ARCH Business Case:

An Opportunity for Addiction Recovery Community Housing in Northeast BC

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Original Business Case Template Contributors

The present North Wind Wellness Centre (ARCH) Business Case is adapted from a business case template developed for Streetohome by Denise Bradshaw, Project Manager, Streetohome and Mehrzad Zonji, Consultant, KPMG. The inspiring vision in support of people seeking and in recovery was sponsored by John McLernon and Kevin Falcon (Co-chairs of Streetohome Foundation's Addiction Recovery Committee) and Rob Turnbull (President & CEO, Streetohome Foundation).

This business case template would not have come to fruition without the forward thinking, creativity and courage of the following people whom volunteered their time to contribute to the Addiction Recovery Working Group at Streetohome.

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Adapted Business Case Contributors

The vision: supporting the adapted business case; ensuring cultural safety to reduce barriers to accessing recovery supports; promoting a connection to land, culture and traditional healing as integral to wellness for First Nations in Northeast BC; and embracing a warm welcome to non-aboriginal clients was Isaac Hernandez, Executive Director, North Wind Wellness Centre. The North Wind Wellness Centre Board of Directors endorsed the project.

NORTH WIND WELLNESS CENTRE

Assisting to achieve balance in life

Denise Bradshaw, Program Director at BC Mental Health and Substance Use Services, Provincial Health Services Authority and Annie McCullough, Executive Director, Faces and Voices of Recovery Canada provided constructive feedback on earlier versions of the business case. The Streetohome Team (Rob Turnbull, President and CEO; Tracey Harvey, Administration and Donor Manager; Dave Nelson, Project Coordinator) provided content editing and graphic design support.

Executive Summary

The North Wind Wellness Centre (NWWC) has committed itself to addressing and preventing homelessness and addiction in Northeast BC. In terms of prevention, North Wind concurs that *"we cannot build ourselves out of homelessness"* – *rather,* we need to address the underlying root causes of homelessness. While homelessness is multi-faceted, it is understood that there can often be a relationship between homelessness and addiction.

Historically, BC has struggled to address the issue of addiction. Addiction is a complex health and social issue that has significant relationships to the social determinants of health. Any response to addiction at the systems level requires an understanding of the interrelationship between homelessness and addiction, addiction and trauma, and addiction and the social determinants of health.

At a systems level, what we know is that the system of supports for people seeking recovery is fragmented. There are many high quality, evidence-informed programs across the province providing exceptional care and support to people with addiction. Unfortunately these programs are disjointed, not easily accessible, often have long waitlists and after-care supports are lacking (or not sufficiently addressed); not to mention the gap in providing a complete continuum of care that would enable recovery to become effective. Most treatment programs do not focus on client intentions in terms of education/training, employment or meaningful activities. Furthermore, many programs do not harness the resources of the broader recovery community (i.e., peers, families and friends contemplating a recovery journey; people in long-term recovery, their families, friends and allies; recovery-focused professionals; and organizations whose members reflect pathways of recovery).

The intent of this business case is to present a viable solution of how the Northeast of BC can build Addiction Recovery Community Housing that is *'health care lite'* and addresses the fragmentation in the treatment system, has a foundational housing component, is recovery oriented and is largely led by people in recovery. The Addiction Recovery Community Housing (ARCH) model includes four programs that can stand alone; however they are stronger and more effective as an integrated synergy:

Executive Summary

A. Recovery Community Centre (RCC): A safe place for people in recovery to gather, support one another, take part in programs and support peers in various stages of recovery. Development of social enterprises is an opportunity that ought to be realized at an RCC.

B. Early Recovery Housing (ERH): A temporary housing landing zone for people on waitlists for treatment, being discharged from hospital, or identified by the RCMP as motivated for treatment. Addiction Medicine Physicians will provide assessments and treatment referrals to ensure the right treatment (level of care) is prescribed.

C. Addiction Treatment Housing (ATH): Housing for people in treatment. It combines housing with a holistic program that is spiritual and trauma based, violence and gender-informed combining best practices and Indigenous traditional values to guide participants to a balanced life.

D. Recovery Supportive Housing (RSH): Housing for people that have completed a treatment program or are committed to recovery and want to live in a supportive Addiction Recovery Community. Education/training, employment and meaningful activity are key to recovery and a priority focus. Tenants will have access to the RCC for ongoing support from peers and will provide support to people in the ERH and ATH.

The ARCH model is based on the philosophies of Recovery Community Organizations (RCO) and Recovery Community Centers (RCC) which have existed in the U.S. since 2001. There are 750 entities of the RCO and 80 of the RCC. The integration of the four components of the ARCH model is unique in Canada – there is a fledging ARCH model being considered by the Salvation Army in London, Ontario.

The CARMHA (2017) report indicated that three major challenges in the current BC treatment system need attention:

1. Waitlists for live-in treatment are too long.
2. Live-in treatment is not enough on its own, and not long enough (length of stay varying from 30 to 90 days).
3. Live-in treatment programs rarely address vocational and employment needs.

Executive Summary

The ARCH model proposed here addresses all three challenges while providing a continuum of care that people struggling with addiction ought not to 'fall out' of once they enter. The intent of such a model is to keep individuals engaged in their recovery journey regardless of their stage of change. The aim is engage participants where they are at, and at a pace that is comfortable to work on, so as to support them on their journey to recovery.

The business case outlines the evidence for development of a continuum of housing and recovery supports that stretches program engagement to 2.5 years with lifelong aftercare and involves peers (people with lived experience) and family throughout. The overall operating costs for the option of providing an integrated model comprised of a Recovery Community Centre, 8-bed Early Recovery Housing, 16-bed Addiction Treatment Housing and 16-unit Supportive Housing Program is $2.0M. Common property management and the sharing of staff across four programs is intended to create efficiencies that contain expenses. The strong network of peers and family/allies contribute to both the efficiency and effectiveness of the Addiction Recovery Community Housing model.

The First Nations Health Authority currently contributes funding to a 45-day, culturally based, 10-bed residential treatment program for ages 19 and up and a two-week program for youth ages 13 to 18 at the North Wind Wellness Centre in Farmington. A request will be made that this funding be increased for early recovery and addiction treatment supports and ported as the program transitions into the ARCH model. The capital funding and additional operating funding required (i.e., tenant support and property management) is within the range of BC Housing funding for housing the most vulnerable of the homeless population. In addition, as the Recovery Community Centre gains traction, opportunities for the development of social enterprises that contribute to operating expenses and employment opportunities for clients are possible.

The location of the proposed Addiction Recovery Community Housing will be developed on property owned in Pouce Coupe (23 acres) or Farmington (150 acres). Alternatively, either one or both properties could be sold and a more suitable site purchased. Building costs are not confirmed as the site parameters and any existing buildings will determine construction options.

Motivation to Shift to Recovery Oriented System

"It is well known that there often exist brief windows of opportunity during which an individual is ready to address their addiction. It is during these periods that we must engage individuals and guide them towards recovery. Timely matching of services with people whom are most in need, and most likely to benefit from interventions, is necessary to optimize the utility of live-in addiction recovery programs and improve outcomes at the population level." *CARMHA REPORT, 2017*

"Our supports for people living with mental illness or substance abuse are fragmented, uncoordinated - huge gaps. We want to get to a place where you ask once and you get help fast."

B.C.'s Minister of Mental Health and Addictions, Honourable Judy Darcy

"In Dawson Creek, in the last little while, there have been a few families that have lost children to this drug. I ask council to initiate a public education campaign about fentanyl overdoses and provide more services such as addiction clinics, housing and shelter for those struggling with addictions, and counselling services for families."

Theresa Simmonds, mother of Michael Mulligan who was just 21 when he died, CBC News, October 2017

"Migration into urban regions with high concentrations of services may not lead to effective pathways to recovery, while exposing individuals to health and social risks associated with poverty…the implementation of housing and support services adapted for rural settings could prevent the extreme morbidity, personal hardship and escalating rates of services use."

Julian Somers, Faculty of Health Sciences, Simon Fraser University, October 2015

"If we can support people on the waitlist, know they are safe – this will save lives. Often when someone reaches the top of the waitlist, we cannot find them. This is heartbreaking – we don't know where they are or if they are alive."

Streetohome Survey Response from Service Provider Consultation, August 2017

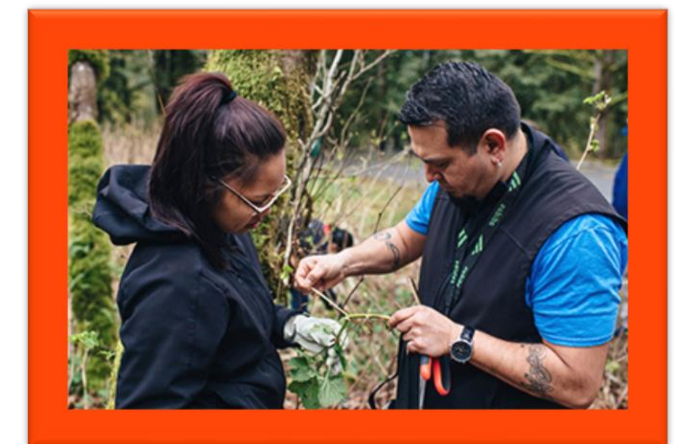
Background

North Wind Wellness Centre: Mandate

The North Wind Wellness Centre (NWWC) is a community-based organization with charity status, established initially to serve the First Nations Communities of the BC Treaty 8 Territory in 1996. Its mission is to meet human needs with compassion by providing tools to assist persons recovering from addiction, gaining self-reliance, discovering their unique gifts, developing their unique abilities, and finding support within their family and community.

As a result to its mission, North Wind has served over 1600 persons struggling with multiple addictions through its **Residential Treatment Program** in a 10-bed facility. This program was initially supported by Health Canada, and later by First Nations Health Authority (since October 2013). An average of 360 individuals, per year, participate in its **Out and Day-Patient Programs** mainly supported by volunteers as well as its youth and adult **Land Based Treatment Program** that is available in specific Indigenous Communities in Northeast BC and Northern Alberta.

In 2014, North Wind began researching for a solution to fill gaps in services particularly the continuum of care component that is missing in most treatment programs. Towards the end of 2015, North Wind began following up on Streetohome Foundation's progress and the puzzle was solved of how to bring together a program that would combine addiction recovery and a rehabilitation process that supported individuals to reintegrate into their community in a holistic way.



North Wind was **shifting its focus to incorporating some sort of housing concept** into its vision of services, unknowing, at the time, of Streetohome's acknowledgement that *"We can't build our way out of homelessness...Housing is but one piece of the puzzle – We must address the root causes" and accompanying* **shift in focus to homelessness prevention**.

North Wind Wellness Centre: Mandate

The North Wind Wellness Centre is opening its doors to serve the Northeast BC including its 54 First Nation Communities and its non-indigenous inhabitants in Northern BC. The Peace River District alone is home to approximately 68,000 individuals and the statistics of addiction effects are not different than those in metropolitan areas. The oil & gas, mining and forestry industries in our area bring extra complex issues to addictions and homelessness.

One of the root causes of homelessness is addiction. Streetohome's Addiction Recovery Committee suggested focusing on an approach to develop a centralized intake location where individuals can access recovery supports immediately when they are ready to do so and have access to supportive housing when they complete a treatment program. North Wind endorsed this vision as it fits into its mandate perfectly and fills the gaps for what our 'centre for excellence' would like for Northeast BC.

