs**	
Accommodation		• Permanent / ongoing		Hygiene supplies	
• Emergency		• Multi-year		Meals/food	
• Temporary		• Year by year		Food vouchers	
• Permanent		• Project to project		Clothing/shoes	
Onsite caretaker				Bus tickets/ Taxi tickets	
Services on-site		**Interventions**		Accompaniment to appts	
Accessible units		Mental health support & tx		Transport of clients	
Group/meeting rooms		Addictions support & tx		Vehicles to transport	
Rental subsidies		Supportive counselling		MSD applications	
• ongoing		Psycho-education		Income assistance provision	
• temporary		Group therapy		Social enterprise programs	
Housing costs aid heat/hydro		Self-help groups			
Housing Applications		Crisis planning/ counselling		**Specific programming**	
Landlord recruitment		Recreational activities		Child & family support	
Tenancy support		Social inclusion activities			
Landlord support		Financial Aid not MSD		Cultural sensitive programs	
Tenant-Landlord mediation		Job/ vocation related		Gender Sensitive programs	
Outreach/assertive engagement		Budgeting /financial advice		Age Sensitive programs	
In-reach / Drop-in		Legal aid/advocacy/support		Faith sensitive programs	
		Independent living		Harm reduction practices	
Case Management Activities		Life skills		Abstinence based practices	
Intake		Computer access		Settlement services &language-training	
Triaging/matching		Advocacy			
Assessment					
Planning				**Consumer engagement / feedback activities**	
Referral and linking		**Access**			
Advocacy		Street outreach		**Facilities**	
Monitoring and evaluation		Home outreach		Day center	
Transition		Community outreach		Recovery	
Discharge		Co-location with others		Sobering	
Coordination of supports		On-site provision only		Detox	
Key-working of services		Part time business hours M-F		Offices	
		Full time Bus hours M-F		Group / meeting rooms	
Staffing		After hours access		Hygiene facilities /showers	
F/Time		24/7 hours access		Wheel-chair accessible	
P/Time				Child-care	
Casual				Kitchen facilities	

AHERO COMMUNITY CAPACITY MAPPING QUESTIONAIRE

Name:_____ Organisation:_____

Position:_____Contact:_____

COMMUNITY CAPACITY INVENTORY Information will be added to the assets inventory in the top section and collated into other practitioner's responses and into pathways/systems mapping for the CVCCIC scoping report.

Funded target groups:	
Eligibility criteria for service:	
Duration/frequency limits:	
Conditions to maintain involvement:	
Reasons for forced discharge/ service refusal:	
Percent or number of clients with homelessness concerns (risk or experiencing) at present?	
Percent of time per hour appointment you spend on housing matters (finding info, looking for housing, making referrals)?	
Where do you have enough resources to attend to the needs adequately?	
What knowledge/training have you found most helpful in responding to homelessness?	
How many referrals per week do you make with people experiencing homelessness or needing housing?	
Which services you use most regularly to help you support people experience homelessness?	
Reason your referrals to other services are not accepted?	
What constraints do you see exist for your service in meeting the needs of this group?	
What constraints do you see exist for other services in meeting the needs of this group?	

UPDATING Local Research. Your input is essential to identify themes and any new trends that need attention. It will be collated with other practitioners input and not attached to an organisation. In March 2011 ***Comox Valley Housing Needs, Gaps, Barriers and Opportunities,*** Butler Associates Consulting and Bazink Solutions Inc. Information come from AHERO's survey 2009 and during the Standing Committee Priority Setting Session 2010.

1. Review the attached list.
2. Indicate if the item is now Filled or F and next to it HOW (by which program, service or role) or if that gap remains in the community indicate Gap or G.
3. Use the last section to detail any gaps or needs you observe not included in the B&B report.

UPDATED PRACTITIONERS REVIEW: ***Comox Valley Housing Needs, Gaps, Barriers and Opportunities,*** Butler Associates Consulting and Bazink Solutions Inc. (March 2011)

