Northern Health Authority

Downtown Prince George Health Services Review

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Prepared by:

Jeannie Wexler and Doug Zabkar

2000 – 1188 West Georgia Street, Vancouver BC V6E 4A2 Tel: 604.687.0391 Fax: 604.687.2315 www.wmc.ca

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Glossary

ACT: Assertive Community Treatment for severe & persistent mental illness

Addictions Day Program: Recovery oriented day programs in group settings

AWMU: Adult Withdrawal Management: Nechako Detox Centre

BC Crises Line Centre: Crises Prevention, Intervention & Information

BCSS: BC Schizophrenia Society, Community Programs

Blue Pine: Primary Care Home

Car 60: Northern Health & RCMP partnership; MH & Addictions urgent community response team

CINHS: Central Interior Native Health Society, Primary Care Home

CMHA: Canadian Mental Health Association, Community programs

DART: Drug Awareness Recovery Teams, Community services re employment

DTPG Site: The term used to define the physical area which includes a variety of services provided by or through Northern Health Authority. These services support the vulnerable population central to this review.

HIV MASP: Medication Adherence Support Program for HIV, HCV. Located at CINHS

IPT: Interprofessional Practice Teams

SST: HIV/Hepatitis C Specialized Support Team

ICMT: Intensive Case Management Team

Nechako Opioid Substitution: Opioid treatment & counselling, education, support for people with drug dependency

HIV/AIDS Prevention Program (Needle Exchange)/Overdose Prevention Site; Primary care services; Harm reduction supplies

PLN: Positive Living North: HIV/AIDS education, daily living supports

St. Patrick's, Native Friendship Centre, Phoenix, AWAC: Supportive Recovery Services. Supported beds for recovery

Executive Summary

The Northern Health Authority (NH) provides and contracts a variety of services to care for vulnerable populations in the downtown PG area. Many of the people in this population suffer from mental health and substance use health issues and live on or near the streets.

The purpose of this review was to ensure that the population is obtaining the best outcomes given the resources allocated; to assess whether the services are organized in a model that meets current best practices in this area; and to explore a service model that improves access to services, reduces duplications in current services and has potential co-location opportunities.

Data and information was gathered from several sources to support this review:

- Interviews and focus groups with NH staff for in-scope services provided in downtown Prince George and regionally
- Interviews with organizations contracted by NH to provide in-scope services in downtown Prince George
- Interviews with organizations not contracted by NH but who operate in the downtown Prince George area
- Internal documents/information provided by NH
- Best practices research for mental health and substance use practices to support homeless/vulnerable populations
- Meetings with the External Advisory Committee and the downtown Prince George (DTPG) business community members

The key findings are as follows:

- ***Service silos***: Silos exist across contracted service providers and NH & within NH. There is a need for more formal links between services to support people served in navigating the system.
- ***Duplications***: Similar services are provided by multiple providers with many groups capturing the same information from the same people served.
- ***Primary Care Service Delivery Model***: NH is following best practice for its Primary Care Homes (PCHs). In downtown Prince George, two PCHs primarily serve the homeless/vulnerable population. Each PCH has its own model with their own unique strengths.
- ***Access***: There are waitlists for various services. Other access issues include limited after hour services and the existence of criteria/requirements in order to receive services.
- ***Gaps/Shortages***: There is no primary care available for unattached patients and no immediate care. There is no sobering centre and a shortage of social/rehabilitative spaces and housing options.

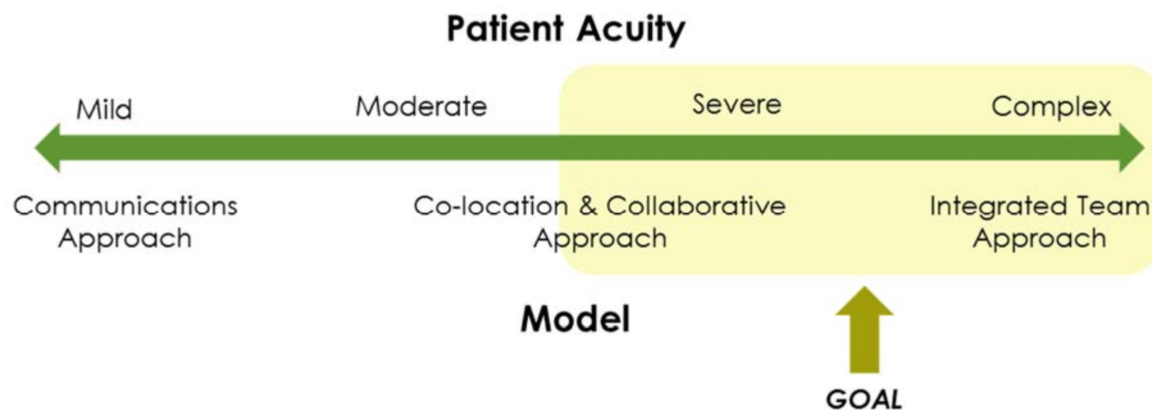
- ***Co-location, location of services***: Most interviewed has a strong preference to relocate the HIV/AID Prevention Program from its current location. Many commented that it should be co-located with an existing primary care home.

Context for Recommendations

Recommendations were informed by **Principles** developed by the Caring for People with Addictions Internal Steering Committee and the External Advisory Committee. These are as follows:

1. Commitment to patient-centred care – Northern Health Idealized State Model
2. Harm reduction is part of everyone's work
3. Attach patients for better care. Even 'drop-in clinics' must have the goal of attaching patients
4. Integration of services is fundamental
5. No door is wrong door – every door is the right door
6. Care must be Trauma Informed
7. "Make it easier for client" rather than for us
8. Be sensitive to the needs of downtown businesses and citizens

The recommendations offered as a result of this review support the **goal** of creating a collaborative, integrated Downtown Prince George (DTPG) Health Service Delivery Model as per best practice. This model is seen to be the best "fit" for meeting the needs of patients/clients, providers and the community alike.



Summary of Recommendations

We considered the results from the consultation process, best practice research, and experience and expertise in developing 15 recommendations.

The Overarching Recommendation describes the future service model. This overarching recommendation is supported by recommendations that relate to Functions within the Service Model i.e. functions and tools that will improve accessibility and integration.

The overarching recommendation is also supported by a set of Service Model Enabler recommendations describing support structures that are necessary to implementing this future service delivery model.

Recommendations are as follows:

Overarching Recommendation

1. **Implement an Accessible, Integrated Service Model (the "what")**
   This involves establishing a fully integrated, wraparound, inter-professional team that provides primary and community care and specialized Mental Health and Substance Use (MHSU) services to the Downtown Prince George (DTPG) site.

Functions Within the Service Model

2. **Outreach/Transportation Functions**
   Establish an outreach function to provide support to the DTPG population served
3. **Coordination Function**
   Establish a Coordination function located in the DTPG service area that is responsible for coordinating and connecting patients to appropriate DTPG site services and resources.
4. **Primary Care for the Unattached**
   Introduce primary care services for unattached patients.
5. **Access to Primary Care**
   Primary care home hours to be revisited to improve access and availability of after-hours care for the DTPG population served, using low barrier systems such as flexible appointments and non-traditional hours.

6. **Care Plans**
   Develop a single care plan for each patient. Care plans to be dependent on client needs.

7. **Community Programs**
   Perform joint program development across service providers for similar programs.

Service Model Enablers

8. **Site-based and Site Leadership**
   Implement a site-based model for delivery of health services in downtown Prince George (DTPG) site.

9. **Co-location/ Service Integration**
   Integrate and co-locate services where possible, increasing co-location over time as opportunities present.

10. **Central Interior Native Health Society (CINHS) Contract**
    Combine the Primary Care Home and the HIV/HCV CINHS contracts into a single contract and revise contract deliverables to include both primary care and Medication Adherence Support Program (MASP) related activities

11. **Contracts - Partnership Philosophy**
    Implement a contracting philosophy that builds long-term, collaborative partnerships with service providers in the DTPG site.

12. **Supportive Recovery Services**
    Identify one qualified partner to supply and manage supportive recovery beds and services to meet NH needs.

13. **Community Programs**
    Leverage existing resources to provide additional programming for the population served

14. **Training**
    Ensure that all service providers in the DTPG site have the necessary skills to work with the Mental Health and Substance Use (MHSU) population.

15. **Partnerships with Others**
    NH to engage with partners to solve problems jointly and to work together to address areas where overlapping mandates exist.

Review Context

Purpose

Northern Health (NH) provides and contracts a variety of services to care for vulnerable populations in the downtown Prince George area. Many of the people in this population suffer from mental health and substance use health issues and live on or near the streets.

The purpose of this review was to ensure that the population is obtaining the best outcomes given the resources allocated, to assess the services are organized in a model that meets current best practices in this area, and to explore a service model that improves access to services, reduces duplications in current services and has potential co-location opportunities.