North Wind Wellness Centre: Increasing Demand for Addiction Recovery Services and Supports

A variety of communities benefit from NWWC addiction recovery programing including Dawson Creek, Fort Saint John, Chetwynd, Hudson Hope, Tumbler Ridge; our Seven First Nation Communities of BC Treaty 8; Kelly Lake (BC) and Horse Lake (AB) Reserves.

A year-to-year growing demand for services is outpacing resources. Bed utilization of the existing live-in treatment program from April 2017 - March 2018 was 113.37%. Day and Out-patient program participation climbed by 24% over a 10-year period. The adjacent table illustrates program utilization data for the past year. Visits may involve multiple visits by the same individual.

April 2017 – March 2018 Program Utilization Data		
Program	Description	Participants
Outpatient Program	Stress Management	1311
	Dialectic Behaviour Therapy	1102
	Alcoholics Anonymous (AA) and Acquired Brain Injury (ABI) Support Meetings	789
Day Patient Program	Cultural/Spiritual-based ceremonies including Sweat, Pipe, Blanket, Burning-bundle, etc.	969
Continuum of Care Program	Continuing Care Phone Support	706

While existing programs are culturally safe, community driven within an Indigenous framework, spiritual, and trauma based, violence and gender-informed, there remains a stigma to live-in treatment that causes individuals to seek these services in a community where they are unknown. It is hopeful that an integrated ARCH model will remove this stigma thereby increasing accessibility to a local centralized Treatment Housing Program and further empower NWWC to serve our community at large within our geographical area.

Substance Use: The Canadian Context

Mental health and substance use problems affect 1 in 5 Canadians directly and almost everyone indirectly. This number holds true for British Columbians as well.

Addiction is a complex health and social issue that affects Canadians, causing harm to individuals, families and communities. Costs related to substance use are rising in Canada. Hospitalizing people with substance use disorders cost $267m in 2011, an increase of 22% from 219m in 2006.

In 2011, those aged 45–64 collectively stayed the most days in hospital on account of alcohol; 25–44 year olds stayed the most days for opioids; and 15–24 year olds stayed the most days for cannabis. The number of days stayed in hospital because of cocaine decreased significantly over the five years studied (-48%), whereas the days stayed for alcohol (+8%), opioids (+48%) and cannabis (+39%) increased.

The first national survey of people in recovery from alcohol and drugs – Life in Recovery from Addiction in Canada – was conducted in 2016 by the Canadian Centre on Substance Use and Addiction. Two key findings of the survey:

- ❑ Many individuals experience challenges and barriers starting their recovery journey including problems with accessing services, long waitlists for treatment, financial barriers with privately funded treatment services, lack of culturally safe programs and location outside their communities.
- ❑ Individuals use many different pathways in their recovery journey, including professional treatment services, informal supports and mutual support groups.

Intersection of Substance Use and Homelessness

- The relationship between substance use and experiences of homelessness is complex. While rates of substance use are disproportionately high among those experiencing homelessness, homelessness cannot be explained by substance use alone (53% of homeless people reported substance use problems in the latest Vancouver Homeless Count).

- Once on the streets, an individual with substance use issues will face many hurdles to access housing as they face significant barriers to obtaining health care, including substance use treatment services and recovery supports. The longer people live on the streets the poorer their health status becomes.

- When people experiencing homelessness complete substance use treatment, they often find themselves homeless again due to a lack of supported housing and aftercare options – a situation that puts their recovery in jeopardy.

- People that live on the street or chronically stay in shelters have many risks in addition to poor health, two of which are difficulty obtaining and maintaining employment and housing.

- The *At Home Chez Soi* study, led by Dr. Julian Somers, found that there was no change in in daily substance use with Housing First.

Indigenous Context: Homelessness and Opioid Crisis

Homelessness is a significant economic, social and health issue across Canada. The issue of homelessness is especially pronounced within the Indigenous population. For example, while less than 2% of Vancouver's population is Indigenous, over 34% of the current homeless population in Vancouver is Indigenous.

- The issue of homelessness in BC, has been further compounded by the recent opioid crisis.
  - ***According to the Office of the Chief Coroner, deaths from illicit drug overdoses in BC were nearly 80% higher in 2016 compared to 2015. The Coroner's Report (November 2017) indicates that 1,103 people had died from an overdose from January to end of September, up from 607 for the comparable timeframe in 2016. The BC Government declared a public health emergency because of a steep rise in overdose deaths across the province.***
  - The homeless population is particularly susceptible to the crisis. For example, in Vancouver, 53% of the homeless population reported struggling with substance use.
  - The opioid crisis in BC is disproportionately impacting Indigenous people. Indigenous people make up 3.4% of BC's population and yet account for 14% of all overdose events in B.C. Indigenous people are 5 times more likely to experience an overdose event than non-Indigenous people.
  - From 2006-2011 there was a 23% increase in hospital stays due to opioid related disorders and the number of days stayed in hospital due to opioid related disorders increased by 48%.
- The interplay of the aforementioned issues has put a significant burden on the current health and housing continuum, especially for individuals looking to address their addiction. Thus, the need for a stronger recovery and housing continuum which is accessible and effective in providing services for B.C.'s most vulnerable population is more critical than ever.

Recovery Community Centres: The Power of Peers and Family/Ally Volunteers

- The last decade has seen new forms of peer support emerge from a '*new addiction recovery advocacy movement'.* One structure for organizing peer support is the Recovery Community Centre (RCC), which combines social fellowship with the service mission of a community centre, while offering system navigation, assessment, referral and new services like recovery coaching. The backbone of the RCC is its volunteers from the recovery community, who instill hope, role model recovery, and dispel stigma. This movement took root in the USA in 2001 and since the implementation of the first RCC, there are now 80 in the United States. To date, there are no true Recovery Community Centres in Canada, however, there are programs with elements of an RCC program.
- Recovery Community Centre activities are determined by the community and generally focused on addressing identified gaps in service. Activities usually include skill building, employment, advocacy, information sharing, system navigation and social activities for individuals and families that all contribute to building recovery capital.
- Research describing this model suggests that RCCs may serve as hubs of recovery-oriented systems of care, serving as the impetus for more rigorous research to be conducted on the role and effectiveness of this emerging form of service delivery. Faces and Voices of Recovery Canada was founded in 2013, and the opportunity to partner with them exists in Vancouver and Northern BC. FAVOR is a National Organization founded in 2001 in the U.S. and has recently expanded to both the UK and Canada. The mission includes fostering recovery community organizations; collaborating with local, provincial and national organizations operating within the realms of addiction and recovery; and conducting public education and awareness campaigns for recovery. FAVOR could collaborate with organizations, such as *From Grief to Action,* to build on a foundation that already exists in British Columbia.
- In the first ever systematic evaluation of Recovery Community Centers in the USA, the Recovery Research Institute is conducting an ongoing, longitudinal National Institutes of Health-funded study. Preliminary data show that Recovery Community Center participants (in recovery for 4 years on average) report that their center engagement has been extremely helpful in their recovery and overall well-being.
- A revised *Core Elements of a Recovery Community Center* is available to guide such efforts http://www.williamwhitepapers.com/pr/Recovery%20Community%20Center%20Role%20Clarity%20Valentine%202014.pdf

Recovery Community Centre Principles:

- ✓ Sanctuary anchored in the heart of the community where the recovery community can organize, socialize, learn from each other and help others maintain and sustain their recovery.
- ✓ Place where Peer-to-Peer Recovery Support Services are delivered for individuals, families, allies and professionals
- ✓ Services are designed, tailored, and delivered by the local community to ensure the community is reflected and that the Centre is culturally safe, spiritual, trauma, gender and violence informed to ensure a safe place for all.
- ✓ Volunteer Leadership– including people in long-term, sustained recovery.
- ✓ People in recovery can come and feel safe, be with others in recovery and help the next person coming in the door.
- ✓ Portal to other community-based and government services. It is important to note that Recovery Community Centres are open to people at all stages of recovery and in all stages of change. Given this, it is equally as important to insure that people in long term recovery are thoughtfully engaged in the development of the concept as their leadership will be critical to the success of such a model in Northeast BC.
- ✓ There are many diverse pathways to recovery. All pathways are respected and supported within the RCC.

Addiction Recovery Community Housing (ARCH): What is it?

The broadly defined 'Addiction Recovery Community Housing' (ARCH) model includes people in recovery, their families, friends and allies.

ARCH also includes:

- recovery-focused addiction and recovery professionals and the programs they work for.
- organizations whose members reflect religious, spiritual and secular pathways of recovery.

The sole mission of an ARCH model is to ***mobilize resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from alcohol and other drug addiction.***

Public education, policy advocacy and peer-based recovery support services including family are the strategies through which this mission is achieved.

Proposal

Addiction Recovery Community Housing (ARCH)

ARCH in Northeast BC brings together the 4 critical elements of support for people seeking recovery:

1. **Recovery Community Centre (RCC)** will be open to people seeking recovery and those in long term recovery. It will be supported and operated by people who are committed to long term recovery and are interested in giving back to the recovery community.

2. **Early Recovery Housing (ERH)** will provide a safe landing zone for people waitlisted for addiction treatment housing whether they are exiting hospital and expressing a desire for treatment, or brought by the RCMP because they have indicated a motivation for treatment '*in the moment*', or entering through some other intake source. The ERH will provide: stabilization of addiction; assessment to ensure people are matched to the level of treatment they need; withdrawal management supports; referral to other services as required; and meaningful activities while they wait for admission to treatment. The ERH will use a 'health care lite' approach and peer coaching navigation of the system.

3. **Addiction Treatment Housing (ATH)** will be a holistic program that is spiritual, and trauma based, violence and gender-informed that combines best practices/traditional values to guide participants to a balanced lifestyle.

4. **Recovery Supportive Housing (RSH)** will provide housing for people post treatment who wish to live in a Recovery Community. People living in RSH may access the ATH for further therapy needs and they may provide support to people in ERH beginning their journey. RSH tenants may also access the RCC and be guided to education and vocation training, employment and meaningful activities in order to build recovery capital.

Addiction Recovery Community Housing (ARCH)

Addiction Treatment Housing (ATH) is a 90-day program that incorporates Traditional Healing, Western Medicine, vocational training and back-to-the-land camps as therapeutic options. It is culturally safe, spiritual, trauma based, and violence and gender-informed. This holistic opportunity is sandwiched between ERH and RSH that collectively provide an estimated 2.5-year supported recovery journey that may start and continue with RCC engagement.

Recovery Supportive Housing (RSH) provides a home for up to two years after individuals graduate from ATH or are enrolled in a lower tier of services but require drug free housing. While living in RSH, graduates will focus on education/training and employment - building their recovery capital. They may also provide peer support to people in the ERH and/or RCC. They may also take advantage of RCC after care options including individual/group support as needed to strengthen their 'recovery tool box'.

Recovery Community Centre (RCC) will provide opportunities for people in recovery, friends and families to support one another, assist with navigating the system, and provide advocacy and fellowship regardless on where one is at in terms of their recovery journey. Social enterprises such as a bistro, bakery, thrift store or bicycle repair shop could be operated from this space and contribute revenue to subsidize operations.

Early Recovery Housing (ERH) provides beds for people waitlisted for ATH. It entails a 'health care lite' model that provides access to a sessional MD for assessments and referrals to the most appropriate addiction recovery supports. Structured programs, recreational and social activities are provided to ensure connection is maintained until the individual moves into appropriate level of treatment. The day and out-patient programs of the NWWC would provide leadership from this space. The addition of a medically supervised detox may be considered.

Foundation = Education/Training/Employment & Meaningful Activities

How does the ARCH Model Fit NWWC's mandate?