Service gaps specific to the needs of the target groups identified included:		
Indicate if the item is now Filled or F and next to it HOW, by which program, service or role or if that gap remains in the community writing Gap or G.	G or F	HOW or any comments.
Place to go during the day and/or when time runs out at the shelter		
Transportation limits where services can be located		
Helping to connect to medical/dental/health		
System managing – access on-line		
Clearinghouse for coordination		
The support services identified as being important for all the target groups included:		
Housing support to landlords		
Access to services 24/7		
A place for people to go during the day, with programs		
Onsite caretaker, at a minimum		
Appropriately trained program staff, i.e., mental health, addictions, violence, abuse, youth and culturally sensitive		
Financial assistance for rent payments and ownership assistance		
Housing charges/payments that include heat and lights		
Hygiene facilities		
Public washrooms & adequate washroom facilities in services		
Sunday meals		
System navigation		
Programs including life skills, relationship building, financial management		
Accessing medical & dental care, i.e., connecting to a doctor/dentist		
A ready-to-rent program		
Cooking - meal preparation - shopping		
Improved community kitchen access		
Access to childcare (safe & affordable) that is part-time		
Literacy (reading, writing and computer)		
Lack of housing that allows pets		
ANY GAPS (filled or missing) OR NEEDS NOT LISTED ABOVE		

PRACTITIONERS CAPACITY QUESTIONNAIRE - LIST OF QUESTIONS

INDIVIDUAL ASSETS - AS A PRACTITIONER

1. What are the strengths and assets you bring to your clients?
2. What are the strengths and assets you bring to your team?
3. What are the strengths and assets you bring to your community?
4. Which of your skills, knowledge and experience do you find yourself using more often on your daily activities?
5. What strengths do you feel you have that are currently not being used by your organisation?
6. What models of working or broad approaches do you use when working with the homeless or those at risk of?
7. What interventions do you use that have help people maintain accommodation?
8. What interventions do you use that helps prevent people becoming homeless?

PROFESSIONAL DEVELOPMENT

9. What training or resources whether formal or self-directed have you found most helpful in meeting the needs of this target group and responding to homelessness?
10. What training opportunities have been made available to you specifically around homelessness and housing by your employer? By your community?
11. How recently have you engaged in any education opportunities around homelessness?
12. What other training not-specific to housing or homelessness but helpful in your work have you participated in?
13. What professional or practice supervision (supervision to clinician) do you have available in your role?
14. What peer supervision (clinician to clinician) do you have?
15. What more information, training or supervision would you like to have to support you in your role if it was available?
16. What training and education would you like to see other practitioners in the community receive around responding to homelessness and housing?

ORGANISATIONAL CAPACITY

17. How do you feel your service is best meeting the needs of this group?
18. Where do you have enough resources to attend to the needs adequately?
19. In what situations do you feel you have to go beyond the expectations or resources available in your service to assist a client with this need?
20. Are there any changes in your role you would like to see to do the best job you wanted to do?
21. What are the most common reasons your referrals to other services are not accepted?
22. What are the reasons clients would not be accepted to your service?
23. What constraints do you see exist for your service in meeting the needs of this group?
24. What constraints do you see exist for other services in meeting the needs of this group

AS LEADERS IN THE COMMUNITY

25. What are the biggest capacity challenges in our community?
26. If given the resources, what other services or programs would you like to have available for your clients?
27. For yourself as a practitioner?
28. For other service providers?

29. What improvements could be made to how your service delivers its work?
30. In how other services delivery their work?
31. What are the best changes you have seen your organisation make? Why?
32. What are the best changes you have seen the service provider community make? Why?
33. What are the barriers to working better together as a homeless service community that you would address as a priority?
34. What accomplishments in working to end homelessness do you feel your organisation has made?
35. What future accomplishments would you like to see your organisation make?

Any other comments?

COMOX VALLEY COMMUNITY CAPACITY INITIATIVE

In joining together to improve the service system…..

What should we KEEP doing?_____
_____

What should we START doing?_____
_____

What should we STOP doing?_____
_____

Looking at the list of identified client needs, service gaps and support services…..
What do you think ? are these still relevant?
_____
Are their gaps or services missing?
_____

Which ones are more important to you?
_____

How could services involve people who use support services or need housing in helping determine which services we need, how they should be run_____
_____

Thank you very much for your contribution.
If you would like to be kept up to date and involved in future discussions you can let Amanda know.

CVCCIC SERVICE USER FEEDBACK:

Identified needs, gaps and useful support services for responding to homelessness in the Comox Valley. 2008-2011 (Butler & Bazink 2011)

Other Housing Related Needs Identified in the Survey by Homeless Persons					
Affordable housing	64%		Mental health supports	32%	
Damage deposit	36%		Child care	10%	
Outreach worker/advocate	39%		Personal housing reference	33%	
Internet access	27%		Phone/mailbox	34%	
Jobs	28%		Shower/laundry	35%	
Low cost cheque cashing /bank account	32%				

27

What do you think ? are these still relevant?