Scope

This review is focused on the services provided directly by NH and contracted services funded by NH. The in-scope services are provided by:

Current Northern Health Services	Current Contracted Services
1. Assertive Community Treatment (ACT) 2. Intensive Case Management Team (ICMT) 3. Urgent Community Response Team (Car 60) 4. Adult Withdrawal Management Unit (Nechako Detox Centre) 5. Nechako Centre Opioid Substitution Treatment 6. Addictions Day Program 7. Prince George HIV/AIDS Prevention Program (Needle Exchange) /Overdose Prevention Site 8. HIV and Hepatitis C Specialized Support Team (SST)	1. Blue Pine Clinic 2. Central Interior Native Health Society (CINHS) 3. Positive Living North (PLN) 4. Association Advocating for Women and Children (AWAC) 5. Prince George Native Friendship Centre 6. Phoenix Transition Society 7. St. Patrick's House (Supportive Recovery for Men) 8. BC Schizophrenia Society – PG Branch 9. Canadian Mental Health Association, Prince George Branch (CMHA) 10. Drug Awareness Recovery Team (DART) 11. Northern BC Crisis Centre 12. Northern HIV Coalition

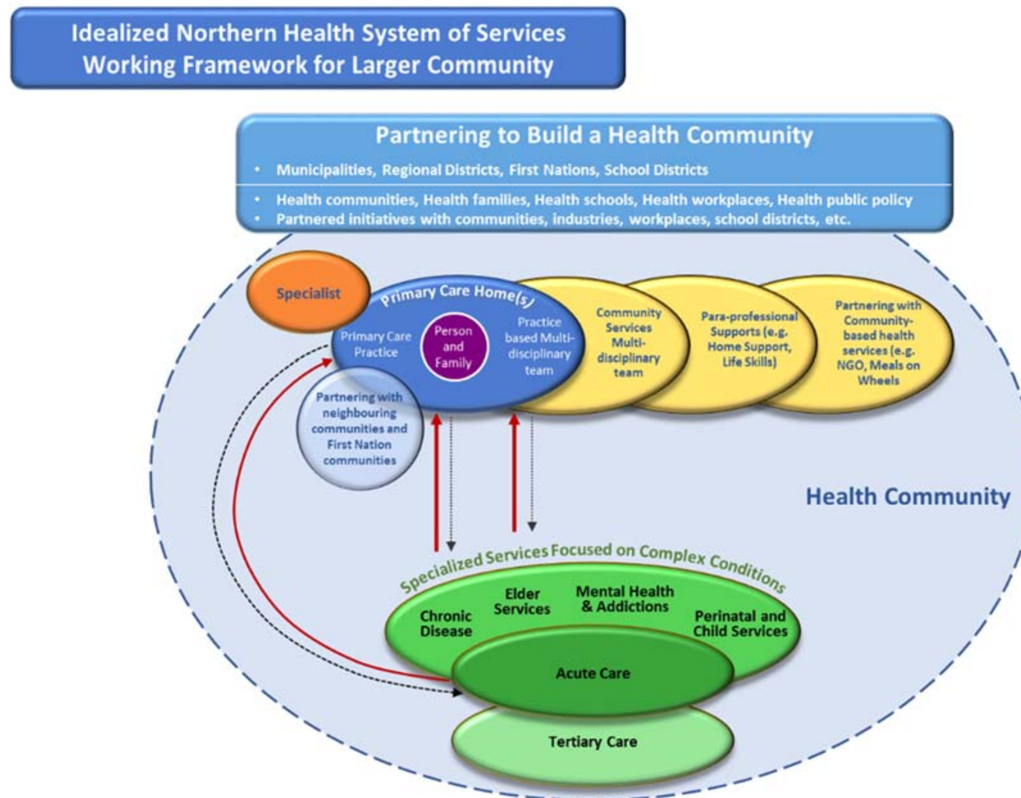
During the review, we consulted with 15 out-of-scope service providers and gathered their input regarding downtown health services to inform our review. Their services are not commented upon in this report.

- Northern Health Community Inter Professional Teams (IPTs)(Team 5)
- Active Support Against Poverty (ASAP)
- BC Housing
- Community Corrections
- Forensics Services (BC Mental Health and Substance Use Services – Regional Clinic)
- Prince George Regional Correctional Centre
- Elizabeth Fry Society
- Immigrant and Multicultural Services Society (IMSS)
- John Howard Society of BC
- The Society of St. Vincent De Paul
- Fire Pit
- Four (4) pharmacies

Organizing Framework

Northern Health (NH) has developed an Idealized State Model for services delivered by NH and community partners. The Idealized State Model is in line with best practice thinking and the Ministry of Health's vision as articulated in vision/policy papers. For this review, WMC has adopted the Idealized State Model as the organizing framework for its findings / observations, analysis and for formulating recommendations.

Idealized State Model



Data/information Inputs for This Review

To inform this review's findings and recommendations, WMC sought and synthesized a range of service delivery data, as well as information and perspectives from NH employees, community partners and other stakeholders. Major information sources included:

- interviews and group meetings with all in-scope service providers, both NH and contracted (Appendix A)
- interviews with out-of-scope service providers (Appendix A)

- Community perspectives from an external advisory committee, which met four times over the course of the project (Appendix A)
- Downtown Prince George (DTPG) business stakeholders' perspectives (Appendix A)
- Best practices and common themes from the literature, as well as real-world experiences from other regional health authorities
- Information from focus group meetings, held by Northern Health in November 2015, with people who use drugs in Prince George (Appendix B)

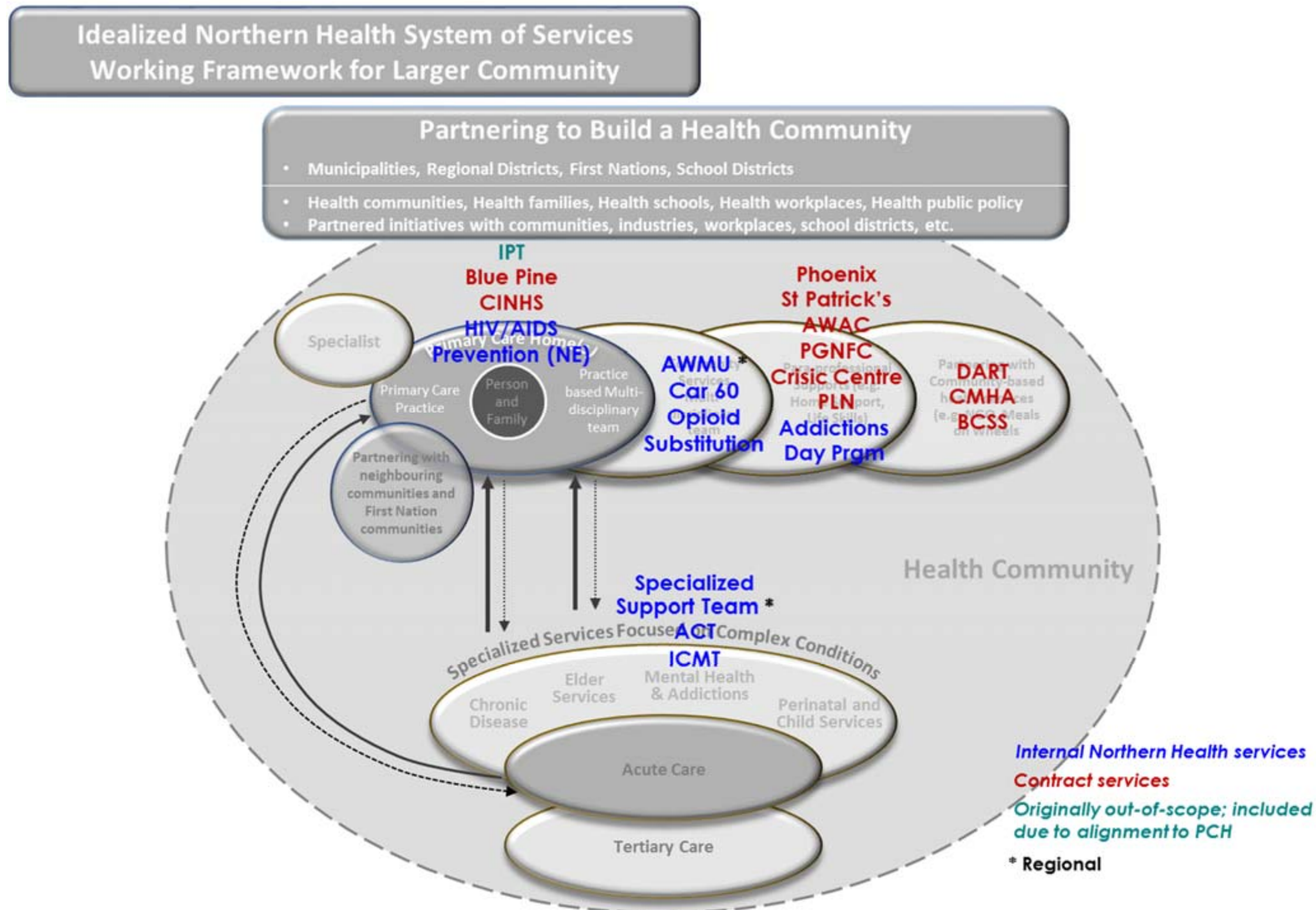
Overview: Current State

Northern Health Service Delivery

- Northern Health (NH) has eight internal services that operate in the downtown Prince George (DTPG) area; the health authority also funds twelve organizations providing health services in the downtown area. Four in-scope services are provided regionally.
- The current DTPG health service delivery model evolved over time – both proactively planned and reactive to needs.
- Several Best Practices are in place:
    - Primary Care Homes (PCH): NH is recognized as the B.C. leader in this best practice care delivery model
    - Patient attachment model and approach
    - Involvement of Elders as part of care delivery to Indigenous clients
    - Car 60 seen as progressive and as a good partnership arrangement with the RCMP
- The Idealized State Model is being used as a guide for changes being introduced. NH staff are supportive and proud of it

- Current services mapped on NH Idealized State Model:

Northern Health Idealized State Model



Note: Except *for IPT*, "out-of-scope" entities that provide service to the downtown client are not shown on this chart. IPT is shown because of its integration with the Blue Pine PCH.