- ***Innovative*** – there is no other Addiction Recovery Community Housing model in Canada that has a Recovery Community Centre, Early Recovery Housing, Addiction Treatment Housing, and Recovery Supportive Housing brought together to create a unique Recovery Oriented Community. This model harnesses the energy and resources of people in long term recovery to support those making the first steps on the recovery journey. There is a fledging model similar to ARCH taking form in London, Ontario led by the Salvation Army.
- ***Cost Effective*** – given the high cost of health care, this model uses a significant amount of volunteer hours to achieve its mission and intends to be 'health care lite' while at the same time ensuring people are matched to the level of support they require and are in a safe place.
- ***Inclusive*** – this model will be spiritual and trauma based, gender and violence-informed within a framework of Indigenous cultural safety and wellness.
- ***Best Practice Orientation*** – the model has a significant focus on peer support and the development of recovery capital for individuals seeking recovery.
- ***Research Opportunity*** – the research opportunities within this model are plentiful.
- ***Fosters Thriving Citizens*** – *through supporting wellness, treatment, education, housing and employment.*

How the ARCH Model Addresses the 3 Pillars of BC's Mental Health and Substance Use Strategy 2017-2020

The 3 Pillars of the *Strategy* Include:

1. Wellness:

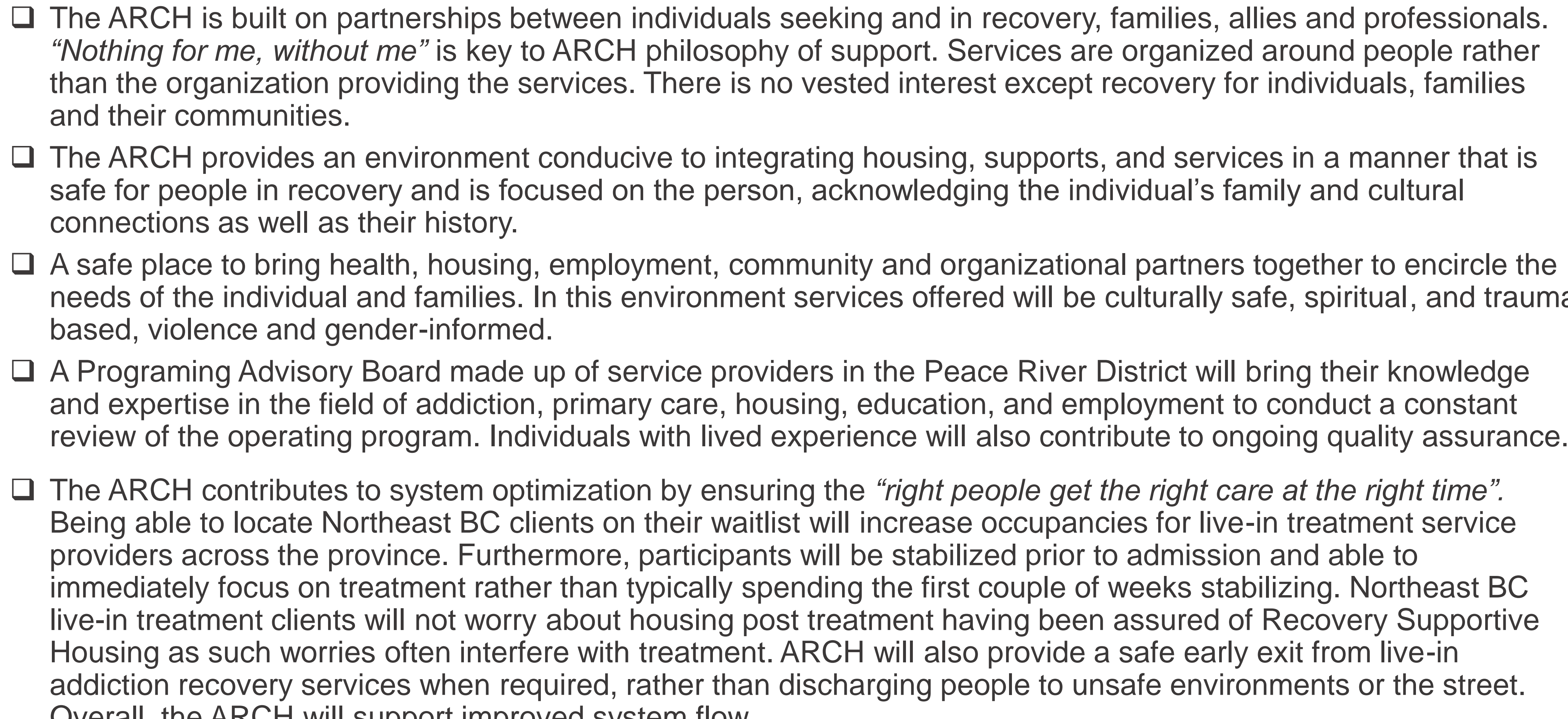
   - ❑ The ARCH will create a supportive environment in the RCC where individual, family and community strengths are harnessed and fostered, community action enabled, stigma reduced and healthy choices are modelled. The Early Recovery Housing, Addiction Treatment Housing and Recovery Supportive Housing will be inclusive of peer supports, and clients and tenants will have opportunities to take part in programs within the RCC.

2. Access:

   - ❑ The RCC will assist individuals in system navigation. Peers are in a unique position to support others trying to work their way through an often fragmented, siloed system of supports.
   - ❑ The primary intent of Early Recovery Housing is to ensure that individuals are assessed for, and referred to the appropriate level of care. A secondary intent is to provide temporary housing and support for people who are on waitlists for live-in treatment throughout the province including North Wind Wellness Centre's Addiction Treatment Housing.
   - ❑ BC Housing, First Nations Health Authority, Northern Health Authority, Ministry of Social Development & Poverty Reduction and community agencies will be invited into the RCC to provide services directly to individuals and families as appropriate and to provide relevant information sessions in order to expand the reach of current services. Shared office space will be available for these partners.

How the ARCH Model Addresses the 3 Pillars of BC's Mental Health and Substance Use Strategy 2017-2020.

3. Partnerships:



- The ARCH is built on partnerships between individuals seeking and in recovery, families, allies and professionals. *"Nothing for me, without me"* is key to ARCH philosophy of support. Services are organized around people rather than the organization providing the services. There is no vested interest except recovery for individuals, families and their communities.
- The ARCH provides an environment conducive to integrating housing, supports, and services in a manner that is safe for people in recovery and is focused on the person, acknowledging the individual's family and cultural connections as well as their history.
- A safe place to bring health, housing, employment, community and organizational partners together to encircle the needs of the individual and families. In this environment services offered will be culturally safe, spiritual, and trauma based, violence and gender-informed.
- A Programing Advisory Board made up of service providers in the Peace River District will bring their knowledge and expertise in the field of addiction, primary care, housing, education, and employment to conduct a constant review of the operating program. Individuals with lived experience will also contribute to ongoing quality assurance.
- The ARCH contributes to system optimization by ensuring the *"right people get the right care at the right time".* Being able to locate Northeast BC clients on their waitlist will increase occupancies for live-in treatment service providers across the province. Furthermore, participants will be stabilized prior to admission and able to immediately focus on treatment rather than typically spending the first couple of weeks stabilizing. Northeast BC live-in treatment clients will not worry about housing post treatment having been assured of Recovery Supportive Housing as such worries often interfere with treatment. ARCH will also provide a safe early exit from live-in addiction recovery services when required, rather than discharging people to unsafe environments or the street. Overall, the ARCH will support improved system flow.

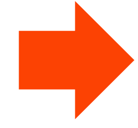
Approach

Approach to Developing Business Case Template

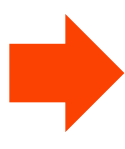
The ARCH business case template was informed through engagement with relevant stakeholders to ensure the vision for this innovative model fills a gap in the continuum of supports for recovery and is a viable model.

Business Case Development Process

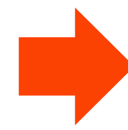
Problem context and initial hypothesis



Literature review, CARMHA Report, interviews and stakeholder focus groups



Model Development



Business case development

Model refinement

- An initial hypothesis was developed regarding addressing gaps in the continuum based on work completed by Streetohome and collaboration with agencies.
- The initial hypothesis was refined multiple times through consultation with stakeholders and additional research.

To validate and refine the initial hypothesis, efforts included:

- Literature review on similar programs in the U.S. and Europe
- Interviews with academics, medical practitioners, social workers, service providers, and people with lived experience of addiction/services provided
- Survey of live-in addiction recovery service providers
- Research on Recovery Community Organizations and Community Centres
- Site visits to a range of programs across Canada, USA and Italy

- The Early Recovery Housing and Recovery Supportive Housing components were developed to address key gaps facing individuals with lived experience who may be at-risk for homelessness while pursuing addiction recovery.
- The model was refined multiple times through further consultation and collaboration with stakeholders including the Streetohome Addiction Recovery Working Group. Concept of 'Addiction Recovery Community Housing' (ARCH) germinates.

- Once the Addiction Recovery Community Housing model was conceptualized, a deeper dive was performed to understand the financial requirements to implement this model.