Service gaps specific to the needs of the target groups identified included:

Number 1-5 which ones are more important to you?

• Place to go during the day and/or when time runs out at the shelter	
• Transportation limits where services can be located	
• Helping to connect to medical/dental/health	
• System managing – access on-line	
• Clearinghouse for coordination	

List from 1 -3 which are the most important to you.

The support services identified as being important for all the target groups included:	
• Housing support to landlords	
• Access to services 24/7	
• A place for people to go during the day, with programs	
• Onsite caretaker, at a minimum	
• Appropriately trained program staff, i.e., mental health, addictions, violence, abuse, youth and culturally sensitive	
• Financial assistance for rent payments and ownership assistance	
• Housing charges/payments that include heat and lights	
• Hygiene facilities	
• Public washrooms & adequate washroom facilities in services	
• Sunday meals	

Are their gaps or services missing?

STRUCTURED INTERVIEW SURVEY SHEET

CVCCIC --- CV Service User Feedback

Survey no: _____ Time: _____
Locations:_____

This is a confidential survey about housing and homelessness services in Comox Valley.

The purpose of this survey is to collect information that will help us to improve the quality of services that we provide.

To remain anonymous, DO NOT put your name on the survey.

Data will be collected and the survey will be destroyed, unless you opt to have a copy placed in your file for future reference. Thank you for taking the time to fill out this survey and for providing us with your honest feedback.

If you would like a copy of the survey added to your file to use in future service planning , or would like someone to follow up with you regarding the survey , then please put your name and signature below and indicate your preferences by checking the appropriate options.

Once you have completed the survey, please hand it in at either AIDS Vancouver Island office, Comox Valley Transition Society Office, or Wachiay Friendship Center.

IF you would like to have someone follow up with you regarding the survey and/or would like to be contacted to participate in future focus groups concerning homelessness and housing service provision, then please indicate by checking the appropriate boxes, and print and sign you name below:

☐ **I would like someone to follow up with me about the survey.**	**Name:** **Date:**
☐ **I am interested in participating in future focus groups related to this survey.**	**Signature:** **Contact me thru:**

If limited time – go straight to last page!!

If feels best to use a short survey – go straight to last page!

Comox Valley Transition Society

Dawn to Dawn ACTION ON HOMELESSNESS SOCIETY

AIDS Vancouver Island

iGNITE

Survey no: _____ Time: _____
Locations:_____

CVCCIC --- CV Service User Feedback

BEGIN ANONYMOUS SURVEY HERE.

Age:_____ Gender:_____ Marital Status:_____Home Community:_____

Supports: (Do you have family/friends in the community there for you)_____

Q1.Have you lived in any of the following situations?	**Time in days.**		**Q2.What periods throughout your life have you experienced homelessness?**	**Time Period**	**Definitions**
					Living on streets, places not usually fit for habitation **Staying in shelters.** **Accommodation is temporary or lacks security of tenure. Eg. Couch surfing or short stay places.** **Precarious situation or does not meet health standards.**
The Shelter			Unsheltered		
Living with friends			Emergency sheltered		
Living out of a vehicle			Provisionally accommodated		
Sleeping on the street			At risk of homelessness		
Transitional Housing					
Permanent supported housing					
Living in a motel room					
Other (describe)					

Q3.What service needs do you have? Are they available?	**Need**	**Use**	**If need but not use- why not?**		**Need**	**Use**	**If need but not use- why not?**
Shelter				Mental Health Supports			
Affordable Housing				Public Phone			
Outreach worker/advocate				Low cost cheque cashing/bank account			
Place to go when time runs out at the shelter				Identification Replacement			
Hygiene facilities/shower				Assistance w income assistance/PWD appli			
Transportation to services				Assistance with taxes			
Legal assistance				Sunday Meals			
Medical/Dental				Internet access			
Laundry							

Q4.The following are some previously identified gaps in service. Which gaps seem the most important to you?	**List from 1-3**	**Q5. Have you ever been refused service for any of the following reasons?**	**Tick any**	**Notes**
Place to go during the day/and or when time runs out at shelter				
Transportation limits where services can be located		Intoxication		
Helping to connect to medical/dental/health		Had taken drugs		
Sharing information between services helpful to my care/support		Personal Hygiene		
Coordination between services- appts, applications, treatment.		Previous aggressive behaviour		
Others???		Others???		