Patient & Financial Snapshot of Downtown Prince George (DTPG) Health Services

- The two Primary Care Homes (PCHs) have a total of 2,749 active attached patients: Blue Pine - 1,653, CINHS – 1,096
- Annual patient visits per PCH are: CINHS – 11,746 (est.), Blue Pine – 9,410
- 205 (estimated) homeless people

The total budget and contract values for in-scope service providers is $11.2 million. The amount spent specifically for services to the DTPG population is $4.6M plus a proportion of the remaining $6.6M.

Change is Afoot: Influences on Downtown Prince George (DTPG) Health Services

- Opioid crisis and its impact are bringing more attention to Downtown Prince George (DTPG) as is the discussion for a supervised consumption service
- Organizational changes in Northern Health are impacting delivery of DTPG health services, e.g. PPCC
- New businesses (e.g. restaurants) are opening, bringing people downtown. This contributes to growing tension between business and health services
- Northern Health meetings are increasing with outside stakeholders. In the past, stakeholders felt there was limited interest in engagement. That is changing
- The Medical Adherence Support Program (MASP) study is being conducted concurrently with this review. There are some similarities of findings and ideas. This program is now housed at Central Interior Native Health Society (CINHS)
- A period of change for CINHS as it is undergoing changes in leadership

Service Silos: Issues & Impacts

Care for downtown Prince George (DTPG) patients/clients is currently delivered as a patchwork of services, each operating largely independently of the others.

Silos are observed across independent services and within Northern Health (NH) itself. NH services which are delivered to DTPG report to different NH executives. Internally, leaders recognize that services are fragmented within NH.

Across the various services there may be different philosophies about how services should be provided (e.g. degree of support a client should have in moving/navigating between services). At times, tensions/infighting exists between groups.

For clients, the use of different services can result in multiple care plans, non-coordinated care plans, and/or care plan information not being shared between providers.

NH has taken steps to reduce silos and PCHs are seen as helping in this regard. Assertive Community Treatment (ACT) and Intensive Case Management Team (ICMT) now operate under common leadership, which has resulted in enhanced communications between team members to the benefit of clients.

However, an ongoing lack of service integration results in challenges in a variety of areas, including:

- Gaps, disconnects and overlaps in services
- Service differences between the two primary care homes
- Client access to services
- Contracted service operations and management
- Information sharing between services
- Support/training to treat Mental Health and Substance Use (MHSU) co-morbidities
- Transitions in housing

Gaps, Disconnects/Overlaps in Services

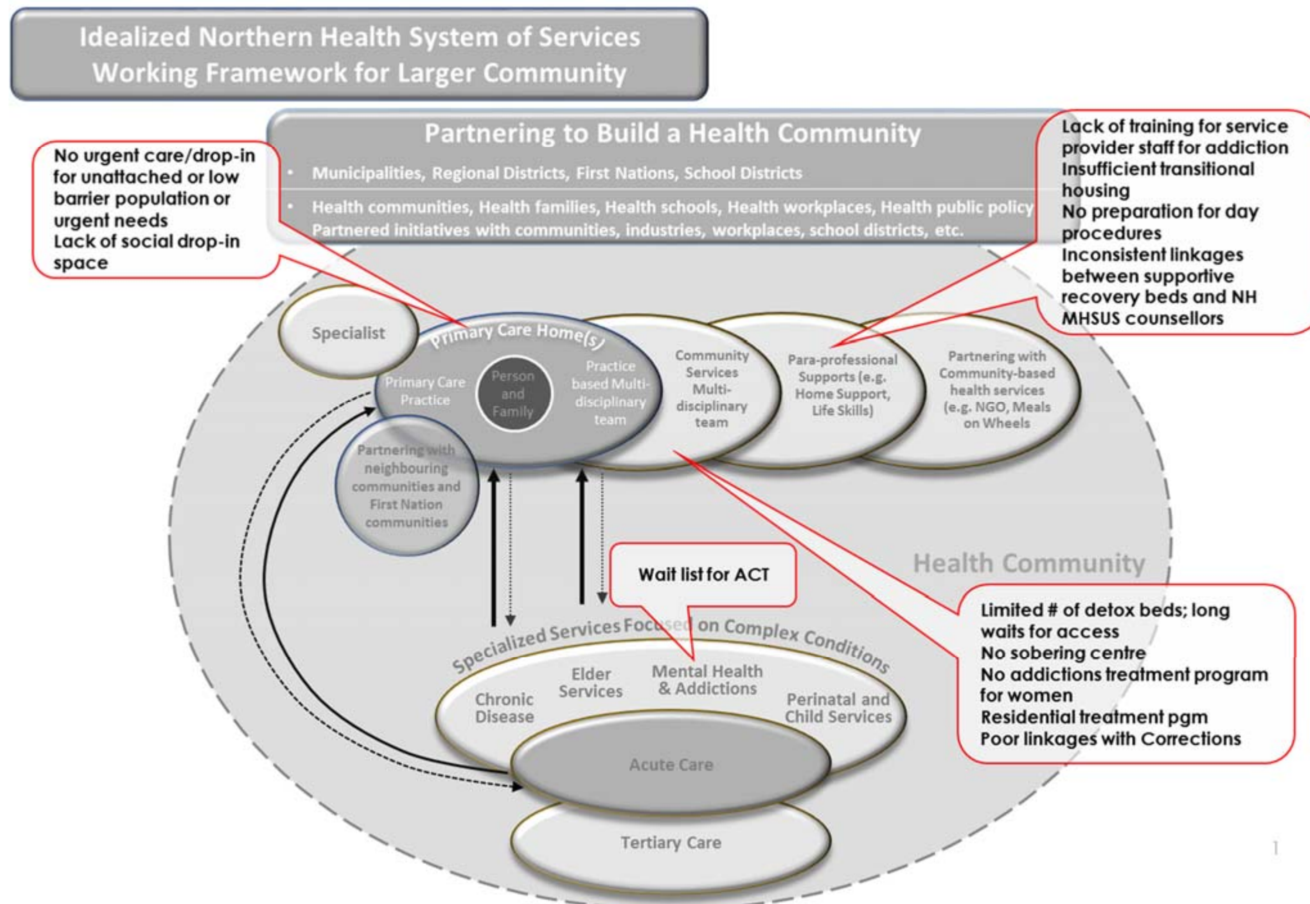
Siloed services, complexities in systems and the number of different providers within a small geography contribute to duplications and disconnects between services. Connections between providers and Northern Health are not clear.

Formal links are lacking between services to support clients who need to navigate the system. At best, ad hoc coordination occurs between programs. There are few (if any) formal links supporting clients to transition through multiple services. Clients must navigate different systems of services and supports that are not well-coordinated, resulting in gaps in care. Navigation is particularly difficult for clients struggling with health and/or social issues.

Service providers within Northern Health and externally contracted have had discussions on how to better integrate services across the organizations. Some providers get together to discuss clients in common (inter-case management); but not all providers participate.

Gaps

Against the backdrop of the Northern Health Idealized State Model, a number of gaps in service have been identified.



Disconnects and Overlaps

There are notable disconnects within the system that negatively affect clients requiring health services. These include:

- Clients falling through the cracks during transition between services (post-prison, post-treatment, post-detox), including waitlists and delays for detox treatment and a lack of supports to avoid relapse after treatment. This includes barriers to accessing transitional housing (not managed by Northern Health)
- Inconsistent sharing and updating of care plans
- Not enough space to provide home support services in supportive recovery

Overlaps and inefficiencies are also observed:

- The same information is collected from clients at different locations
- Many similar services are offered by multiple providers (Appendix C)
- Clients are often driven to appointments using clinical/program resources, which is costly
- The time spent by clinicians, social workers, and other supporting staff in trying to locate clients; finding out information about clients (includes care plans, primary care doctor information, results from other providers.)
- No shows – at Primary Care Homes (PCHs), for treatment beds

Primary Care Homes – Different Models of Care

Primary Care Homes (PCHs) are seen as having positive impact on services to the downtown Prince George (DTPG) population. There are two PCHs in the DTPG area serving the population of focus: the Blue Pine Clinic and Central Interior Native Health Society (CINHS). Each has its own patient profile and service delivery model (Appendix D). There are significant differences between services and supports available to clients at the two clinics:

- CINHS offers valued outreach services
- Blue Pine has a flow-through model that is effective in attaching patients
- IPT provides Blue Pine with inter professional support; CINHS has in-house resources providing these services

See Appendix D for additional details.

Each model is considered to be of value to patients/clients.

The location of both PCHs is downtown and accessible to the client population. Access to services is limited to daytime hours. After hours, options are for clients to go to UHNBC Emergency or to walk-in clinics. However, these services are not close by and there is no

walk-in clinic close to the downtown core (Superstore Clinic – 53-minute walk from downtown Prince George (DTPG); Spruceland – 40-Minute walk from DTPG). These clinics are not welcoming to the DTPG population.