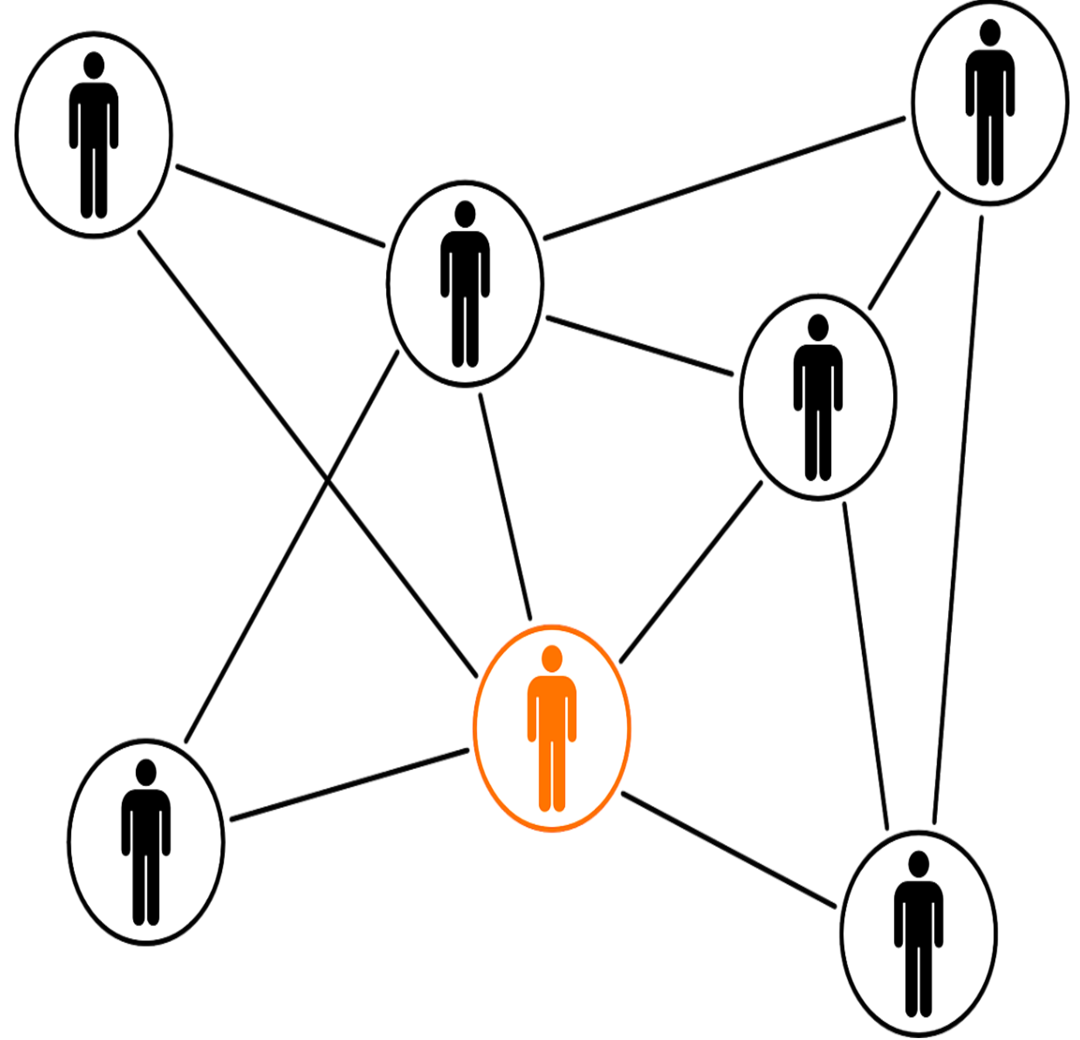
Key Documents Influencing Business Case

- ❑ 2017 Homeless Count in Metro Vancouver – Final Report (September 2017)
- ❑ A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Use 10 Year Plan (2013)
- ❑ Aboriginal Health, Healing and Wellness in the DTES Study (2017)
- ❑ Addiction Treatment in Canada: National Treatment Indicators Report (December 2017)
- ❑ B.C.'s Mental Health and Substance Use Strategy 2017-2020 (2017)
- ❑ BC Overdose Action Exchange (August 2017)
- ❑ First Peoples, Second Class Treatment (2015)
- ❑ Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia (2010)
- ❑ Housing Matters (2006)
- ❑ Life in Recovery from Addiction in Canada - First national survey of people in recovery from alcohol and drugs (CCSA, 2017)
- ❑ Moving Toward a Recovery Oriented System of Care (2017)
- ❑ Publicly-Funded Live-in Addiction Recovery Services in BC (CARMHA, 2017)
- ❑ Recovery Community Organization Tool Kit (2012)
- ❑ Recovery Management and Recovery-Oriented Systems of Care (2008)
- ❑ Strengthening Substance Use Systems of Care for Indigenous Peoples (2011)
- ❑ Systems Approach to Substance Use in Canada: Report in Short (2008)
- ❑ Task Force on Homelessness, Mental Health and Addictions (2014)
- ❑ VCH Peer Framework (2016)
- ❑ Workbook: A Systems Approach to Substance Use in Canada: Developing a Continuum of Services and Supports (2012)

Influencers of ARCH Model

The major influencers of the ARCH model:

- ❑ People With Lived Experience
- ❑ Botticella/San Patrignano model in Northern Italy
- ❑ Association Model from Italy adapted in the UK, Croatia and USA
- ❑ Portage and other Therapeutic Communities in Canada
- ❑ Central City Concern, Portland
- ❑ Delancey Street, San Francisco
- ❑ Faces and Voices of Recovery, a National Organization in the USA, UK and Canada bringing together and supporting the development of Recovery Community Organizations and Recovery Community Centres
- ❑ Subject Matter Experts inclusive of the Streetohome Addiction Recovery Working Group and others



Stakeholders Engaged and Literature Review

Through multiple dialogues with various stakeholders actively engaged in the system of care, various viewpoints were captured in order to develop a meaningful and thoughtful business case that addresses tangible issues facing individuals seeking addiction recovery services. In addition, discussions with stakeholders were validated with literature and policies published by the BC Government, leading health care institutions across Canada and the CARMHA report. The end goal was a robust model readily adaptable for both rural and urban communities.

Stakeholders Engaged	Output Trends
Partners • Vancouver Affordable Housing Agency • City of Vancouver • BC Housing • Vancouver Coastal Health - Central Access and Intake Team, Withdrawal Management Services	• *Housing policies, costs and construction process (modular, stick frame)* • *Challenges in addiction recovery continuum from health, housing and justice viewpoints*
Addiction Recovery Service Providers • Turning Point • Together We Can • Central City Lodge • New Dawn / Chrysalis • Pacifica Treatment Centre • Heartwood Centre for Women	• *Defining, refining and validating ERH and ATH clinical and service model* • ***Challenges in current addiction recovery continuum from service provider perspective.*** *Operating and capital costs of running facilities and various programs*
Individuals with lived experienced • Focus groups with over 50 individuals with lived experience was a key input in the development of this business case	• Riskier drug use common once on wait list for treatment • Homelessness when entering treatment takes focus away from recovery • When admitted to treatment, first two to four weeks spent focused on stabilization rather than recovery

Overview: Addiction Recovery Community Housing (ARCH)

Recovery Community Centre + Early Recovery Housing + Addiction Treatment Housing + Recovery Supportive Housing = Addiction Recovery Community Housing (ARCH)

- ARCH will complement and enhance existing addiction recovery services and recovery-based supportive housing in Northern BC and potentially create a system of recovery whereby no one falls out of it once they begin to receive support.

- The ARCH model will promote housing with an addiction treatment and recovery community as opposed to an additional service operating in isolation. ARCH will improve flow into and out of publicly funded live-in recovery beds and withdrawal *management*. ARCH is a recovery based model that will manage *'slips and relapses'* and will focus on wellness.

- The ARCH model will provide individuals and recovery services a safe exit option other than a shelter or the street when it is determined an individual cannot remain at a live-in recovery program due to behavior or drug use.

- In this way, individuals will remain in the system of care rather than lost to it and having to re-engage all over again. Individuals will enter ARCH's Early Recovery Housing and make a decision whether returning to the same live-in recovery program is 'right' for them or whether they want to be referred to another program.

Target population for ARCH :

- ✓ Have low to severe addiction and mild to moderate mental health needs
- ✓ May be homeless or at risk of homelessness
- ✓ Likely to have poor primary health care and presence of chronic disease
- ✓ May have an incarceration history
- ✓ May have histories of childhood trauma and complex trauma

Addiction Recovery Community Housing Goals

Overarching goal: The **Addiction Recovery Community Housing** model is intended to prevent individuals from falling out of the recovery system of care at transition points (such as corrections, hospitals, withdrawal management, live-in treatment, day treatment services, recovery housing and supportive housing) and to build a unique recovery community that improves access and navigation through the system and is readily adaptable in urban and rural communities across BC.

1. Provide a landing place for people, particularly the homeless, that are being discharged from hospital, and would like to seek further treatment although confronted with lengthy waitlists. People with lived experience express that being on a waitlist increases their risky drug use patterns. People with lived experience also express that not having housing when they enter treatment deflects their focus on recovery in treatment to finding housing after they leave treatment.
2. Provide urgent admission for people identified by community partners including RCMP as ‘*in the moment’* wanting treatment.
3. Provide a safe exit to Early Recovery Housing for people being asked to leave a live-in recovery program.
4. Create and maintain a recovery community that is safe and focused on wellness for people with addiction to live while waiting for admission to live-in recovery, and to ensure individuals are matched to the appropriate level of care. Early recovery will ensure people are ready to engage in live-in treatment when they arrive – individuals will have gone through withdrawal management and will already be accustomed to structured days.
5. To create a seamless system of recovery that ensures that people do not fall out at any of the transition points (corrections, hospital, detox, treatment, aftercare, recovery housing and supportive housing).
6. Provide the missing ‘Aftercare’ support (aka ‘continuing care’) component to dramatically improve outcomes and make a better use of limited government funding allocated to addiction treatment and recovery options that previously ended abruptly.

Key Characteristics of Addiction Recovery Community Housing

- **Health care lite model** – The clinical model for Early Recovery Housing is to be *'health care lite'*. The target population will have medical concerns that need to be addressed, however the clinical model will be able to support them. As far as withdrawal management is concerned, Early Recovery will provide 'social detox' including opiate withdrawal. Early Recovery will not manage alcohol and/or benzodiazepine withdrawal as this requires a medically managed withdrawal protocol. Medically supervised detox will be considered if funding becomes available.
- **Evidence-based treatment** – Early Recovery Housing will utilize various evidence-based treatment practices for individuals with more severe addiction such opiate agonist therapy which will be available and managed by an Addiction Medicine specialist. Traditional healing practices, vocational training and back-to-the-land camps will also be therapeutic options. Individuals will partake in communal activities to rebuild life skills that contribute to their recovery capital (shopping, cooking, cleaning, paying bills, getting along with others, making and keeping appointments).
- **Addiction-free** – The program will manage slips and relapses; however, clients will not be using substances on a regular basis.
- **Family friendly** – ARCH will include diverse opportunities for families, friends and allies to visit and take part in programs.
- **Culturally sensitive** – All staff will receive Indigenous Cultural Safety Training, or will be of indigenous descent, and Elders will be on staff as it is expected that a significant number of people flowing through ARCH will be Indigenous.
- **Landing Zone** – Early Recovery Housing will effectively act as a 'landing zone' for individuals waiting to be admitted into addiction recovery programs or who have been discharged directly from hospital or corrections and want to be assessed and waitlisted, as well as those who have been discharged from an addiction recovery program or supportive housing due to program non-compliance or disruptive behavior, in order to prevent individuals flowing out of the system of care.
- **Program co-location** – ARCH will have the Recovery Community Centre, Early Recovery Housing, and Addiction Treatment Housing and Recovery Supportive Housing all contained in a single facility. This integration ensures that individuals, upon any entry point, remain in a recovery system and enables cross-program synergies. New program entrants will be assigned an 'associate' (peer/mentor) who are currently in the program and considered stable in their recovery, to provide mentorship, navigation and recovery support.
- **Temporary length of stay** – The intended length of stay for individuals flowing into Early Recovery Housing will range between approximately 2 weeks to 1 month as individuals are waiting to be admitted into a live-in addiction recovery program or other treatment option. The maximum length of stay in recovery supportive housing is 2 years with the expectation that many will move on earlier with successful labour market engagement or meaningful activity. The short length of stay timeframe ensures that people flow through the program and the continuum.