CVCCIC --- CV Service User Feedback

Survey no: _____ Time: _____
Locations:_____

Q6. What challenges have you experienced in accessing services?	**Tick All that Apply**	**Q7. Have you been referred from one service to another? If so, which services?**	**Q8. What was helpful or easy about the process? What was not helpful or challenging?**
Location of Program			
Communication ie telephone			
Regular Address			
Documentation			
Program is full			
The way staff treat clients			
Complexity of the application process			
Criminal History			
Wait time to access service			
Other			

Q9. 4 How satisfied were you with the outcome of the referral? Eg. Was the next service more helpful, helpful? Did the referral make sense to you? 1 2 3 4 5 6 7 8 9 10 (1 = very unsatisfied, 10 = very satisfied)

Any comments?

Q.10 What are 3 things you would like service providers to

KEEP DOING?		**STOP DOING?**		**START DOING?**	
Being flexible about where and when we meet		Asking us to leave phone messages		Come see us together	
Give us advice for safer drug use		Making negative assumptions about me		Have a drop-in center we can access all services	
Talking to other service providers about your case		Expecting us to stop drinking/using to see you		Share your resources	
Advocating to decision makers on our behalf		Making us tell our story over and over again		Join money together to do bigger projects	
Treat us as individuals		Referring us services we're not eligible for/won't work for us		Be clearer about who does what	
Showing how much you care		Letting staff burn-out		Give other services our info they need to do their job	
Arranging referrals before we arrive at the referral		Having excessive paperwork		Make it easier to know what is available	
Working together to advocate when I face barriers		Having waitlists		Involve us in decisions about what we need	
Being available as often as possible				Use the same language to describe things	
				Accept everyone as client even when they have a bad history	
				Give us just one case worker who works with all resources	
				Change the rules of organizations to make getting help easier	

THANK YOU so much for your input. Your information will be valuable in helping us improve our services in the Comox Valley.
How else has your opinion been sought on service provisions? _____
How else could we involve service users in designing, planning and running services? (Circle three ideas that sound the best.)

Surveys- paper? Online? Talking?	Lunch or dinner with talking	Representation in planning groups	Town Hall meetings
Small groups talking	Photo/ arts projects to express ourselves	Invitations to meetings	Meet with us and our workers together
Large groups talking	Writing our own stories	Projects we come up with	Let us decide on leaders who represent us.
Other ideas??			

What could we do differently next time?_____ THANKS AGAIN!! (remind to give name if want to participate again)

HOUSING PROVIDERS PHONE INTERVIEW SURVEY SHEET.

Name:_____ **Organisation:** _____

Date: _____ **Position:** _____

Q1. Please confirm the following details about your organisation.		
What are the groups targeted by this service? Changing the clientele , more singles mothers,	Tenants who use substances	
	Families	
	Women	
	Pregnant Women	
	Mental Health Patients	
	Tenants with disabilities	
Are there any vacancies?	Yes	No
Is there a high rate of turn-over?	Yes	No
		.

Q2. General Inquiries.		
How do tenants get referred to your facility?		
Are the tenants in the facility typically from your community or out of town?		
Is there a contract which must be signed by tenants staying in your facility? If yes, what are some of the key components of the contract?		
How are site guidelines established for tenants at your facility?		
What are some of the key guidelines for your facility? (eg. Curfews, guest, pets, crime-free housing etc.)		
How are guidelines communicated to the tenants in your facility?	Verbal	
	Written	
	Other	
What are the consequences for not following guidelines?	Verbal Warning	
	Written Warning	
	Notice to Vacate	
What are the rent guidelines for your facility?		
Does your facility ask tenants to pay damage deposits when they move in?	Yes	No
Are the units in your facility furnished or unfurnished?	Furnished	Unfurnished
What occupancy standards do you have in place for units in your facility?		
What is the maximum length of stay?	Overnight 1 week 1 month Several years	A few days 2 weeks 1 year
How is your program funded?	BC Housing	
	Community Funding	
	Federal Funding	
	Donor Support	
	Other	

How are the decisions made about an applicant's eligibility?	Application References Panel Decision Director's Decision
For what reasons would they not be eligible?	
What are the reasons you would need to exclude or remove someone from your housing?	Violent Behaviour Use of Drugs Damage to property Theft or other criminal behaviour Other
What is your referral or application process?	