Concurrently, the HIV/AIDS Prevention Program (Needle Exchange) provides a subset of primary care services primarily for people requiring low barrier options. The HIV/AIDS Prevention Program (Needle Exchange) provides a safety net for those patients who are unattached, or attached but in need of urgent services and unable to get a timely appointment with CINHS.

Access Issues

A number of issues hinder access for clients seeking health services in downtown Prince George (DTPG):

- There are waitlists for Primary Care, Detox, and transitional beds. Waitlists of varying length exist for:
  - Assertive Community Treatment (ACT) services
  - Addictions Day Program
  - Adult Withdrawal Management (AMWU) - Detox
  - Supportive recovery beds
  - Central Interior Native Health Society (CINHS)
- Additionally, managing waitlists is difficult for providers and affects placements. Challenges include:
  - A lack of resources to answer calls and do follow-up
  - Spaces not being filled efficiently when beds are held for patients/clients who do not show up
- Several organizations keeping housing lists – yet BC Housing indicates it does not receive 'housing-ready' people
- While there are multiple services located within the DTPG area, there is little available to patients/clients outside of normal office hours (Appendix E) and there are no walk-in clinics nearby. HIV/AIDS Prevention Program (Needle Exchange) is the only service open to clients after 4:30pm work days and on Saturdays. This is the same time people come to downtown restaurants and hotels, a situation that causes the most anxiety to citizens and the business community
- The siloed system of service delivery makes it difficult for care team members to help people find the care they need. Several care providers indicated they often do not know who to contact, e.g. Supportive Recovery services' staff did not know NH mental health counsellors. Referrals are most frequently influenced by the nature of the relationships between providers
- There are many different possible entry points to care, requiring good knowledge of the services delivered and who manages them in order to navigate to the right place. For example, Opioid Substitution accepts referrals from any "door" – including self-referrals – but people have difficulty finding out about this service
- Outreach services are not coordinated or consistent. Multiple providers are providing outreach

Information Sharing

Sharing of information is difficult for varying reasons:

- The means of data capture differ across providers
- System issues (e.g. Positive Living North (PLN) did not have an updated system at the time of the interview)
- Information capture is not a judiciously followed practice, e.g. HIV/AIDS Prevention Program (Needle Exchange)
- Use of different systems
- Privacy concerns

Barriers to data sharing have a direct impact on care. For example:

- Providers are unable to obtain Emergency Department discharge information
- RCMP-Car 60 cannot access basic information, e.g. primary care physician
- Care plans are not always shared
- Discharge information is not shared
- CINHS nurses drop in on Blue Pine patients at New Hope and Adult Withdrawal Management (AWMU), but information is not shared with Blue Pine
- Teams only share plans when they are explicitly asked to

Contracted Services

There are a number of systemic issues associated with Northern Health's practice of contracting a variety of agencies for different health services:

- Contracted agencies have their own governance and management structures; their preference is to maintain autonomy and contract funding
- Contracted agencies vie for funding. Agencies focus on providing their own services as opposed to having a system-wide view based on patient/client needs
- Most contracts are renewed on an annual basis (Appendix F); this inhibits/affects a provider to do long-term planning from the Northern Health perspective:
  - It is challenging to get a broad overview of effectiveness of services provided
  - There are overheads related to managing short-term contracts. They require more administration than longer term contracts
  - Focus may be greater on renewal versus focus on outcome measurement or contract deliverables

- Difficult to determine "best service" providers except anecdotally

Mental Health and Substance Use Supports

Many clients require both mental health and addiction support services. More support is required to treat these co-morbid conditions:

- Contracted organizations report that their staff are trained to support clients with mental health issues; however, no staff training is available for working with addiction clients
- It is difficult to refer a patient to NH mental health services if the patient is actively using; mental health providers are hesitant to accept these patients
- ACT team members require more training on behavioural conditions

Transitions in Housing

Northern Health has a limited role in housing. It only provides supportive recovery beds for clients prepared to start making changes in their lives. Challenges include:

- 90-day length of stay limit can be challenging due to frequent waitlists for the Nechako Centre detox beds
- Available wraparound services are not consistent across the sites
- No formal referral links between supportive recovery beds and other forms of transitional housing. This work is done on an ad-hoc basis. There is no formal process
- Shortage of transitional housing for clients to transfer into
- There is no shelter strategy

Exploring Co-Location and Integration

Three basic collaborative models for Mental Health Substance Use (MHSU) care, as described in the literature, were discussed with interviewees:

1. Leave-As-Is (no changes to current model of service provision)
   - This model is not supported especially by the business community and the City
2. Co-locate Central Interior Native Health Society (CINHS), HIV/AIDS Prevention Program (Needle Exchange), Positive Living North (PLN), Fire-pit as described in the March 2012 Business Case developed by RPG

- Generally speaking, interviewees are supportive of a co-location model. However, they recognize that co-location is only one part of the solution, rather than a total solution. Most interviewees indicated that co-location on its own will not result in improved outcomes to clients but is a better model than exists today
- CINHS, HIV/AIDS Prevention Program (Needle Exchange), and Fire-pit are most commonly cited as the services that should be co-located. CINHS is reluctant to support the HIV/AIDS Prevention Program (Needle Exchange) or supervised consumption services
- This option is generally seen as having some benefits to patients/clients and to service providers. For example:
    - It will result in the HIV/Aid Prevention Program (Needle Exchange) moving from its current location
    - It would enable communications amongst the providers

3. Co-locate and integrate
    - Some interviewees talked about co-locating Blue Pine and CINHS and fully integrating their services

The following chart provides highlights of the three models identified:

Collaborative Care

Low ⟷ High

	As Is	Co-location	Co-location & Integration
Model	• Each provider remains in own space	• Co-locate CINHS, Firepit AIDS/HIV Prevention Program & PLN Organizations remain independent (as proposed in RPG Report 2012) • Services not integrated	Co-location potentials: • CINHS • Blue Pine • Firepit • HIV/Aids Prevention Prgm • PLN Services integrated
Collaboration	• As today i.e. little or informal collaboration	• Collaboration is not formalized • Communications and access are improved due to shared space	• Single inter-professional/ specialist team with 1 care plan • Responsible for overall care of an individual • High collaboration
Cost	• No incremental cost	• $23 million (2012 RPG estimate)	• Will depend on which services/organizations are being integrated • More expensive than colocation only model

External Advisory Committee and Downtown Prince George Perspectives

The External Advisory Committee and the Downtown Prince George (DTPG) business community members articulated their concerns. At all times, the Committee members and business leaders were respectful of the DTPG patients and clients.

Their concerns included:

- Safety on the streets
- Drug use and visible drug dealing
- Debris, needles etc. on streets, behind and with business spaces
- Lack of zoning for health and social services
- DTPG population having to leave shelters early in the morning and lack of places to go during the day
- The vulnerability of the populations
- Homelessness

Success was described as follows:

- The Prince George Community recognizes that "their needs are our needs"
- Approaches to be compassionate and inclusive and positive in action and tone
- A clean and safe downtown through remedial and policing actions
- Increased lighting, fixes, safety, tools
- The population gets the right level of care
- The population has a place to be, stay warm, watch tv. A better facility for the population – a destination
- Multi agency space is in place for health and other services (washrooms, showers, etc.).
- Existence of wraparound services
- Investors are attracted to invest in housing in downtown Prince George
- There are more residences downtown that includes both market rate and affordable housing
- There are more people and events downtown
- There are employment programs and training in place

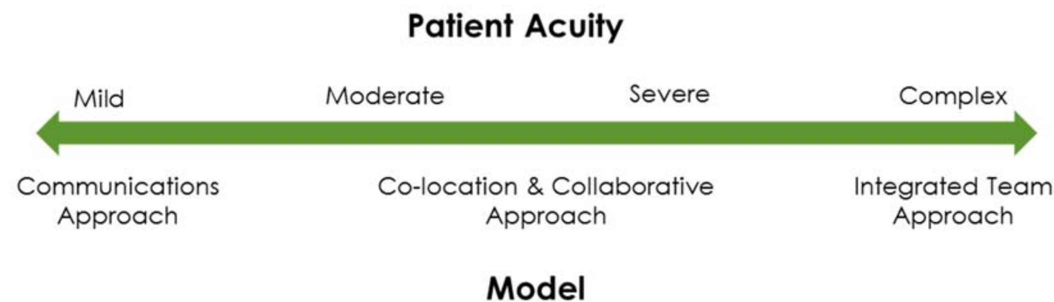
The External Advisory Committee clearly stated it will not support anything if it does not include moving the HIV/AIDS Prevention Program (Needle Exchange).

Best Practices, Common Themes from the Literature

Many of the challenges identified for delivering services in Prince George are shared by other communities around the world. The following common themes appeared in the best practice research:

Collaborative Mental Health and Substance Use (MHSU) Models

The literature describes three basic collaborative models for MHSU care. As shown in the diagram below, the higher the level of MHSU acuity, the greater the need for collaborative and integrated care.