Model guiding principles for Addiction Recovery Community Housing (ARCH)

In creating the Addiction Recovery Community Housing (ARCH) model, a set of guiding principles was considered from *Systems Approach to Substance Use in Canada* and community models from Botticella and San Patrignano in Italy and Central City Concern in Portland, Oregon to ensure the program takes a systems perspective in addressing gaps along the continuum while maintaining a health care lite and therapeutic community model. The key guiding principles in developing this model are:

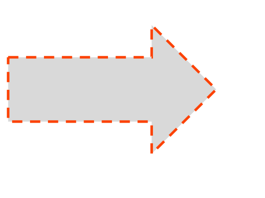
Model's guiding principle	Addiction Recovery Community Housing
System of care enhancement: Services provided ought to enhance the current continuum instead of duplicating services or creating a parallel system of care	ARCH addresses specific gaps within the addiction recovery continuum that are not being met by the current system as opposed to duplicating current service offerings.
Service matching: Services provided to patients ought to ensure individual needs are matched to correct tier of services. (See reference 1 in notes)	Individuals will be assessed by a physician at the outset of program admission, and then at regular intervals to identify needs and determine the appropriate level of care.
Flexibility: Individuals in the program ought to be able to move upward or downward through the tiers as needed. (ibid)	In cases where the individual is determined to no longer require live-in treatment, individuals will be referred to the appropriate community-based treatment option and potentially, Recovery Supportive Housing.
Collaboration: Collaboration between all levels of services and supports to ensure quality treatment and facilitate the individual's journey through the tiers. (ibid)	ARCH intends to work closely with various referral sources (e.g., hospitals, police, corrections, recovery programs, housing providers) to ensure individuals flow through tiers appropriately.
Recovery and Peer Oriented: Building recovery capital, modelling recovery and reducing stigma are key to sustaining recovery.	The Recovery Community Centre (RCC) will be led and operated by people in long term recovery. All people and their family and friends are welcome in the RCC.
Coordination: There ought to be easy sharing of information between systems. (ibid)	ARCH intends to work closely with referral sources, centralized intake and access teams and addiction recovery programs to provide up-to-date information on the availability of beds and, with consent, current status of the individual.
Gender, trauma, cultural and violence informed approach to recovery: Services provided do not re-traumatize, do not necessarily require disclosure of trauma and instead focus on the need for physical, psychological and emotional safety. (See reference 2 in notes)	ARCH programming will emphasize a culture of nonviolence, learning and collaboration underpinned with a focus on safety and trustworthiness. Training on Trauma and Gender Informed Practice and Indigenous Cultural Safety will be provided for volunteers, peers and staff.
Biopsychosocial and spiritual informed approaches to recovery: This approach ensures a holistic understanding of recovery and ought to fully meet the needs of individuals seeking recovery.	ARCH programming will be grounded in the biopsychosocial spiritual approach to recovery to ensure the holistic needs of people are met.

Current State

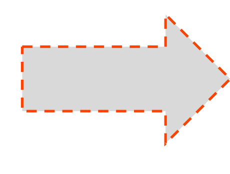
Current System of Care for Addiction Recovery *(Simplified)*

Individuals seeking addiction recovery often face a disjointed and fragmented journey. Services currently operate in silos and work in isolation from one another.

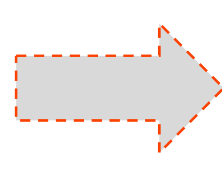
Referral pathway

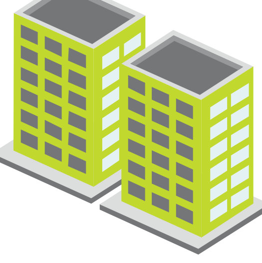


Treatment



Supportive Housing





Market Housing

Clients enter the continuum through a number of various referral pathways, including, but not limited to; hospitals, primary care, corrections facilities, shelters, police, withdrawal management and community services and organizations.

Clients are referred to one of the five tiers of services defined by the BC Ministry of Health, based on the assessed needs of the client. Clients are often referred to live-in treatment that is not a match for their needs and service providers are left with few options to refer elsewhere.

Clients who complete an addiction recovery program may transition into supportive or second stage housing attached to the live-in treatment facility or elsewhere. These programs offer short to medium term housing as well as support services (e.g. employment services) and access to community health services.

Clients who can support themselves without significant assistance are reintegrated into society as functional citizens. Clients are able to access community mental health and addiction services and primary health care as needed.

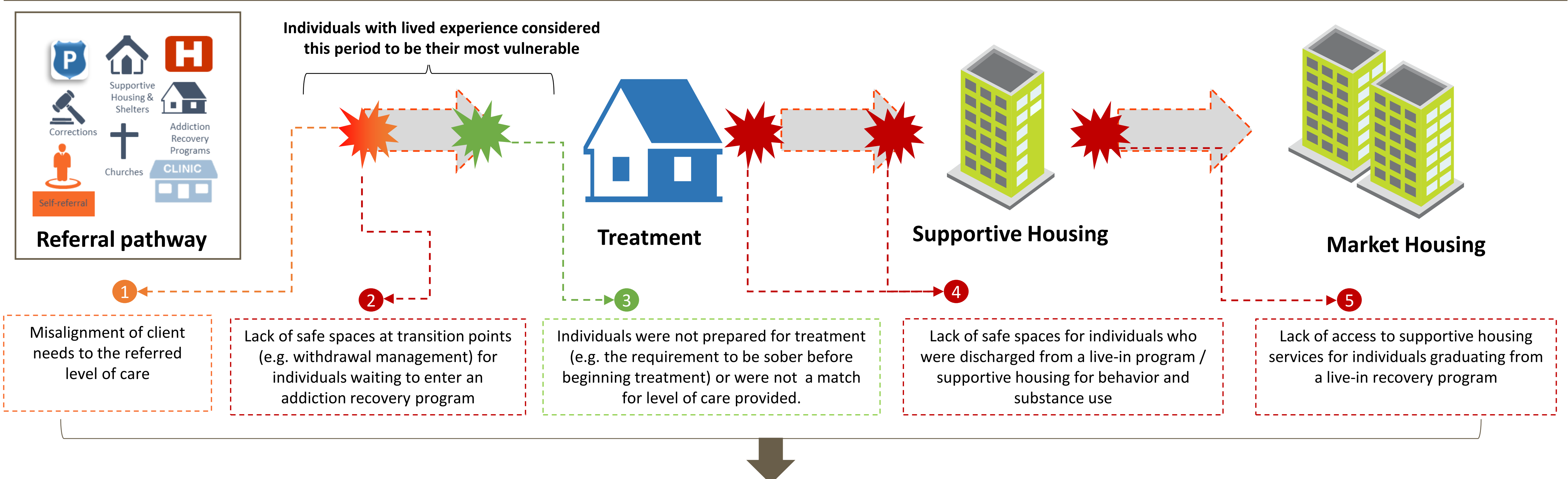
Community health services (Daytox, outpatient clients, community health centers)

0-6 months — **3-6 months** — **years** — **2+ years**

Gaps in Addiction Recovery *(Simplified)*

Refer to the appendix for detailed survey results from service providers

However, through discussions with individuals with lived experience and service providers, there are multiple barriers for entry into the addiction recovery continuum as well as challenges in sustaining addiction recovery especially **for individuals who are homeless.** The key issues centered on supporting individuals while they transition into and out of treatment by providing short-term living spaces to prevent individuals from falling out of the continuum.

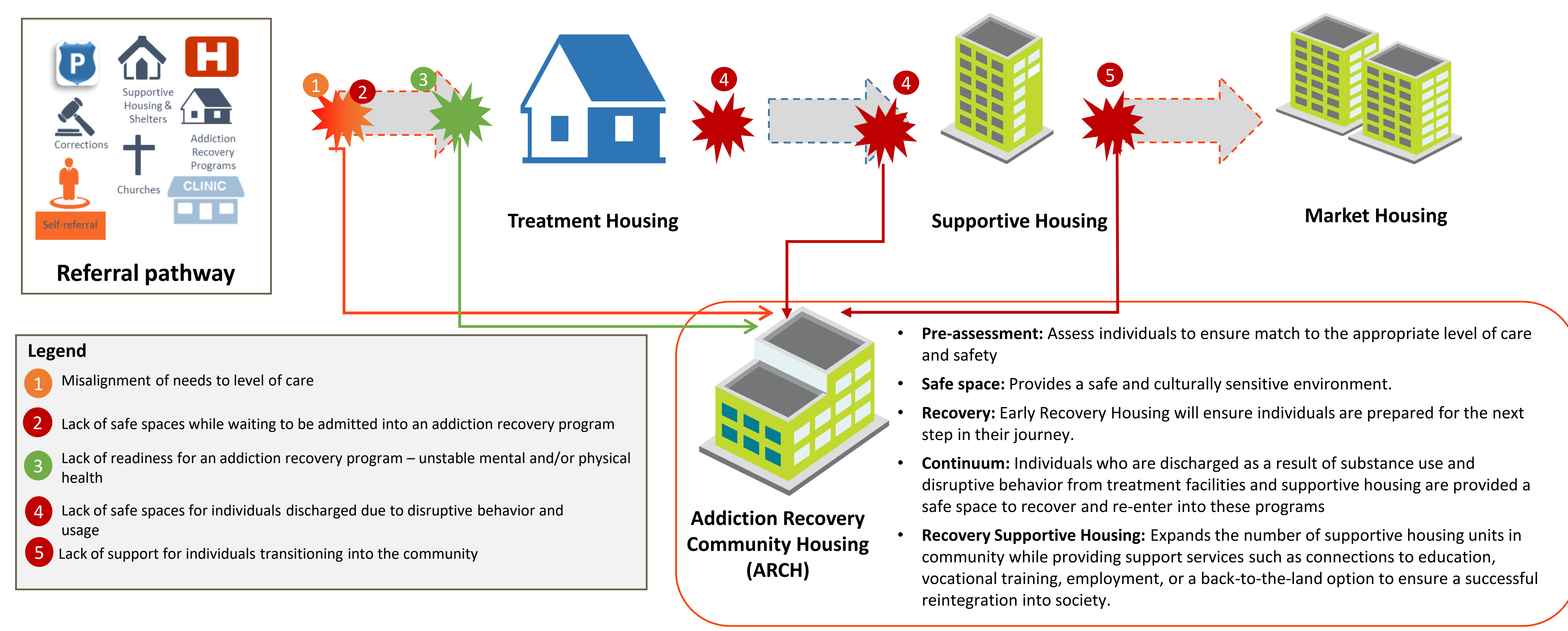


Impacts on Continuum

- Individuals repeatedly fall in/out of the system of care resulting in using expensive acute services and/or returning to homelessness and living in shelters and on the street.
- Costly resource and service allocation to individuals who may not need the suggested level of care or the service is unable to provide the level of care required and hence creates unsafe environment for all.
- Live-in addiction recovery beds occupied by individuals who may not necessarily need that level of care drive up wait times for these programs

Addiction Recovery Community Housing within the Continuum

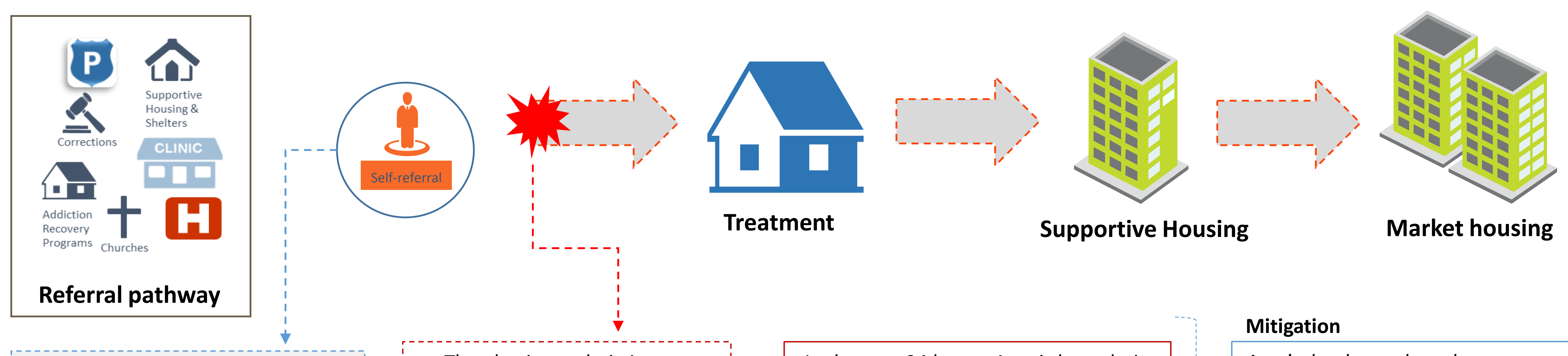
To prevent individuals falling out of the continuum of recovery due to structural barriers identified earlier, and ultimately to reduce the usage of acute care services and enhance the current continuum, ARCH has been developed as an innovative model to optimize the flow of individuals within the addiction recovery continuum.