Q3. Tell us about your support services.			
Do you provide tenant support services?	Yes	No	
If so, what are they?			
Which services and referrals are accessed more often by your tenants?			
Do service providers visit your facility? What do they do there?	Yes	No	
Do you have any arrangements in place with other organisations or services who provide support to your tenants? What are they?	Yes	No	
How is this arrangement working for you?	Not well	Well	Very Well
What would make this arrangement better?			
Are there additional services or programs you would like to see at your facility? What are they?	Yes	No	
How would you like service providers to better support your tenants?			
What training or education or support has been made available to you from CV services? helpful?			
If you could have more training or support from a service provider, what would this training be?			
In your opinion, what are the biggest unmet needs for community members in terms of housing? In terms of services? In terms of coordination?	Housing:		
	Services:		
Any other comments?			

Q6.Issues/Challenges		
Has there been an increased prevalence of any particular issues at your facility?	Yes	No
If yes, does the increased prevalence pose any additional challenges? (If yes, explain)		
If yes, how do you address these additional challenges?		

THANK YOU! Your responses are important to us. Thank you very much for participating in this survey.

Appendix C – CVCCIC organisational resources accessed

ORGANISATION	TITLES
AIDS Vancouver Island	2011- 2012 Annual Report Code of Ethics Policy Manual Positive Wellness Program Member Intake Form Strategic Plan 2009-2012.
Comox Valley Transition Society	Addictions Program Admission Intake Draft Nov 2012 Community Facilitation Intake Form Community Facilitator July, August, October, December Stats Lilli House Program Intake form Lilli House Program Release of Information Limits of Confidentiality Agreement Release of Confidential Information Review of Women's Transition Housing and Supports Program: Consolidated Report: Key Findings and Recommendations. Second Stage Transitional Housing for Women in the Comox Valley March 5 2013 Surviving Not Thriving- The systematic Barriers to Housing for Women Leading Violent relationships. BCNPHA 2010 Understanding Women's Second Stage Housing Programs in BC BC Housing October 2012 Women's Transition Housing: Women's Transition Housing and Supports Program Framework. BC Housing Working off-site policy
Dawn to Dawn	Prospective Candidate Referral Form Residential Program Policies and Guidelines
Wachiay Friendship Center HOP	Case Planning Guide for Homelessness Services Providers 2010 BC Housing Consent form Form A BC Homelessness Services Engagement/Referral Form C BC Homelessness Services Intake Information Form F BC Homelessness Services Personal Goal Setting – Enhanced Homeless Program Client Rights and Responsibilities HOP Activities & Accomplishments report April 1 – October 1 2012. HOP Contract Part 2- Service Description

- Six practitioners from the four CVCCIC organisations completed the confidential questionnaire.
- Below is a summary of practitioner's responses provided.

How the organisations best meet needs	• Provide housing and follow-up support services • Cold weather outreach rudimentary equipment such as tents and sleeping bags • Free and confidential service with outreach providing more support needed by community • Harm reduction suppliers drop in • Low barrier services, no appointment is required, no time limits
Perceived constraints	• Lack of funding • Lack of staffing capacity • Lack of affordable housing • Lack of information & education of others • Community involvement • Needing to maintain relationships with external parties including in the private sector • Service barriers for clients
Accomplishments	• Good clean subsidised housing with follow-through support and recreation activities • Accessible in-house services and drop-in, • Cold weather outreach • Collaborating to operate cold weather outreach program for eight years; • Assisting in emergency weather protocol • Making service programs available at no cost to client
Changes, improvements and/ or resources that practitioners would like to see with their organisation or between partnering organisations	• Improved referral process • Clarity around services provided • Improving understanding of working where clients are at with their level of engagement, participation and preferences. • Housing worker that supports people to maintain housing; • Worker that supports women in transition; • Increase housing capacity • Full year street outreach services • Daily drop-in with service provider access. • Additional staff to assist current roles and administration • More hours to expand program components
Future accomplishments practitioners would like to see	• Dialogue towards an assisted living facilities in the valley, • Year-round mobile street outreach, • Increased capacity • Another housing program • Programs employing those needing employment skills

- Audit delivered during AHERO meeting and sent via email to AHERO email recipients.
- Inventory was primarily self-reported by organisations as listed (SR) and completed by third party most familiar with operations of the varying organisations during AHERO meeting as indicated by (FOR) in the Participating professionals and described organisations list.
- Number listed below reflects total number of organisation indicated they provide the listed services.