1. **Communications Approach**

   In this model:

   - The family physician is the primary care provider and either provides basic mental health and substance use care, or refers patients to the appropriate Mental Health and Substance Use (MHSU) services
   - The model is not considered collaborative as there is limited care management between providers
   - This model is suitable for individuals whose health and MHSU needs are mild or sporadic

2. Co-location and Collaboration Approach

There are two main co-location and collaboration models:

- Shared Care/Co-location Model
    - Mental Health and Substance Use (MSHU) and primary care are delivered at one site, i.e. the primary care site. Shared space/co-location improves patient access to services
    - The Most Responsible Person (MRP) is the primary care clinician
    - The plan is a primary care plan with mental health as a component
    - The model is most suitable for individuals with mild to moderate disorders, those with substance use issues and those with severe mental illness where symptoms and functioning has been stable for a period of time
- MHSU-based model:
    - MSHU and primary care are delivered at one site, i.e. the MHSU site. Shared space/co-location improves patient access to services
    - The MRP is the MHSU clinician
    - The plan is a mental health plan with primary care as a component
    - The model is most suitable for those individuals that will not access traditional primary care services and/or have experienced difficulties attaching to a GP for individuals with mild to moderate disorders, those with substance use issues and those with severe mental illness where symptoms and functioning has been stable for a period of time.

3. Integrated Team Approach

- Full-service primary care and full-service MHSU care are delivered by one integrated team in one place - responsible for providing all of a patient's health care needs, or appropriately arranging care with other qualified providers
- Varying degrees of: integration amongst the care providers, outreach services, wraparound supports
- Fully integrated care requires that all team members be employed/accountable to one organization. Formal partnerships are established with those providers who cannot be employed as team members
- Suitable for those individuals with severe and complex mental illness and problematic substance use, housing issues and other social challenges

Stepped Care Models

- Stepped Care models are prevalent in the literature and generally describe how services should be organized for an entire population. The focus of the NH review is on sub-set population with higher acuity levels. However, the characteristics of the Stepped Care models are relevant in servicing any population

- Stepped Care models are premised on providing the least intrusive and cost-efficient care to a patient's current needs and adjusting that care based on response to treatment and/or changing needs
- These models typically have several tiers with each tier representing a logical grouping of services and supports. Each tier represents a cluster of services and supports that offer similar levels of access/eligibility; that address problems of similar severity; and that are of similar intensity and specialization
- A key aspect the Stepped Care model is that patients "step up" and "step down" between the tiers and that the pathway for Mental Health and Substance Use (MHSU) is not a linear one
- Characteristics of a Tiered MHSU Model:

No Wrong Door	A person may access the continuum of services and supports at any tier and be linked to other services either at the same tier or in a different tier. The system, not the patient, should coordinate the services
Availability and Accessibility	Services and supports should be available and accessible within a reasonable distance and travel time of each person's home community
Matching	A person should be matched to services and supports whose intensity is appropriate based individual needs
Choice and Eligibility	If more than one service or support meets a person's need, the person should be able to choose among those services and supports
Flexibility	A person should be stepped up or down between tiers of care as their needs change
Responsiveness	People's needs change over time. People should be given the help needed to ultimately shift the care to services and supports in lower tiers
Collaboration	A person's pathway should be facilitated by collaboration between providers. Collaboration should be provided at both the clinical and administrative levels. Collaboration should occur both across tiers and between tiers.
Coordination	Health information systems should allow easy sharing of information between systems

Role of Primary Care in Providing Mental Health and Substance Use (MHSU) Services

- Primary care is foundational in that it provides a medical home for patients and helps to navigate the complexities and services of the health system. The role of primary care in servicing MHSU patients with high severity should include a coordination role that ensure patients receive more intensive treatment
- Severe MHSU patients benefit from an integrated approach where their whole health needs are addressed by a primary care and MHSU team that shares responsibility for care and provide services where patients actually are (e.g. same office, team approach to outreach, etc.)
- Examples of an expanded role for primary care could include:
    - Establishing outreach programs to identify and engage with individuals with mental disorders
    - Facilitating access to services that provide different aspects of health care, including mental health, and thus reducing the need for further referrals
    - Strengthening the collaboration and coordination between different services
    - Disseminating information on services both to marginalized groups and practitioners in the area

Access to Services

- Traditional office-based health and Mental Health and Substance Use services are not welcoming or appropriate nor accessible for many complex patients. A study of characteristics of services provided to the socially marginalized mental health population identified the following considerations that impact access:
    - Accepting of self-referrals
    - Open outside of normal office hours
    - Open on weekends
    - Requirement for out-of-packet fees
    - Operating a waitlist
    - No exclusion criteria
- Other ways to improve access to services include:
    - Provision of outreach services available where the patient is located
    - Service location should be convenient, preferably with multiple services at the same location and no long distances to travel. Locate traditional hospital-based services, where appropriate, closer to patients in the community. Convenience affects patient adherence to physician counsel

Themes from Discussions with Fraser Health

During the course of the review, we met with the Executive Director of Mental Health and Substance Use (MHSU) at Fraser Health. His comments included:

- Opioid crisis drives a need for more partnership on street (service providers and police)
- Police involved are doing less enforcement work, more social services work
- Limit the number of providers on the "strip", i.e. have a prime provider. FH contracts with the Lookout Society that operates 1-2 shelters, runs a primary care clinic, manages the HIV contract, provides needle pickup/clean up services, and runs the supervised consumption site. Having a dominant visible supplier is good – they develop a presence in the community that helps things get done
- Lookout Society pulls people from street to shelters
- Do inductions at clinics – close to the patient. Provide Opioid Agonist Therapy induction as close to people as possible
- Home and mobile detox (for mild to moderate detox) has been successful, particularly for Indigenous people. They are supported by their families in their communities
- 24hr medical detox service is most expensive – dissuade people from using it
- Do everything you can to stop tent cities
- Use of open contracts with six month semi-annual reporting. Focus on improvements/measurement
- Sobering centre – Fraser Health put one in. It saved 3,000 ER visits per year at start. It now saves 7,000 ER visits per year. Length of stay is 23 hours or less. Clients can consume after they leave but not while there. The City of Surrey donated land. Fraser Health provides nurses, support staff, social workers

Good Practice Examples

Support & Contact Person Scheme (Denmark)

- Legislation was put into place that requires the municipality to be responsible for providing support and contact persons to citizens with mental disorders, drug- and alcohol- addictions or citizens with special social problems who do not have or cannot live in their own housing
- The service is based on the idea of help to self-help and functions as an active bridge-builder between marginalized citizens and the established system of social services
- The scheme is anonymous and does not require registration of personal data

Health Team for Homeless (Copenhagen)

- Joint social and health outreach services for homeless people who do not have or cannot go to their own doctor

- The health team, comprised of four nurses and a physician, meet and treat people on the street, or wherever they are staying
- The goal is to make the homeless population more fit in their daily life on the street

Social Nurses at Hospitals (Denmark)

- Introduction of social nurses to create a positive experience for addicts admitted to hospital
- The role of the social nurse is to support communications between patients and hospital staff to avoid conflict and provide a plan for patients after discharge

Drug Injection Site (Insite – Vancouver)

- Manage concerns of local businesses having an injection site as a neighbor by "being the best neighbor on the block". This entails owning the sidewalk and alley in front and behind the site, e.g.
  - Keep the sidewalk clean and free of debris
  - Good lighting out front and back to prevent people gathering
  - Encourage clients to use the site but then move on once done
- Provide training to injection site staff on how to deal respectfully with clients; provide supports to deal with the potential trauma associated with working at the site
- Work with local police to implement a community policing role/presence:
  - Community resource is meant to interact with clients and encourage use of the injection site and even walk them there. This changes the dynamic between clients and police
  - A marked police car with an officer "walking the beat" deters crime
  - Police to meet with clients to set expectations that it is acceptable to use and that police will respect process at site; recognize that addiction is a health issue and that police will not arrest/convict

Context for Recommendations

Principles Guiding the Recommendations

The Caring for People with Addictions Working Group and the External Advisory Committee identified the following principles to guide the Downtown Prince George Health Services review. These principles informed the recommendations.

- Commitment to patient-centred care – Northern Health Idealized State Model
- Harm reduction is part of everyone's work
- Attach patients for better care. Even 'drop-in clinics' must have the goal of attaching patients
- Integration of services is fundamental
- No door is wrong door – every door is the right door
- Trauma Informed Care
- "Make it easier for client" rather than for us
- Be sensitive to the needs of downtown businesses and citizens

Service Delivery Model Goal

The recommendations offered as a result of this review all support the goal of creating a collaborative, integrated downtown Prince George Health Service Delivery Model as per best practice. This model is seen to be the best "fit" for meeting the needs of patients/clients, providers and the community alike.

Patient Acuity

Mild
Moderate
Severe
Complex

Communications Approach
Co-location & Collaborative Approach
Integrated Team Approach

Model

GOAL

The Northern Health Idealized State Model provides the starting point and is the foundation for the recommendations.

Recommendations

Introduction

Our recommendations are organized as follows:

The Overarching Recommendation describes the future service model. This overarching recommendation is supported by recommendations that relate to Functions within the Service Model i.e. functions and tools that will improve accessibility and integration.

The overarching recommendation is also supported by a set of Service Model Enabler recommendations describing support structures that are necessary to implementing this future service delivery model.