Profiles of Individuals Accessing Recovery System (1/3)

The following individual profiles capture how gaps, or structural barriers, in the current system of care could have been addressed if an addiction housing continuum such as ARCH was in place.

Example #1: Amy is a 27 years old, has a severe alcohol addiction and lives in women's transition housing.



Amy goes into the emergency department on a regular basis due to alcohol overdose. Typically, Amy refuses treatment; however, on this visit she sees an addiction medicine specialist and agrees to go to live-in treatment.

The plan is to admit Amy to psychiatry until she can be admitted to a live-in treatment program. There are no beds in psychiatry and Amy is discharged.

In the next 24 hours, Amy is brought in to emergency department again by paramedics – she was found collapsed on the street. Amy dies as a result of complications related to her alcohol dependence.

Mitigation

Amy's death may have been prevented if she was transferred to a safe place for further assessment and was supported while waiting for live-in treatment.

Profiles of Individuals Flowing through Recovery System (2/3)

The following individual profiles capture how gaps, or structural barriers, in the current system of care could have been addressed if an addiction housing continuum such as ARCH was in place.

Example #2: Daniel is a homeless 23-year-old Indigenous man from the Northern part of Vancouver Island.

Supportive Housing & Shelters
Corrections
Addiction Recovery Programs
Churches
Self-referral

Referral pathway

CLINIC

Treatment

Supportive Housing

Market Housing

Daniel came to Vancouver when fishing season ended and due to chronic back pain, he was using prescribed opioids. Daniel was not able to get his prescription renewed and began to use IV heroin to manage his chronic pain.

Daniel went to a Downtown Eastside clinic and was referred to a live-in treatment center. **The waitlist was 5-6 months.**

In the interim Daniel was referred to a Downtown Eastside program to wait for live-in treatment but left and was again living on the streets.

While Daniel continued to live on the streets of the Downtown Eastside, he died of an opioid overdose.

Mitigation

Daniel's death may have been prevented if Daniel had the option of *waiting for treatment, in a culturally safe environment, in his home community, outside of the Downtown Eastside and supported by ARCH.*

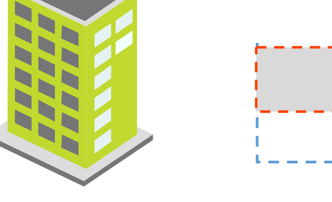
Profiles of Individuals Flowing through System Care for Addiction Recovery (3/3)

The following individual profiles capture how gaps, or structural barriers, in the current system of care could have been addressed if an addiction housing continuum such as ARCH was in place.

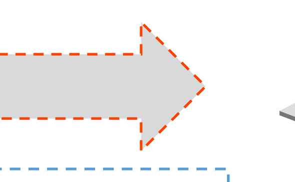
Example #3: Stephanie is a 33-year-old, homeless Indigenous woman with two children.

Referral pathway

Treatment

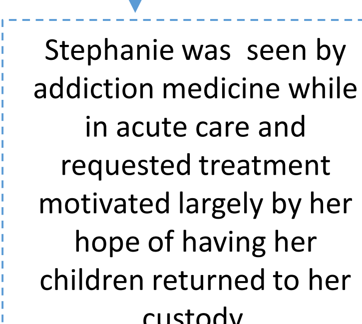


Supportive Housing



Market housing

Following a traumatic event, Stephanie relapsed after 7 years of sobriety. Stephanie lost her children to the foster care system and began to work in the sex trade. Stephanie was admitted to hospital due to endocarditis. She has a significant trauma history that includes childhood sexual abuse and sexual assault as an adult.



Stephanie was seen by addiction medicine while in acute care and requested treatment motivated largely by her hope of having her children returned to her custody.

The waitlist for live-in treatment was a month long. Stephanie was able to stay in hospital during her wait based on the advice of her doctor.

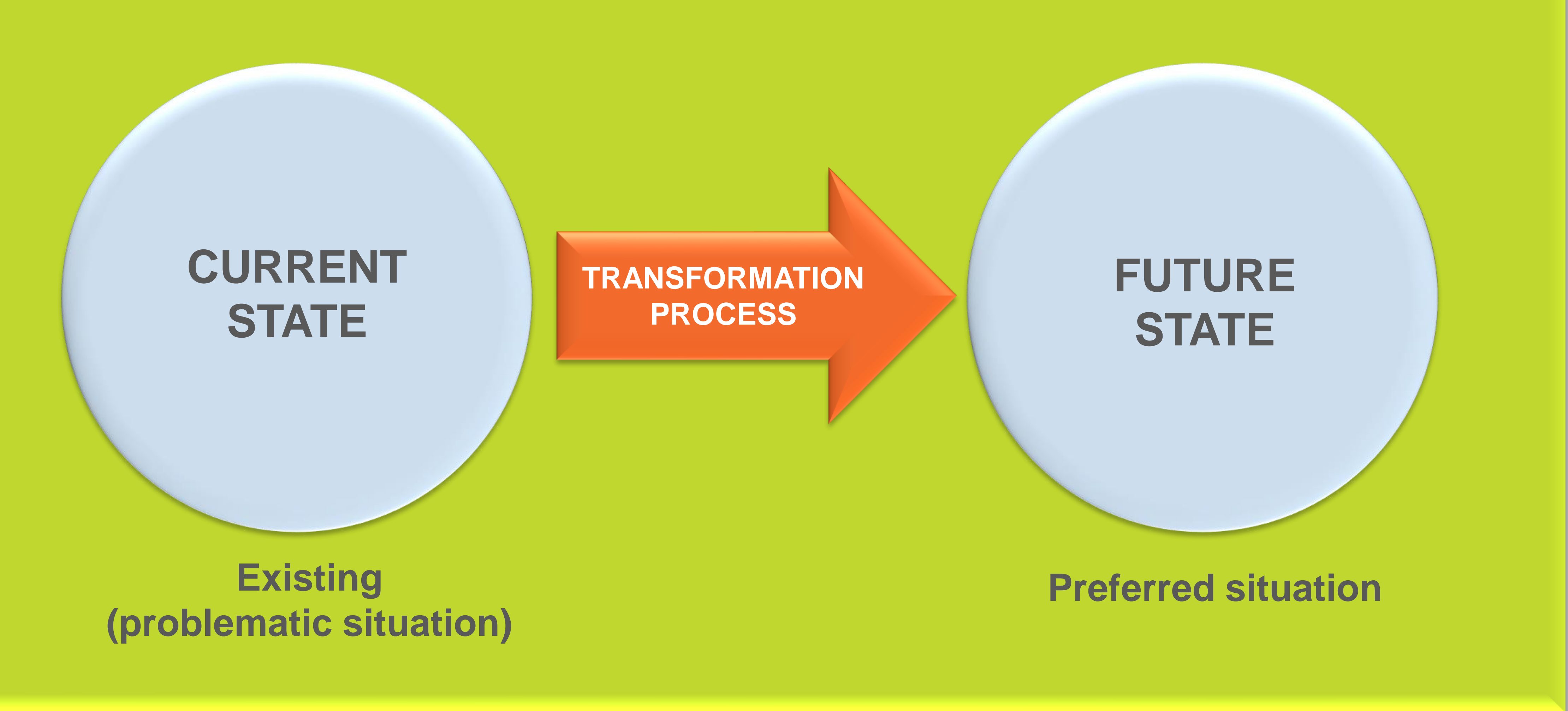
Stephanie attends live-in treatment and 120 days later graduates. With the assistance of the treatment program social worker, Stephanie finds supportive housing, resolves her legal issues, and works with the MCFD social worker to begin the process of having her children returned. Her stay in treatment is extended due to a tenuous housing plan and legal appointments. Six months later, Stephanie has her children returned with conditions, is working as a personal trainer, and is able to focus on her and her family's wellbeing.

Rather than an expensive acute care bed, Stephanie may have been housed in a safe environment and supported by ARCH. Prior to going into live-in treatment and while at Early Recovery, Stephanie's housing needs could be addressed. Subsequently, her focus in treatment could solely be on recovery. Stephanie's extended stay in live-in treatment may not have been necessary.

Addiction Recovery Community Housing benefits to the Continuum

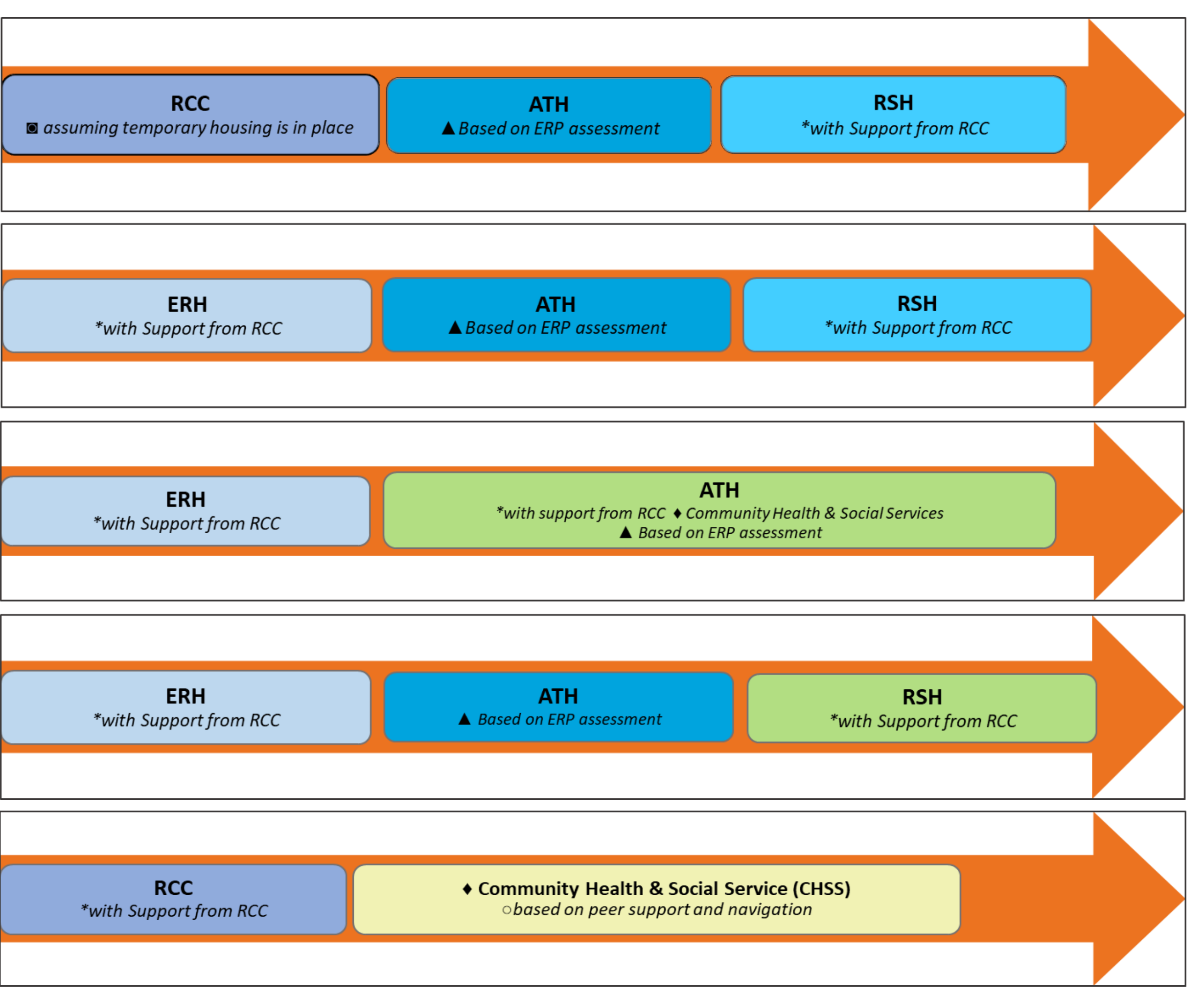
Stakeholders	ARCH Outcomes	Short- to Medium-term Benefits
Individuals whom are homeless or at-risk for homelessness and have an addiction	▪ Safe place to land while transitioning between programs ▪ Support from peers at the Recovery Community Centre ▪ Access to stable housing after completion of a live-in addiction program ▪ Development of social, vocational and employment skills ▪ Extends the recovery continuum to 2.5 years and provides the *'right'* supports for people	▪ Reduced likelihood of addiction relapse ▪ Reduced likelihood of returning to homelessness ▪ Increased likelihood of completing live-in recovery program and connecting to peers in long term recovery ▪ Increased likelihood of integrating into mainstream society and becoming self-sufficient
Live-in Addiction Recovery Service Providers	▪ Only individuals who *need* live-in services are referred. ▪ People referred will be assessed and will receive the *'right'* level of support. ▪ Live-in Recovery Programs will not have to focus on stabilization. This will improve safety at live-in programs.	▪ Reduced wait times and demand for live-in programs and optimal placement and occupancy ▪ Improved health status of people entering live-in recovery allowing focus to be on recovery program rather than stabilization or housing post treatment ▪ Safe recovery exit pathways whether premature or upon graduation (System Flow)
BC's Health and Human Services	▪ Fewer emergency department and acute care admissions from target population. Decrease of discharges to the street from hospital and withdrawal management. ▪ Fewer individuals requiring high support service needs such as tier 5 programs due to earlier intervention. ▪ The system will provide the *"right service at the right time"* to individuals and families. ▪ Improves accessibility and decreases fragmentation within the recovery system ▪ Improved connection and partnership between all parts of the recovery system	▪ Reduction in legal / justice costs ▪ Reduction in homeless service costs ▪ Reduction in healthcare spending

