Proposed Service Delivery Model for Hard to Reach Populations in Victoria

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Introduction

Vancouver Island is facing a challenging population of hard to reach individuals. Despite over 350 organizations offering services for the homeless, addicted and/or mentally ill across the island, approximately 700 individuals remain hard to reach in this service area. This includes 500 individuals in the Greater Victoria area, of which 100 individuals are in the City of Victoria. Victoria’s situation is not unique; cities across North America and around the world are confronting similar challenges and grappling with comparable questions about the most effective model to support these individuals and ensure the safety of the public.

Over the last decade there have been five reports focused on the needs of Vancouver Island’s street entrenched population. The themes of these reports are consistent and reflect best practices in the field: an overriding philosophy of harm reduction with an emphasis on a ‘housing first’ strategy, a client centred delivery model, and an integrated approach to policy and service delivery (City of Victoria 2003, 2005, 2007; Chandler 2008; VIHA 2006/07).

In 2007, the Victoria Mayor’s Task Force identified three priorities for immediate action: (1) improved access to low barrier housing; (2) establishment of Assertive Community Treatment (ACT) teams; and (3) integration of existing services. Across Vancouver Island, 864 new units of subsidized housing have been established, including 314 units in Victoria. In addition, five ACT teams are in operation, four in Victoria and one in Nanaimo. The teams are working at capacity, with initial data showing improvements in housing occupancy and reductions in hospital utilization. Less progress has been made on an integrated approach to service delivery. A review of the literature and recent lessons learned from Vancouver’s Downtown Eastside indicate the most successful models are based on partnering across agencies and integrating services to reduce gaps.

In response to the need for a more collaborative approach, a working group of South Island stakeholders, including VIHA (Mental Health and Addictions Services, Public Health, Primary Care), City of Victoria, the Victoria Police Department, the Victoria Cool Aid Society and AIDS Vancouver Island reviewed the current model of care with an eye to identify gaps in service delivery and opportunities for integration of existing services. The model acknowledges and incorporates the successes in Victoria since the Mayor’s Task Force (2007), specifically those related to housing and outreach services, and is founded on the assumption that much of the infrastructure and services are already in place. While additional investments are likely to be required, the focus of the model is on managing existing funds and resources in a more efficient way. This offers benefits to clients by improving access to services through co-location and enhanced collaboration across community agencies, and benefits the public through efficient allocation of public funds.

The South Island Working Group recently endorsed the model and developed the recommendations outlined in this report. The recommendations will be presented to VIHA Senior Leadership, the VIHA Board and elected officials of the involved agencies.
Current Services

Currently, there are over 200 organizations in the Greater Victoria area and another 150 across the island engaged in serving the homeless, addicted and/or mentally ill. Services include low barrier housing, mental health outreach, secondary and mobile needle exchange services, emergency shelters, a continuum of housing options and advocacy supports, among others.

Opportunities to Improve Current Model

The literature indicates that shifts at the broad systems level offer the greatest gains – notably by integrating services and coordinating a continuum of diverse, easily accessible care, with the client at the centre (Griffiths, 2002; City of Victoria 2005; Craig, Eby and Whittington 2011). The research also highlights the disconnect between the often chaotic lives of transient people living with addictions and/or mental illness, and the traditional, linear, fragmented approach to services (Task Force, 2007; Gulcur, Stefancic & Shinn, 2003). Aligning existing services with best practices requires an integrated, cohesive and culturally safe approach to service delivery, with a focus on the coordination of client care.

A number of services have been developed in Victoria since 2007 that require collaboration across community agencies (e.g., Housing First, ACT teams, Streets to Homes). The success of Streets to Homes and ACT teams is well documented and the data indicates sustained improvements in access to supports for hundreds of clients. It also indicates savings to the overall system, as evidenced by outcomes that show a reduction in the utilization of acute care services for those clients supported by ACT teams.

While there have been notable successes in the past five years, more can be done to align existing services with best practices. In particular, the following enhancements to current services are recommended: (Kendall 2011; Marlatt & Witkiewitz, 2010; Shoveller J, DeBeck K, Montaner J., 2010):

- Establish two service hubs where individuals can access a continuum of health and non-medical services, including food and temporary respite and/or refuge services as well as harm reduction supplies such as needles. Services would be targeted to those ready to receive support and provided in a service focused manner.

- Expand availability of Highly Active Anti-Retroviral Therapy (HAART).
- Target outreach services to hard to reach (e.g., multidisciplinary outreach team with a focus on engaging clients).
- Expand availability of addictions services.
- Improve access to low barrier housing and emergency shelters.
- Strengthen linkages between emergency housing and transitional housing.