Overarching Recommendation

Recommendation 1 | **Implement an Accessible, Integrated Service Model (the "what")**

This involves establishing a fully integrated, wraparound, inter-professional team that provides primary and community care and specialized Mental Health Substance Use (MHSU) services to the downtown Prince George (DTPG) site.

This team:

- Is an integrated team dedicated to DTPG
- Created by combining existing resources from Assertive Community Treatment (ACT), Intensive Case Management Teams (ICMTs), Interprofessional Practice Teams (IPTs) and potentially Primary Care Homes (PCHs)
- Is to be co-located
- Provides wraparound support wherever possible where the patient is located. E.g. PCHs, supportive recovery beds, transitional beds, shelters.

Comments:

- Team members are Northern Health employees
- Aligns with best practices: "Severe MHSU patients benefit form an integrated approach where their whole needs are addressed by a primary care and MHSU team that shares responsibility for care and provide services where patients actually are (e.g. same office, team approach to outreach, etc.)"
- The co-location of ACT and ICMT at Professional Building is already proving to be positive
- In this service model, services surround the patient. The ideal situation is one in which the patient is not experiencing major transitions between services or between levels of service.

Functions Within the Service Model

The following recommendations relate to the functions provided in the accessible, integrated, wraparound service model:

Recommendation 2

Outreach/Transportation Functions

- Establish an outreach function to provide support to the downtown Prince George (DTPG) population served
- Function to be created from existing Primary Care Home (PCH) and HIV/Aids Prevention Program (Needle Exchange) resources and will service DTPG clients
- Outreach function to connect population served to DTPG health services and to ultimately attach patients to PCHs

Comments:

- Currently Central Interior Native Health Society (CINHS) and nurses from the HIV/Aids Prevention Program (Needle Exchange) provide outreach services. CINHS services today include:
    - Delivery of HIV antiretroviral medications
    - Alcohol & Drug Counsellor facilitated Wellbriety weekly support group
    - Inpatient visits at UNHBC
    - Support with attendance at medical or social programming appointments
    - Advocacy
    - Elder visits

- There is potential to expand outreach services. Examples include:
  - » Home and mobile detox. At Fraser Health, this has been successful with the Indigenous population who are supported by their families and communities
  - » Services to jails: providing re-entry programs such as life skills programs now delivered to downtown Prince George (DTPG) clients; attaching clients
  - » Van services to take/accompany people to appointments, hospital, meals
  - » Life skills support

Recommendation 3	**Coordination Function**
	Establish a Coordination function located in the downtown Prince George (DTPG) service area that is responsible for coordinating and connecting patients to appropriate DTPG site services and resources. The Coordination function: • Promotes access to services & communications between services • Has knowledge of all DTPG services; maintains a central inventory; is able to direct patients to services; is able to provide care providers with referral information • Has information related to waitlists. It could be a call centre for waitlist management of inquiries • Facilitates the sharing of care plan information amongst care providers • Has responsibility for certain administrative/logistical (non-clinical) services such as housing directory management; serves as a prime link to BC Housing

Comments:

- Acts as a linkage mechanism to reduce silo issues
- Eliminates the need for each service provider to have their own mini-referral network
- Housing lists are currently maintained at different service sites. Currently all contracts with Support Recovery providers include the clause "provide support to linkages to housing services"

Recommendation 4	Primary Care for the Unattached
	Introduce primary care services for unattached patients Create capacity in the downtown Prince George area by: • Introducing a flow through model (similar to Blue Pine) to enable unattached patients to access primary care services, and assist in placing unattached patients in the most appropriate Primary Care Home (PCH) • Identify a locale for this service

Comments:

- A flow through model will require additional physician and/or nurse practitioner resources

Recommendation 5	Access to Primary Care
	Primary care home hours to be revisited to improve access and availability of after-hours care for the downtown Prince George population served, using low barrier systems such as flexible appointments and non-traditional hours.

Comments:

- Currently clients use the Emergency Department for after-hours care
- To improve access, after-hours urgent care should be available within a reasonable distance to downtown Prince George

Recommendation 6

Care Plans

Develop a single care plan for each patient. Care plans to be dependent on client needs:

- Longitudinal relationships with care providers – care providers collaboratively develop plan; to be housed in Primary Care Homes; updated, shared and maintained by primary care provider
- Episodic client interventions – "plans of care" developed by care providers to describe/communicate involvement with client related to episodes. Plans of care to be informed by, and feed back into, the overarching care plan
- The coordination function facilitates the sharing of care plan information

Recommendation 7

Community Programs

Leverage existing resources to provide additional programming for the population served
Ensure programming is inclusive and available for the population served

Service Model Enablers

Recommendation 8

Site-Based & Site Leadership

Implement a site-based model for delivery of health services in downtown Prince George (DTPG) Site. The model considers DTPG as the Site, e.g. similar to UHNBC being a site.
The model allows for:

- A holistic view of all services delivered to the DTPG population served (both site specific services and regional services)
- A DTPG Site Leader who:
  - Has clear accountable leadership for all Northern Health delivered services and all Northern Health contracted services
  - Owns budgets and contracts for the DTPG Site
  - Interfaces with Mental Health and Substance Use regional programs and services through a matrix model
  - Promotes collaboration between services/service providers and ensures linkages are in place between services
  - Monitors measures and outcomes. Monitors health status, health needs and experience of care of the population through qualitative information and consultation. Works with Public Health within NH to conduct these population based assessments.
  - Manages relationships with:
    - Downtown Prince George service delivery partners. E.g. RCMP; Programs; Corrections, etc.
    - The City and business community
    - Acute and program leaders
  - Develops an overall philosophy on approaches to working with clients in downtown Prince George and working together across services (eliminating barriers for clients)

Recommendation 9 | **Co-location/Service integration**

Integrate and co-locate services where possible, increasing co-location over time as opportunities present.

Comments:

- The ideal state is a fully integrated co-located model that includes primary care homes, AIDS services, drop-in space, social program space, etc.
- Future integration/co-location opportunities need to be explored, subject to funding availability

Recommendation 10 | **Central Interior Native Health Society (CINHS) Contracts**

Combine the Primary Care Homes and the HIV/HCV CINHS contracts into a single contract and revise contract deliverables to include both primary care and Medication Adherence Support Program (MASP) related activities.

- Promotes integration of CINHS resources to better serve its patients
- Streamlines contracting process
- A review of CINHS existing contracts and service model will be required to determine how best to integrate the 2 contracts and new services (HIV/AIDS Prevention Program (Needle Exchange) and outreach for downtown Prince George

Recommendation 11 | **Contracts - Partnership Philosophy**

Implement a contracting philosophy that builds long-term, collaborative partnerships with service providers in the downtown Prince George site.

- Extend terms of contracts beyond one year to:
  - Provide greater stability to service providers
  - Enable longer term joint planning
- Focus to be on contract outcomes and deliverables; less focus on contract renewal
- Contracts to incorporate explicit terms that services are to be provided to the population served

Recommendation 12 | **Supportive Recovery services**

Identify one qualified partner to supply and manage supportive recovery beds and services to meet Northern Health needs
Allows for:

- Development of a strong partnership with a prime supplier
- Provider to create a stronger presence in the downtown Prince George (DTPG) site, thereby enabling better linkages to their beds
- Provider to develop a critical mass which allows for an enhanced ability to provide support services and programs, e.g. Home Support
- Reduces administrative burden by not having to deal with multiple service providers
- Expanding contracts to include tangential services (drop-in space, outreach)

Comments:

- Consider changes to existing contracts, e.g. lowering barriers to acceptance, establish overflow beds, provide beds to complex patients being discharged from hospital, etc.

Recommendation 13 | **Community Programs**

Perform joint program development across service providers for similar programs, e.g. vocational skills; life skills, social programs.

- Joint work to be facilitated by DTPG site leader

Recommendation 14 | **Training**

Ensure that all service providers in the DTPG site have the necessary skills to work with the Mental Health and Substance Use (MHSU) population.

Comments:

- Training to include trauma informed care, harm reduction, and cultural competency
- Consider peer to peer training making use of peer skills that exist

Recommendation 15	Partnerships with Others
	Northern to engage with partners to solve problems jointly and to work together to address areas where overlapping mandates exist There are other areas that require attention. These relate more to housing and social services than to health services. These include housing, social services for people released from jail

Comments

a. **Social/rehabilitative space**
   - Safe consumption site needs a designated physical location.
   - Expand social/rehabilitative spaces to support for the downtown Prince George (DTPG) population served. The most appropriate providers should be providing services based on the needs and location of the client

b. **Sobering Supportive Care Space**
   - Introduce supportive care space for the DTPG site.

c. **Most Responsible Practitioner (MRP)**
   - Introduce an MRP model for RCMP "familiar faces"

Appendices

A. NH Downtown Services Review - List of Stakeholders

Northern Health Employees

Executives, Senior Leaders, Staff

1. Cathy Ulrich
2. Penny Anguish
3. Aaron Bond
4. Anne Chisholm
5. Andrew Gray
6. Fiann Crane
7. Suzanne Campbell
8. Jim Campbell
9. Ciro Panessa
10. Sandra Allison
11. Michelle Lawrence
12. Graham Hall
13. Maria Tejero
14. Shawn Arnott
15. Bareilly Sweet
16. Dr. Fredeen
17. Linda Keene
18. Jennifer Hawkes
19. Brenda MacDougald