Future State



Recovery Community Centre (RCC), Early Recovery Housing (ERH), Addiction Treatment Housing (ATH) and Recovery Supportive Housing (RSH) within the ARCH Continuum

Types of Flow – Examples



ARCH: Pre-screening and entry into Early Recovery Housing

Pre-screening and entry

Description: Prior to setting up Early Recovery Housing, a simple pre-screening tool will be developed and shared with key referral partners to ensure admission into Early Recovery Housing is focused on the target population with select characteristics (see below).

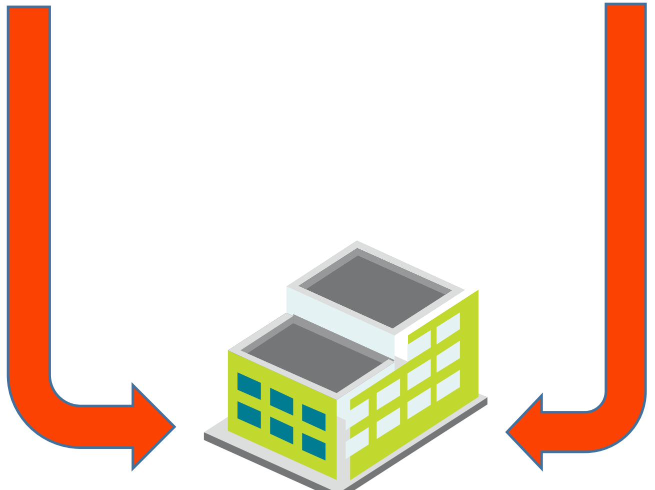
The program will be open to: individuals waitlisted for treatment and referrals from hospitals, withdrawal management, outpatient clinics, Police, shelters, community service providers and other recovery programs.

Early Recovery Housing is ideal for local individuals **waitlisted** for live-in treatment (NWWC's Treatment Housing Program or other publicly funded treatment programs across the province) who meet a combination of the following criteria:

- Have an addiction and low to moderate mental health needs
- May be homeless or at risk of homelessness
- May have poor primary health care and a possibly chronic disease
- May have histories of childhood trauma and complex trauma
- May have an incarceration history

- Police
- Hospitals/Clinics/Detox
- Corrections
- Community Service Providers
- Shelters

- Individuals discharged from live-in treatment and/or housing for program non-compliance and/or disruptive behaviour



ARCH: Assessment and Recovery Support

2 Assessment and Recovery Support

Description: Once an individual is admitted into Early Recovery Housing, they are assessed by an addiction physician to understand the individual's current medical needs and determine their current primary and addiction health needs. Through ongoing assessment, the physician and client will determine the level of care required. The main objective of the assessment process is to ensure safety for the individual and to match their needs to the right level of care.

While individuals are waiting to be admitted to a live-in addiction recovery program, or other level of care, Early Recovery Housing will be structured to focus on wellness, life skills development and meaningful activity in a substance-free space. A small clinical team, peers and volunteers will ensure the day is coordinated and people develop the skills to manage everyday in a non-judgmental, culturally sensitive and stigma-free space.

There may also be some individuals, who have a temporary safe place to reside, that will be sufficiently supported by the Recovery Community Centre on a daily basis while they are waiting for live-in treatment.

Other people may, depending on assessment, flow directly from Early Recovery Housing to Recovery Supportive Housing. They are able to access the Recovery Community Centre and the clinical supports they need through primary health clinics and local community resources.

Examples of programming and meaningful activities in Early Recovery Housing include:

- Medically monitored withdrawal services (excludes alcohol and benzodiazepines and other complex withdrawal due to health status)
- Indigenous healing practices (e.g., smudging, talking circles) including traditional medicines (i.e., medicine wheel and sacred herbs)
- Back-to-the-land camping excursions
- Daily chores to support life skills enhancement (personal hygiene, time management, shopping, cooking, cleaning, paying bills, getting along, making and attending appointments, employment readiness soft skills development)
- Relapse prevention and mentorship by peer support workers and 'senior' individuals in the program (and mandatory Naloxone training)
- Family days and mutual self-help groups
- Group recreation activities (All outings are escorted.)
- Vocational training

ARCH: Program exit from Early Recovery Housing

Program Exit

Description:

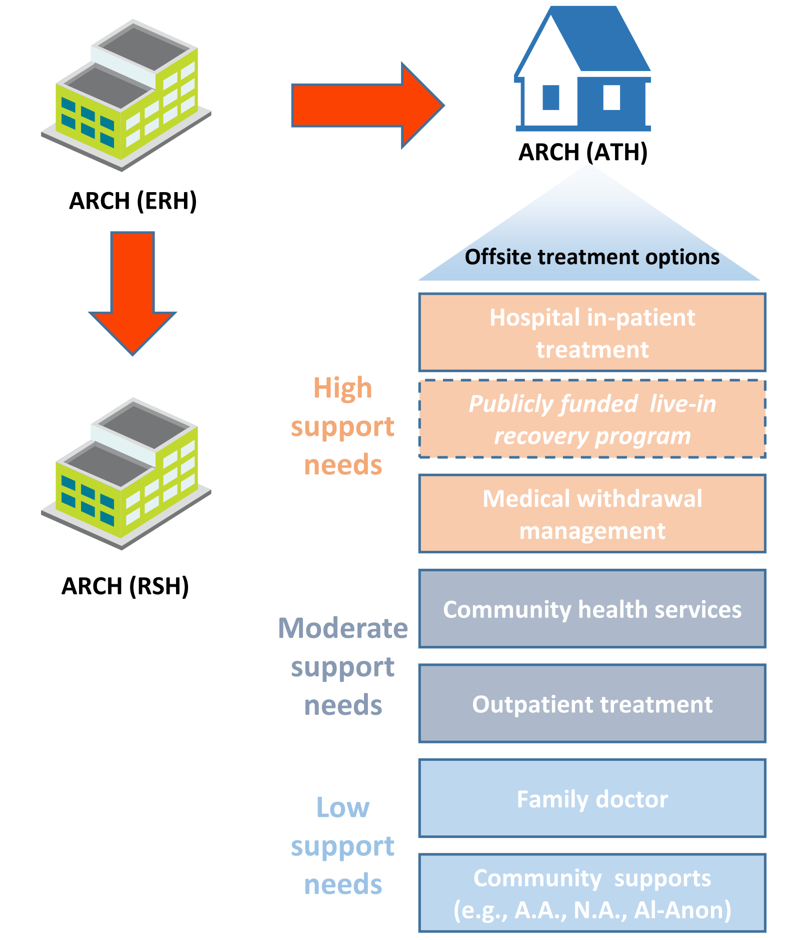
Individuals will leave Early Recovery Housing when;

- Individuals are accepted into Addiction Treatment Housing or another live-in addiction treatment/recovery program
  or
- Individuals no longer require the same level of live-in treatment that was initially recommended and are discharged to a lower-tiered level of care
  or
- Individuals do not require live-in treatment and are accepted into supportive / transitional housing

Individuals will only be discharged if they have been accepted into a live-addiction recovery program, supportive housing program or other housing supports or have decided to leave the program on their own accord.

Individuals will be asked to leave Early Recovery Housing for any of the following reasons:

- Violence towards staff, peers or other clients
- Bringing substances on site for the purpose of selling/sharing with other residents.



ARCH: Entry into Recovery Supportive Housing

Entry and Supports

Description:

The Recovery Supportive Housing Units are intended primarily for people completing live-in treatment programs and ready for a supportive housing environment. RSH tenancy is expected to be up to two years.

The Recovery Supportive Housing will be *'addiction free'* and slips/relapses will be managed. The tenants will receive support as needed from tenant support workers. Peer support will also be key to the success of the model. The tenants will have their own tenants' council to provide input into issues related to the Recovery Supportive Housing.

The focus of the tenant support workers and peers will be to assist tenants in developing their recovery capital particularly as it relates to life skills, social skills, vocational training, education and employment. Tenants are expected to maintain their units at an acceptable level of cleanliness and to contribute to the tidiness of the common area – tenant support workers will assist tenants in building a clean, and safe environment for all.

Tenant support workers will work with tenants to inspire the development of a sense of community in the building, and in the broader outside community. This will include coordinating communal functions such as community kitchens, job fairs, holiday festivities, community gardens and more. It will involve a close collaboration with the Recovery Community Centre to develop functions together to support the broader recovery community.

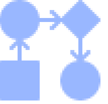
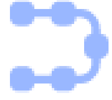
The recovery community will be welcomed into the common area in the Recovery Community Centre to offer support (i.e. mutual self-help, information fairs, healthy living) and a Recovery Community Governance Council will be established to ensure recovery community ownership of the space and purposeful use aligned with building recovery capital.

There will meeting rooms and recreational spaces in the Recovery Community Centre. There will also be clinical/office space for outside supports such as case managers to meet with their clients (including tenants in Recovery Supportive Housing) inside the building in a respectful setting. These same spaces can continue to be accessed by tenants once they have transitioned to other housing options.

ARCH: Exit from Recovery Supportive Housing

- When a tenant identifies as ready to move out of Recovery Supportive Housing, a transition process will be supported by the tenant support workers and the tenant's case manager.
- A smooth transition to other forms of housing is important for the tenant and their ongoing recovery. The case manager will be involved in coordinating and supporting this transition.
- The tenant will be welcome to attend groups and events at the Recovery Community Centre, provide mentorship to new tenants and share in other meaningful activities. Opportunity for employment within the Recovery Community Organization operating the housing may be possible.