Housing		**Funding**		**Basic Needs**	0
Emergency	3	Permanent/ongoing	9	Hygiene supplies	10
Temporary	6	Multi-year	6	Meals/food	14
Permanent	3	Year by Year	9	Food vouchers	8
Onsite Caretaker	1	Project to project	6	Clothing/shoes	11
Services On-site	3		0	Bus tickets/Taxi tickets	9
Accessible units	3	**Interventions**	0	Accompaniment to appts.	13
Group/Meeting rooms	7	Mental Health support and tx	11	Transport of Clients	8
Rental Subsidies	3	Addictions support and tx	14	Vehicles to transport	4
Ongoing	2	Supportive counselling	16	MSD applications	6
Temporary	3	Psycho-education	14	Income assistance provision	2
Housing Costs aid heat/hydro	4	Group Therapy	7	Social Enterprise programs	4
Housing Applications	8	Self Help groups	11		
Landlord Recruitment	5	Crisis planning/counselling	16	**Specific Programming**	
Tenancy Support	10	Recreational Activities	13	Child and family support	8
Landlord Support	4	Social Inclusion activities	14	Cultural sensitive programs	6
Tenant-Landlord Mediation	5	Financial Aid not MSD	4	Gender sensitive programs	8
Outreach/assertive engagement	8	Job/vocation related	10	Age sensitive programs	8
In-Reach/Drop-in	10	Budgeting/financial advice	7	Faith sensitive programs	6
		Legal aid/advocacy/support	10	Harm reduction practices	9
Case Management Activities		Independent living	9	Abstinence based practices	4
Intake	16	Life skills	16	Settlement /Language	4
Triaging/matching	12	computer access	12		
Assessment	16	Advocacy	17	**Consumer engagement**	1
Planning	14				
Referral and Linking	20	**Access**		**Facilities**	
Advocacy	18	Street Outreach	11	Day Center	6
Monitoring and evaluation	17	Home outreach	12	Recovery	5
Transition	13	Community outreach	18	Sobering	2
Discharge	11	Co-location with others	6	Detox	3
Coordination of Supports	17	On-site provision only	6	Offices	12
Key-working of Services	7	Part time business hours M-F	6	Group/meeting rooms	16
		Full time Bus hours M-F	15	Hygiene facilities/showers	2
Staffing	1	After hours access	6	Wheel-chair accessible	16
F/Time	20	24/7 hours access	4	Child-care	3
P/Time	22			Kitchen facilities	1
Casual	13				

Participating professionals and described organisations.

CONTACT		ORGANIZATION	POSITION
Sarah Sullivan	SR	AIDS Vancouver Island	Manager
Jean Ennis (for)	FOR	Alano Club	
Ronna-Rae Leonard	FOR	BC Housing	
Phil Mills	SR	Coastline Community Resources	Case Manager CSW
Barbara Legg/ Catherine Hope	SR	Community Living BC	Facilitator/ Adminstrator
Helen Boyd	SR	Comox Bay Care Society Care-A-Van	Coordinator
Maggie St. Aubrey	SR	Comox Valley Nursing Center	Community Health Nurse (Outreach)
Andrea Gilfillan	SR	Creative Employment Access Society	Resource Technician
Heather Owen	SR	Crisis Line (Nanaimo)	Promotions & Community Relations
Gillian Normandin	SR	Comox Valley Family Services Association	Executive Director
Glenda Dawson	SR	Comox Valley Transition Society	Community Facilitation
Robert Bennett	SR	VIHA - CVMHAS	Housing/Rehabilitation Worker
Grant Shilling	SR	Dawn to Dawn	Res. Program Support
Jean Ennis (for)	FOR	Double Waters	
Robert Bennett (for)	FOR	Food Bank	
Mike Nestor	SR	Hornby/Denman Community Health Care Society	Child Youth and Family MH Counsellor
Sarah Sullivan	FOR	John Howard Society North Island	
Vivienne Gorringe	FOR	Law Foundation	Funder
Nancy Sim (for)	FOR	Lions Clubs	
Cynthia Fitton	SR	Lush Valley	Secretary, Board of Directors
Andrea Gilfillan (for)	FOR	Military Family Resource Center	
Al Hunting	SR	The Salvation Army	
Shelley Marinus		Community Living BC	Self Advocate Liaison
Liz Naish	FOR	Sonshine Club/St Georges Church	Volunteer
Jean Ennis (for)	FOR	Stepping Stones Residential Recovery For Women	
Jean Ennis (for)		Substance Abuse Intervention	David Davidson R.N
Anna Leevers	SR	VIHA - CVMHAS	Housing/Rehabilitation Worker
Maggie St Aubrey	SR	VIHA Public Health CV Nursing Center	Street Outreach Nurse
Chris Bowlby	SR	VIHA Public Health CV Nursing Center	Manager
Ronna-Rae Leonard	FOR	VIRL (Library)	Chair
Rhonda Billie	SR	Wachiay Friendship Center	Homeless Outreach Program
Vivienne Jorringo	SR	Wachiay Friendship Center	Legal Advocate

Keep, Start, Stop Activity.