NH Focus Group Attendees

20. Frantisek Anderko (IPT)
21. Brigitte Loiselle (IPT)
22. Leslie Budac (IPT)
23. Hamsah Hussain (IPT)
24. Brenda Edwards (ACT)
25. Vanessa Mohns (ICMT)
26. Dave Routley (team leader ACT)

Agencies

Contracted Agencies

27. AWAC – Connie Abe
28. BC Schizophrenia Society – Lynn Smoliak
29. Blue Pine Clinic – Olive Godwin, Megan Hunter
30. Canadian Mental Health Association – Maureen Davis
31. Car 60 - Warren Brown (RCMP)
32. CINHS - Murry Krause
33. DART – Glen Grant
34. Northern BC Crisis Centre – Megan Usipuik
35. Northern HIV Coalition – Emma Palmantier
36. Phoenix Transition Society – Executive Director
37. Positive Living North - Vanessa West
38. Prince George Native Friendship Centre – Barbara Ward-Burkitt
39. SST & CINHS HIV Project –Kyle Pearce (Consultant)
40. St. Patrick's House – Lillian Jones

Non-Contracted Agencies

41. BC Housing - Malachi Tohill
42. Community Corrections – Jeff Grainger
43. Elizabeth Fry Society – Kathi Heim
44. Forensics Services – Melanie Carrington
45. London Drugs – Mike Lizotte
46. Prince George Public Library – Ignancio Albarracin
47. Pharmasave - Maureen
48. Rexall Reid's Prescriptions - Jeremy Comba
49. St Vincent de Paul – Lynn
50. Third Ave Evergreen Pharmacy - Patrick

Physicians and Nurse Practitioners

51. Colleen Booth, NP - BP
52. Dr. Tim Bowen-Roberts, GP - BP
53. Tracey Day, NP - CINHS
54. Heidi Dunbar, NP - BP
55. Dr. Basia Hamata, GP - BP
56. Dr. Hamour
57. Dr. Heather Smith, GP - CINHS
58. Linda VanPelt, NP – BP
59. Patty Wilson, NP - BP

Downtown PG Focus Group

60. Canadian Western Bank - Derek Dougherty
61. CIBC - Clint Mouse
62. City of Prince George – Myles Tycholis
63. Coast Inn of the North - David McQuinn
64. Copper Pig BBQ Inc. - Tyler Burbee
65. Downtown Business Owner & Downtown PG Board Member - Eoin Foley, President
66. Downtown Business Owner & Downtown PG Board Member – Rod Holmes
67. Downtown Business Owner & Downtown PG Board Member – Simon Yu
68. Downtown PG - Colleen Van Mook, Executive Director
69. Jon M. Duncan Law – Janelle Smith
70. Kaiten Mixed Martial Arts - Karm Manhas
71. Levine & Company - Ben Levine
72. Majestic Management - Bob Hillhouse
73. Majestic Management - Dave Hillhouse
74. PG Farmer's Market, President & Downtown PG Board Member - Philip Myatovic
75. Prince George Chamber of Commerce – Cindi Pohl
76. Prince George Public Library – David Wyssen
77. Ramada Prince George - Heather Oland, GM
78. Telus - Jill Brander
79. Telus - Michelle Lequereux
80. Tourism Prince George - Erica Hummel

Other

81. EDI Environmental Dynamics Inc

B. Themes from Focus Group Meetings Held November 2015

Purpose of the Meeting

1. To share ideas about how Northern Health can improve services for people who use drugs in Prince George
2. To build a relationship for future collaboration between Northern Health and people who use drugs in Prince George

1. Good things?

- Medical Adherence Support Program (MASP):
  - MASP – "it is the only way I have my virus suppressed is that they come out and find me to make sure I take my meds"
  - MASP does a lot to help people – also provides access to shower, laundry, lockers
- Positive Living North (PLN):
  - Provides a lot of support to people with HIV
  - Wellness Place – does a lot to decrease the risk of transmitting HIV and Hep C and to decrease the drug litter.
  - Wellness Truck – Lower the risk of HIV/Hep C and litter around town
- Needle Exchange
  - Needle Exchange – "There has been a big difference in the past 10 years with the needle exchange helping drug users." "The needle exchange is a good thing. They gave narcan kits and saved 3 people who were overdosing"
- "The Fire Pit:
  - Is critical for food. It's important not to lose."
  - Ability to go there daily
- Housing hub
- AWAC

2. Limited access to medical services and supports

- Hours of service inadequate
- Can't see medical care (NP/GP) at Central Interior Native Health Society (CINHS) sometimes for a week
- Care for HIV population is monthly at the CINHS, more frequent sessions better
- Sometimes go to walk-in

3. **Access to medical services and supports** (mental health, addictions, opioid substitution)
   - Everything in once place makes it easier (e.g. CINHS, specialists, MASP, methadone)
   - There needs to be a drug, alcohol, and methadone program and a detox co-located with a safe injection sight. "When there is a waitlist there is a lost opportunity."
   - "Help is needed for families of people who use drugs."
   - "I would also like to see a safe injection site, drug and alcohol counsellors, OST. Addictions holds people in bad/dangerous situations."
   - People have multiple medical needs but sometimes "to get on one med, you need to be on the others" (e.g. opioid substitution, mental health meds, HIV meds)
   - Specialists may only be available once a month – appointments are easy to miss
   - Street nurses/outreach would help people attend appointments

4. **Access to addiction services**
   - Detox beds are so hard to get
     - 1-2 week waiting period
     - Can't smoke – too difficult to quit two drugs at once: "*I'm not here to quit smoking, I'm here to quit heroin*"; nicotine patches don't work for everyone
     - Kicked out before completing taper and transition to suboxone – unable to continue the process on the street, went back to using
     - No follow-up post-detox
     - We need more beds in detox; Detox availability when we need it
     - Treatment beds, too… how can someone wait so long, and if you aren't ready when it comes up, you miss it
     - "There needs to be a relapse prevention program."
     - A place in downtown for meetings, e.g., NA. "*I've been to other meetings, like in churches, but I don't feel comfortable there. We need a place for us, our peers, where we would feel comfortable.*"
   - "*Dislike: Detox waitlist. Need more OST Access*".
   - "*Alcohol and Drug treatment centres or day programs for women – New Hope is a very good place to be.*"

5. **Continuity of services and seamless transitions**
   - There are no services to support people when they get out of detox or treatment or jail, it is so hard to stay clean without services/new circles of friends/consistent access to methadone
   - Not enough methadone doctors
   - If you can't get carries, you lose your job

- Post-prison, post-treatment, post-detox… you are just left on your own
- Post-prison services include John Howard Society, Elizabeth Fry, Phoenix House
    - But they are not sufficient – many people are still left on their own
- There are no services to support people when they get out of detox or treatment or jail
- Post-prison, post-treatment, post-detox it is hard to get help
- Individual working with us on street

6. What's needed?

- Supervised injection site
    - Overdose risk is higher with fentanyl circulating: "*if I was OD'ing, I'd want a nurse beside me*"
    - "*Trying to hit in the cold*", you can easily wreck your veins, which make future injecting more dangerous and makes it difficult to receive medical treatment for other conditions (e.g. bloodwork for HIV/HCV, IV fluids in emergency situations)
    - Nurses could teach people how to inject properly, to avoid abscesses and protect veins – teaching is better if nurses can actually see what you are doing
    - "*If there was a safe injection site I wouldn't feel rushed doing it. There is more risk when you are rushed. You don't measure as well. My two ODs were when I was feeling rushed*".
    - "*Why not have a safe injection site?*"
    - "*I was turned away twice from the Dr. Peter Centre*."
    - "*People are injecting in front of the needle exchange because they know there will be help close by [if they overdose]*."
    - "What are the next steps, what do we need to do to get a safe injection site?"
    - "[…] seeking a warm place to inject because I can't get a vein in the cold."
    - My name is Nicole Dennis, I have been an intravenous user for 15 years I have been using drugs for 16 years and I honestly believe and trust the safe injection site should and must be opened so less mess of needles on streets and just plain safer for everyone still in the scene.
    - "Dislike: too rushed, no safe place to prepare and inject."
    - "Want: Safe Injection Site, Missing People, Od(ing) Dying."
    - "People are overdosing, dying, there are very dangerous people dropping like flies".
    - Concerns about overdose were frequently mentioned
- Sharps containers out in the open, where people use
- But you would probably get flak from the Downtown Business Association

- People use in the open because they have been pushed out of alleys where sharps containers were installed: there are stories of business owners only becoming aware of drug users, and decrying areas as unsafe/trying to push drug users out of alleys, once sharps containers have been installed.
- "Service providers need to learn how to talk to drug users."
- "Funding for everyone's IDs."
- Pay for people on S.A. Drivers licence – that's a job right there
- "Individual one on one workers so the street people can reach their goals, help get a home for everyone on the street."

7. **Youth on the Street/ Services for Youth**
   - Services for youth
     - Many services cut off once you turn 19
     - The Happening (?), the Reconnect are good but not sufficient
     - Not good that the Reconnect is right across from AWAC
   - "We need a treatment centre and we need one for teenagers too."
   - "More funding for the younger generation for hobbies, start training and disciplining there way of thinking and living and give them more of a positive way in life and living. (Read if you want about me) like when I was younger I wanted to get into kick boxing and we had no money for me to do that, I just weight lifted and learned from my brothers and TV."