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2 HAART is a combination of antiretroviral drugs used to treat HIV. The efficacy of HAART to treat acute AIDS illness and to reduce the transmission of HIV is clearly established in the literature.
- Develop opportunities to improve access to, and exchange of medical supplies.
- Consider future establishment of a supervised consumption services. Supervised consumption (or injection) services are identified in the literature and endorsed by the BC Ministry of Health as best practice within a continuum of harm reduction services (Appendix 1: BC Ministry of Health Guidelines on Supervised Consumption Services). The possible future establishment of a supervised consumption service in Victoria would be a new service and as such would require alignment with provincial guidelines on supervised consumption sites (see: http://www.health.gov.bc.ca/cdms/pdf/guidance-document-for-sis-in-bc.pdf) as well as further consideration and approvals from VIHA, the City of Victoria and others prior to proceeding.

The following strategies were further identified as components of a successful service plan for the hard to reach population, but are outside the scope of these recommendations:

- Opportunities to enhance access to residential addictions treatment.
- Increased supply of supported recovery units as part of the continuum of addictions services.

**Proposed Model for Victoria**

Revisions to the current system were considered in light of the need for prudent management of fiscal resources and effective deployment of skilled and limited human resources. The proposed model is a combination of new and enhanced services and a redeployment of existing resources. It builds on the ongoing success of a collaborative approach to this population, including shared accountability for the delivery of health and social services. Grounded in best practices, it proposes structural changes to the current system to enhance the coordination of care and address gaps in service delivery.

**Service Scope:** The model focuses on hard to reach individuals whose needs are not being met effectively through the current system and who pose a risk to themselves and/or the public. It includes marginalized individuals, with or at risk of blood borne illnesses, who are also experiencing any of the following:

- Homelessness or unstable housing.
- Chronic and persistent mental illness and/or disorders.
- Severe non-adaptive social and behavioural patterns, including substance use.
- Previously identified as a difficult, chronic ‘multi-system’ user.

**Service Mandate:** To facilitate the engagement and stabilization of hard to reach individuals and to enable and support their transition to appropriate health, social and housing services.
**Service Objectives:** The goals and objectives are based on the Triple Aim methodology described by Craig et al., (2011). The goals include:

1. Improve health and social outcomes for the target population.
2. Decrease public health risk.
3. Decrease cost to health and social systems.
4. Enhance the community’s experience.

**Service Values:** Three overarching values underlie the proposed framework (Fry C, Treloar C, Maher L 2007; Pauly, 2008).

1. **Respect for Human Rights:** A belief in the inherent self-worth of individuals, including the right to shelter, food and health care.
2. **Resilience:** All individuals have the potential for growth and change.
3. **Cultural Safety:** An approach to healthcare and social services that recognizes the contemporary conditions of Aboriginal and Metis people result from their post contact history.

**Policy and Funding:**

1. Revise VIHA’s funding structure and contractual arrangements with contracted agencies to incent co-location and collaboration across sectors.
2. Continue to prioritize allocation of funds based on best practices.
3. Establish common policies and protocols across health, social and legal services to ensure individuals are receiving the response and the level of service appropriate to their needs.
4. Establish community based/clinical oversight committees, with autonomy to allocate funding.

**Service Delivery:**

1. Enhance existing services across the health and social sectors to align with best practices in harm reduction and the provision of culturally safe services. Service delivery would continue to be the shared responsibility of stakeholders, including government (Ministry of Health, Ministry of Social Development), VIHA, BC Housing, the City of Victoria and community agencies. Specific recommendations include:
   - Expand HAART therapy.
   - Enhance outreach services (similar to ACT model, with focus on engagement rather than treatment).
• Improve links between emergency housing and transitional housing.

• Enhance addictions services.

• Improve access to and exchange of medical supplies (this includes needles).

• Consider future possible establishment of a supervised consumption service. Approvals, as outlined previously, would be required.

(2) Building on the distributed model of service delivery, enhance engagement with clients through a coordinated care approach to the delivery of care, including:

• *Local shared community based/clinical oversight of affiliated services within the geographic area*. The oversight committee is responsible for care coordination across the continuum including engagement, stabilization and recovery. It also has the autonomy to allocate funding.

• *Integrated service delivery functions*: Service delivery includes a suite of harm reduction, housing, health and social services.

• *Targeted outreach services*. Outreach services are modeled on ACT principles, with the key distinction that these teams are focused on engagement of clients rather than treatment.

**Next Steps**

(1) Obtain approval of new model concept by VIHA, City of Victoria, Victoria Police and others as required.

(2) Based on above, establish a working group consisting of local stakeholders to establish a multi-year implementation plan and address operational issues associated with staged implementation. Specifically, the working group will provide recommendations on:

• Reallocation and re-alignment of resources.

• Implementation timelines to align with availability of resources.

• Locations of two future service hubs.

• Establishment of a governance structure to support and sustain an integrated approach to service delivery.

(3) Develop a community engagement and communications strategy to support these processes and involve a broader community discussion.
References


Fyfe, Dr. M. *Preventing Harm from Substance Use: Harm Reduction*. VIHA Powerpoint presentation. 2009.


Vancouver Island Health Authority. Closing the Gap: integrated HIV/AIDS and Hepatitis C Strategic Directions for Vancouver Island Health Authority. 2006/07-2008/09.