- Approximately 40 people casting 114 votes.
- Delivered at Resources Fair and a CVTS Tuesday Drop-in and via surveys with 19 interviewees.

What are three things you would like service providers to keep, stop, start doing?

KEEP DOING?	Totals
Working together to advocate when I face barriers	11
Treat us as individuals	6
Arranging referrals before we arrive at the referral	5
Talking to other service providers about your case	4
Advocating to decision makers on our behalf	4
Being available as often as possible	4
Being flexible about where and when we meet	3
Showing how much you care	1
Give us advice for safer drug use	0
	38
STOP DOING?	
Making negative assumptions about me	9
Expecting us to stop drinking/using to see you	6
Making us tell our story over and over again	6
Letting staff burn-out	6
Having excessive paperwork	5
Referring us to another service we are not eligible for or won't work for us	4
Having waitlists	1
Asking us to leave phone messages	0
	37
START DOING?	
Have a drop-in where we can access all the services	16
Join your money together to do bigger projects	5
Be clearer about who does what	5
Give us just one case worker who works with all resources	3
Share your resources	2
Involving us in making decisions about what we need	2
Change the rules of organizations to make getting help easier	2
Give other services the information they need about us to do their job	1
Make it easier to know what is available	1
Use the same language to describe things	1
Accept everyone as client even when they have a bad history	1
Come see us together	0
	39

Service user survey & interviews results.

- Service user feedback interviews conducted with 19 survey participants 11 women; 8 men
- Ages ranged from 29 – 64 with an average age of 46.6 (4 no responses)
- 11 single, 1 married, 2 common-law, 2 divorced (3 no responses)
- 16 respondents from CV, 1 recently moved from Victoria (2 no responses)
- Surveys completed on two dates at Food Bank and one date at CVTS Drop-in.

What challenges have you experienced in accessing services? Tick all that apply	
Wait time to access service	11
Complexity of the application process	9
The way staff treat clients	8
Location of Program	7
Program is full	7
Documentation	6
Regular Address	4
Criminal History	3
Communication ie telephone	1
Other	1

The following are some previously identified gaps in service. Which gaps seem the most significant to you? Rank top 3.

Place to go during the day/and or when time runs out at shelter	22
Helping to connect to medical/dental/health	19
Clearinghouse for services coordination	16
System managing On-line access	15
Transportation limits where services can be located	8
Others? Safe Injection site	3

What service needs do you have? Are they available?	Need	Use	Disparity
Place to go when time runs out at the shelter	7	1	**-6**
Transportation to services	**11**	5	**-6**
Medical/Dental	**14**	8	**-6**
Affordable Housing	**11**	8	-3
Public Phone	8	5	-3
Outreach worker/advocate	**12**	10	-2
Legal assistance	**11**	9	-2
Mental Health Supports	**11**	9	-2
Low cost cheque cashing/bank account	8	6	-2
Identification Replacement	9	7	-2
Shelter	10	9	-1
Hygiene facilities/shower	**11**	10	-1
Laundry	7	6	-1
Sunday Meals	8	7	-1
Internet access	10	9	-1
Assistance with taxes,	**13**	12	-1
Assistance w income assistance/PWD app.	**13**	13	0

Challenges in access

Complexity of the application process	9
The way staff treat clients	8
Location of Program	7
Program is full	7
Documentation	6
Regular Address	4
Criminal History	3
Communication ie telephone	1
Other	1

Comparative Ranking - Service Needs Vs. Services Used

Medical/Dental	14	Assistance w income assistance/ PWD application.	13
Assistance with taxes,	13	Assistance with taxes,	12
Assistance w income assistance/ PWD application	13	Outreach worker/advocate	10
Outreach worker/advocate	12	Hygiene facilities/shower	10
Transportation to services	11	Legal assistance	9
Affordable Housing	11	Mental Health Supports	9
Legal assistance	11	Shelter	9
Mental Health Supports	11	Internet access	9
Hygiene facilities/shower	11	Medical/Dental	8
Shelter	10	Affordable Housing	8
Internet access	10	Identification Replacement	7
Identification Replacement	9	Sunday Meals	7
Public Phone	8	Low cost cheque cashing/bank account	6
Low cost cheque cashing/bank account	8	Laundry	6
Sunday Meals	8	Transportation to services	5
Place to go when time runs out at the shelter	7	Public Phone	5
Laundry	7	Place to go when time runs out at the shelter	1
Additional gaps: - safe injection site.			