8. **Drug Dealing**
   - "People dealing drugs outside of the Fire Pit; it's not okay."
   - "Dealers need to be given a helping hand, they are men first." "We help other criminals, why don't we help addicts?"

9. **Street Safety**
   - People used to take care of each other on the street, now they just want to rob each other
   - In the 90s, people used to invite you into their home, nobody would be allowed to sleep on the street – now it's "everyone for themselves"
   - I got jumped this summer, while I slept in a doorway, they wanted to rob me
   - People's stuff is getting stolen all the time
   - We really need a place to lock up our stuff
   - If you get kicked out of the shelter, they throw out your stuff, doesn't matter what's in there
   - How can you keep getting new ID when everyone is throwing away or stealing your stuff?

What's needed?

- Lockers
  - A group of people (Audrey Swartz, Diana Nakamura, Sam ___) tried to set one up at one point, did all the research, but it didn't work out
  - Union Gospel Mission in Vancouver uses plastic bins to avoid infestation – otherwise food left in lockers attracts mice, and bedbugs may spread from one person's things to another's
- A place to keep a current photo
  - It would help police look for you if you ever went missing

10. Housing is a huge problem

- Prejudice and discrimination – drug user, street person, aboriginal, almost impossible to rent. Landlords won't give anyone a chance.
- Discrimination
  - Towards Native people, street-involved people, drug users
  - From health care providers, shelter staff, police, landlords
  - *"Services don't understand how to deal with trauma"*

What's needed for housing?

- Housing First approach
- Options for wet housing
  - You have to be clean, you have to be a certain way for the landlord, lots are unsuccessful once they get a place
  - Shelters
- Not wheelchair accessible, either physically (e.g. showers) or in terms of staff knowledge
  - Staff don't know how to deal with difficult behaviour or drug use, so they just kick us out and they throw away our stuff (including IDs)
  - Only one drug and alcohol counsellor, and no case managers
  - If you have nowhere to go when it's cold, you may do meth and walk all night just to stay warm
  - "When I come out of detox I want someone to call, and housing. But not a shelter."
  - "People are released from prison, they come out clean, but there is nowhere to go but down town. They need someplace to go."

- “A lot of the time the shelters asking the residents who are sick to leave the shelters during the day. We need somewhere to go during the day to stay warm, and off the streets. We know we are homeless we don’t need a reminder every day we have no home its hurtful and depressing.”
- “More affordable housing, when housing rental rates go up automatically our cheques, should go up also. Same as disability cheques too. We can have a chance of living off the streets, instead of on the streets.”

11. Policing

- improved over 4-5 years ago – used to be very disrespectful and aggressive however “Red-zoning” is causing a problem for people, as they need to access services
- Shelters are downtown and lots of services. People get red-zoned out of the exact area that provides the services they
- One of the providers: *My client didn’t show up for her appointment and called me from the police station. She was picked up. When I asked her what for, she said walking to my appointment, she was red-zoned…. The cop was unapologetic to me (the provider) and eventually she was let out and she made her way to my appointment, but why does it have to be so hard??*
- “They encourage people to use the needle exchange.”
- “When police don’t get involved it is like they don’t care.”
- Several people commented that they feel safe with the police around

12. People downtown are seeking normalcy…

- As we would find define it… a home, a meal, a pet, a safe place…
- Jobs
    - *“When I have a job, I do real well”*
    - *“We want to be involved in our community”*, *“why not hire us?”* (e.g. for downtown clean-up)
- “There needs to be more activities.” “Dislike: Lack of recreational activities.”
- Jobs “Hire peers to help, to work. Give us a chance […] It’ll start us thinking positive and want to stop using drugs”.
- “Make up courses for all people who work at the shelters, most of them don’t know how to talk, work or handle the people on the street.”
- “Open up more programs, workshops, work experience so we have an opportunity to move ahead, get off welfare, this will help keep us sober, budgeting, independent living.”

13. **We started to dream big – What if:**
    - We could have a little area of tiny houses, Robert described a project (Calgary) where tiny homes (8x8) were built in a contest… it would be great to have a little community of tiny houses for people… if you run out... make more
    - We helped people build their skills by having a restaurant that is run by our close to the street people… food, safety, somewhere to go... build community, build skills
    - We helped our community by building skills in home renovations... upgrade the housing stock in PG, build skills, gain a job.
    - We could see several of our youth through to successful university completion through the funding programs for youth in care
    - We could have similar consultations in the PGRCC and the PGYCC….

14. **Litter**
    - Needle litter on the street
        - "Needles on the street are a big concern when you are living in the hood."
        - "[We must] educate the kids and daycare teachers about the risks associated with needles."
        - "I'm concerned about the children being exposed [from] stepping on used needles."

15. **Discrimination**
    - In reference to the recent surge in over doses, "some people just think, oh, they are only drug users".
    - "We are looked upon with discrimination whereas alcohol is okay and available."
    - "Someone needs to talk to all Landlords of Prince George, show them different outlooks on everyone and the natives that live out here."

C. Service Overlaps

Many like-services are offered by multiple providers. The chart below is illustrative of potential function overlaps.

Programs	Supportive Recovery	BCSS	BCMHA	Day Additions Program	DART	PLN
Life skills		✓	✓	✓		
Social – recreational & recreational skills; counselling		✓				
Employment – volunteer placement (vocational)/paid employment		✓	✓		✓	
Consumer/peer support & advocacy			✓			✓
Housing Lists	✓		✓			
Food prep		✓				

D. Primary Care Home Comparison

Element	Blue Pine	CINHS
Patient Profile	• Attached patients who require team-based care beyond what is normally available in a physician's office • Unattached Persons who do not: o have a care provider and require team-based care o have a care provider. They will be provided care, assessed and placed in the most appropriate primary care home. • A small proportion of patients are First Nations compared to Central Interior Native Health Society (CINHS) • Takes CINHS appropriate patients if CINHS' intake is closed • Many MH&A patients; chronic pain patients - many of whom are marginally housed	• Marginalized and Aboriginal Population of Prince George • Individuals or families living in poverty • Youth at risk • Individuals living on or close to the streets • Individuals who fit one or more of the above criteria and are struggling with mental health and/or addiction issues • Any person newly diagnosed with HIV or anyone living with HIV • All patients are attached patients
Service Model	• Primarily attached patients • Flow through model to enable unattached patients to access primary care services until they become attached • Connected with multi-professional teams. Aligned with NH Idealized State Model in that it uses services of NH IPT team for social work, etc. IPT employees are NH employees • Limited outreach services	• Attached model • IPT-like services are integrated part of model. Social worker, etc. are employees of CINHS • Operate several outreach services
HIV - MASP		• Operate MASP program

Element	Blue Pine	CINHS
Outreach Services	• Provide home visits to their house-bound patients. May see patients at other locations (e.g. NE)	• Outreach services are implemented to assist patients to be successful in the management of their own health care. Outreach services of CINHS include but are not limited to: o Delivery of HIV antiretroviral medications o Alcohol & Drug Counsellor facilitated Wellbriety weekly support group o Inpatient visits at UNHBC o Support with attendance at medical or social programming appointments o Advocacy o Elder visits o Support and transportation to appointments with MCFD o Transportation to and from Wellbriety o Transportation to CINHS services or specialist appointments o Transportation and support to obtain food hampers, groceries, clothing, necessities, etc. • Two nurse practitioners (1.5 FTEs) who are allocated to CINHS facilitate outreach satellite clinics at New Hope, AWAC, and Nusdeh Yoh

E. Downtown Prince George (DTPG) Health Services Hours of Operation

Health Service	Hours	M	T	W	T	F	S	S
CINHS	8:30am – 4:30pm	✓	✓	✓	✓	✓		
CINHS Outreach	8:30am – 4:30pm	✓	✓	✓	✓	✓	✓	✓
MASP	8:30am – 4:30pm	✓	✓	✓	✓	✓		
BP	8:30am – 4:30pm	✓ ✓	✓ ✓	✓ ✓	✓ ✓	✓ ½		
BP Drop-in (for attached)	1:00pm – 3:00pm	✓	✓	✓	✓			
PLN	9:00am – 4:30pm	✓	✓	✓	✓	✓		
CMHA	8:30am – 4:30pm	✓	✓	✓	✓	✓		
FP	9:00am – 4:20pm	✓	✓	✓	✓	✓		
AIDS Prevention Program / NE	1:00pm – 6:00pm	✓	✓	✓	✓	✓	✓	
AIDS Prevention Outreach / NE	7:00pm – 11:00pm	✓	✓	✓	✓	✓	✓	
BC Schizophrenia	Daytime and scheduled evenings							
DART		✓	✓	✓	✓	✓		

F. Northern Health Contracts Overview

	Length of Contract
Contracts – Supportive Recovery	
Phoenix (14 beds)	1 year
St Patrick's (4 beds)	1 year
AWAC (9 beds)	1 year
Friendship Centre (15 beds)	1 year
Contracts – Primary Care Homes	
BP	1 year
CINHS - PC	1 year
CINHS - MASP	1 year
Contracts – Program Agencies	
CMHA	1 year
BC Schizophrenia	1 year
DART	1 year
BC Crises Centre	1 year
PLN	18 months
PLN	3 years
Agreement	
Car 60	MOU in place