Referrals

16 of 19 respondents indicated that had been referred.

Have you been referred from one service to another? If so, which services?	What was helpful or easy? What was not helpful or challenging?	Satis-faction 0-10
Yes to Mental Health	Someone to talk to.	5
Yes to Mental Health	Lack of communication between staff in Campbell River	2
Yes AVI to Liver Association	Very helpful good referral	10
Yes. Healthy Babies to Transition Society and Social Services	Covered prescriptions and gave compliments. Communication was good.	10
Yes Income assistance to Service Canada	Not helpful; transportation. Services are located on opposite sides of town	10
Yes Nursing Center to CVTS	Communication was good	10
Mental Health to adult day therapy	Confidentiality was violated between mental health and psychiatrist. Dropped me as a client.	-5
Mental health to buildings to hospital to Changeways	Dr referral to specialist was easy other service. Challenging paperwork gets lost. Making decisions without me.	-
AVI to Mental Health	Helpful. AA, early recovery, Alano	-
Yes. CVTS. Nurse Nightingale	Helpful. Its alright. Pretty quick.	9
MLA to BC to Fed	Not Helpful	6
W for W to Nanaimo	Very Easy	10
Maggie – CVTS.	Helpful. Not too sure about it at the time but now they are friendly faces	6
Psych - Mental health. VIRS. Adult Day Therapy.	Alright	8
MSD- Employment Program. MSD-Bridging Program	Easy via computer.	8
Dr to Mental Health	Went really well	10
Dr-PWD	Easy - Dr was great.	8
		Avg 7.1

Service refusals.

Have you ever been refused service for any of the following reasons? (Tick any that apply)		Comments
Did not qualify for the service	6	Staff make personal judgements about services.
Had taken drugs	3	
Intoxication	2	On methadone and accused of being high by staff. Judgemental.
Previous aggressive behaviour	2	
Other?	2	Mental health issues; told could not return to medical clinic
Personal Hygiene	0	

Comments written or noted during interviews.

- When you want help, you want it yesterday.
- "They need a place in this town for people to go during the daytime"
- "Wait time for Lilly House. Unacceptable." "Expectation for the person using the services is really high"
- Medication first by Mental Health. Got Dr. Helped me fill out application.
- Dr referral to specialist was easy other services challenging paperwork gets lost Making decisions without me.
- Feel up against a wall
- How crazy does it have to become before things change?
- Compared to other places, it (CV) has it all- there's a lot of services.
- Food bank intimidation. Feels like you can't do anything about your situation. Need more empowerment.
- "Tell the politicians to put our money where their mouth is".
- "We lie to get what we need"
- The system hasn't help me at all. What an onus to put on a volunteer.
- "There is no place for talk therapy long term." "More instructions on applications would be helpful." "Adult day therapy specifies that you can't be involved in more than one service at once."
- Seems like you can't do anything about your station. Need employment empowerment.
- The Mex Housing has gone up. The biggest issue in the valley the housing is not affordable.
- Rent Control needed. The government doesn't advertise the services it like they don't want you to know - if you don't know you won't access the services and it will save them money.
- Blacklisting – absolutely and because of history 7 years ago. We have to prove and demonstrate ourselves.
- AVI is fantastic. 7 days would be good. Need drop-in location that can be available all day. Open criteria up so all people get support including specialist services.
- Supported living is required. You're pretty much on your own.
- Services been pretty helpful- accept guidelines and priorities of services. Not everything's there. Accept funding limits.
- There's so many different agencies doing work, do they know what the hell is going on.
- There is absolutely no where (day time). It's hit or miss. Closed door unless you know someone here, it's hard to be homeless.

Consumer engagement suggestions.

How else could we involve services user in designing, planning and running services?
Circle best 3 ideas.

Lunch or dinner with talking	8	Representation in planning groups	2
Meet with us and our workers together	6	Invitations to meetings	2
Small groups talking	4	Let us decide on leaders who represent us	2
Photo/Arts projects to express ourselves	4	Projects we come up with	1
Large groups talking	3	Town hall meetings	1
Writing our own stories	3	Surveys-Paper? Online? Talking?	0

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