ARCH: Risks and Mitigation

	Key Risks	Mitigation Strategy
	**Lack of flow out of Early Recovery Housing program**	▪ Work closely with referral sources to ensure only clients that meet the screening criteria are referred into the program (i.e. individuals who are on wait lists for addiction treatment housing, in hospital or detox) ▪ Work collaboratively with Northern Health Authority (NHA), First Nations Health Authority (FNHA) and addiction treatment housing providers to share information on availability of beds ▪ Individuals who show significant progress in Early Recovery Housing will be expedited to Recovery Supportive Housing and will be connected to community resources
	**Lack of flow out of Recovery Supportive Housing**	▪ Continually assess individuals to determine their readiness for next stage housing ▪ Programming will provide life and employment readiness skills and partner with employment and vocational training organizations to help accelerate their transition into the community.
	Population of individuals accessing Early Recovery Housing have more complex mental health and substance use issues than expected	▪ To ensure the appropriate level of care is provided to patients with higher needs, ARCH model will be flexible to changing needs of clients to address complexity. For example, ARCH may access NHA and/or FNHA supports that were pre-existing for the individual which includes in-reach services such as home-based withdrawal management program.

ARCH Implementation Options

Three potential options of ARCH were evaluated to determine the feasibility of implementation.

Options	Description	Facility Specs	Implementation Time	Anticipated Costs
Option 1: Distributed Standalone Early Recovery Housing (ERH)	▪ Early Recovery Housing embedded in communities across Northeast BC ▪ Clients assessed and matched based on individual preferences and availability of publicly funded live-in programs across province.	▪ Existing recovery facilities/programs could designate beds for assessment, referral and temporary housing ▪ Existing facilities space to be retrofitted for this purpose.	▪ 3-6 months depending on the availability of the facility, and cost of renovations, and development of assessment and referral protocols.	▪ Total capital costs estimate: $150k per site for renovations (9 sites?) ▪ Existing programs to cover annual operating costs through shared staffing and health services in-reach.
Option 2: Centralized Addiction Recovery Community Housing (ARCH) – Fully Integrated Model	▪ 8 ERH beds, 16 ATH beds, 16 RSH units, RCC space. ▪ Measurable impact on the flow of patients in the system. ▪ Opportunity to closely follow clients and outcomes in single site.	▪ Build new or renovate/retrofit existing building on preferred site.	▪ 6-18 months and dependent on construction methodology (i.e., wood frame or modular).	▪ Total capital cost estimate (Land/building): $12M – assumes $5M FNHA funding matched with CMHC funding through BC Housing and $2M local fundraising commitment ▪ Yearly operating costs: $2.0M shared between FNHA and BC Housing.
Option 3: Distributed Standalone Recovery Community Centre (RCC) Model	▪ Recovery Community Centre embedded in communities across Northeast BC. ▪ Peer navigation of addiction recovery pathways and continuous support for individual journeys. ▪ Peer driven Aftercare support options.	▪ Existing recovery facilities could designate space <u>or</u> partner with local community centre <u>or</u> seek space opportunity in health authority or BC Housing owned properties in communities.	▪ Up to 1 year depending on the availability of space and renovations required as well as a source of capital funding.	▪ Total capital costs: unknown and dependent on space available to meet needs. ▪ Yearly operating costs: Minor with in- kind/volunteer operations + fundraising to cover expenses. Intention is for RCCs to remain recovery community directed.

Option #1: Distributed and Standalone Early Recovery Housing Model

Option 1: ERH Pilot

Program Description

- 5 Early Recovery Housing beds at sites in communities across Northeast BC
- No Addiction Treatment Housing, Recovery Supportive Housing or Recovery Community Centre on site
- Admission into Early Recovery Housing is restricted to individuals that meet target population criteria and waiting for live-treatment
- Need to develop relationships with publicly funded addiction treatment facilities across province and establish an after care program for clients returning to community

Staffing Requirements

- Existing staffing assuming the following are available/accessible:
    - Addiction Medicine Physician paid sessions (as needed)
    - 24-7 RN
    - Peer support workers/volunteers
    - Elders
- Program coordinator to be shared with existing recovery facility

Implementation Time

- Start-up time is roughly 3-6 months

Pros ✔

- Easiest solution to implement compared to other options
- Immediate short term impact on the continuum by alleviating demand for beds in hospitals
- Local opportunity to test and refine the Early Recovery Program model within a short amount of time
- Use pre-existing Addiction Recovery Housing or other recovery space to support the Early Recovery Housing model.

Cons ✘

- Due to the limited number of beds, program limitations don't support individuals prematurely discharged from live-in programs
- Inherent difficulty to demonstrate measurable impact on the system of care when not integrated
- Lack of flow through of clients (risk of system drop outs)
- Limited synergies with Recovery Supportive Housing
- Aftercare support is missing and key to demonstrating successful outcomes and optimal use of public treatment funding.

Program Duration

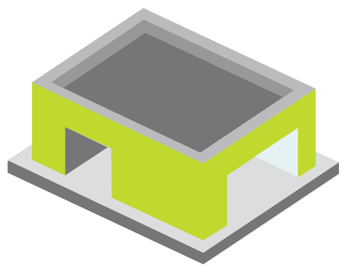
- 2 year pilot

Facility Type

- Existing recovery facility

Complexity of Implementation

- Low



Operating costs

- Stretching existing budgets

Capital Costs

- $150k renovation costs per site
- Land and building assumed to be provided

Option #2: Fully Integrated Addiction Recovery Community Housing (ARCH) Model

Option 2:
ERH, ATH, RSH,RCC
Integrated Model
Proof of Concept

Program Description

- 8 Early Recovery Housing beds, 16 Addiction Treatment Housing beds, and 16 Recovery Supportive Housing units with majority being studio. A few units designated for couples ought to be considered.
- Recovery Community Centre , Early Recovery Housing, Addiction Treatment Housing and Recovery Supportive Housing will be integrated in one facility at the NWWC site.
- Program admission initially limited to individuals on waitlists for Addiction Treatment Housing, discharges from hospital and individuals discharged from live-in addiction recovery programs and supportive housing.

Staffing Requirements

- Building Manager
- Administrative Staff
- Addiction Counsellors Team
- Addiction medicine specialist (General physician) x 4 sessions per week
- Counsellor/Social Worker
- Elders (Female and Male)
- Nurse, RN or LPN
- Peer support workers/volunteers
- Specialized therapists (Yoga, Art, etc.)
- Supportive housing tenant support workers

Implementation Time

- Start-up time is roughly 12-18 months

Pros ✔

- Immediate measurable impact on the addiction recovery and housing continuum
- Increased community engagement with more opportunities to have volunteers and peers involved in programming in ARCH. Opportunity to fully incorporate peer-support framework with people in long term recovery across the board.
- Ability to retain staff and improve employee satisfaction as staff can see impact on the system
- In-reach of health care providers as required.
- Efficiencies due to integration of four programs - Recovery Community Centre, Early Recovery Housing, Addiction Treatment Housing, and Recovery Supportive Housing. Each program will support the other and at the same time can stand alone, all under the same roof.
- Holistic approach to building recovery capital by including housing, health, education and employment goals of individuals accessing ARCH.
- Community is included in the model. Programs are structured to ensure little to no down time. Individuals in ERH, ATH, and RSH will access the resources of the RCC.
- Fully integrated model, first of its class.

Cons ✘

- Difficulty in finding funding available in Northeast BC for capital assets.
- Start up proper/qualified staffing would be a challenge.

Program Duration

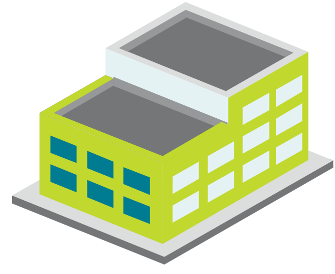
- 10 years

Facility Type

- Facility to be built

Complexity of Implementation

- High



Operating costs

- $2M shared between ported FNHA funding and new BC Housing funding.

Capital Costs

- Furnishings (1/2 in place already)
- Land (23 acres site, 150 acres site or a more suitable property)
- Land/Building construction cost estimate: $12M (assumes $5M FNHA funding matched with CMHC funding through BC Housing and $2M local fundraising commitment)

Option #3: Distributed and Standalone Recovery Community Centre Model

Option 3: RCC Pilot

Program Description

- Building on the success of over 100 Recovery Community Centers across the U.S., this model will ensure that system navigation, peer support, family engagement and Aftercare support (aka continuing care) is available to everyone on their recovery journey.
- Recovery Community Centres established at sites in communities across Northeast BC
- No Early Recovery Housing, Addiction Treatment Housing, Recovery Supportive Housing on site

Staffing Requirements

- Space administrator
- Essentially planned and operated by local addiction recovery community to meet local needs
- Peers, families, friends and stakeholders invited to collaborate

Implementation Time

- Start-up time is roughly 1 year

Pros ✔

- Immediate measurable impact on recovery outcomes – ability to track clients with their permission
- Involvement open to all stakeholders in the Recovery Community
- Increased community engagement with more opportunities to have volunteers and peers to be involved in programming
- Communal multi-purpose meeting rooms and office space available to meet the needs of in-reach service providers

Cons ✘

- Donated space is required (e.g., community centre, church basement, etc.) . Alternatively, significant capital investment would be required from the government and local private donors in each community to build a dedicated facility.
- This is a band aid solution that is disjointed from, and not able to impact, the larger addiction recovery housing system. The isolation and bureaucracy of public institutions may continue to frustrate the recovery community.

Program Duration

- 2 year pilot

Facility Type

- Public space in community

Complexity of Implementation

- Moderate

Operating costs

- $0 if space and administration is provided in-kind or via volunteer(s)

Capital Costs

- Land
- Buildings
- Furnishings

Option Evaluation and Recommendation

Option #2 (*ARCH – Integrated RCC, ERH, ATH & RSH Model)* is recommended as the most attractive option to implement. In our analysis, Option #2 consistently yields the highest possible score on each of four evaluation criteria. ARCH is significant enough to have a sizable impact along the addiction recovery housing continuum, but small enough not to disrupt the existing system. The model promises improved outcomes in terms of preventing addictions and homelessness in the Northeast BC. Lessons learned can be shared with other quadrants in the province hoping to replicate the model and build on our success.

	Evaluation Criteria			
Implementation Options	**Expected impact** Expected immediate impact on acute services (i.e. reduced ED visits and acute care admissions within the target population)	**Implementation Complexity** Ease of: locating facility space; securing operating/capital funding; developing program/system protocols; and establishing stakeholder buy-in	**Client Needs** Ability to address the comprehensive needs of clients and support improved individual addiction recovery housing outcomes	**System enhancement** Impact on optimizing system utilization, navigation and flow across the continuum of housing and support services
Option 1: Distributed and Standalone ERH Model	Moderate	Low	Low	Moderate
Option 2: ARCH – ERH, ATH, RSH, RCC Integrated Model (*Recommended option*)	High	High	High	High
Option 3: Distributed and Standalone RCC Model	Moderate	Moderate	Low	Moderate

Appendix

Appendix – Case Study: San Patrignano

Background

San Patrignano ('Sanpa') was founded in 1978 and is the largest residential treatment centre in the world. To date, Sanpa has provided support for 25,000 individuals and currently houses approximately 1400 residents. Academic research shows that 72% of those who complete the recovery program at Sanpa do not fall back to the use of drugs. The community has been recognized by the United Nations (UN) as a non-governmental organization (NGO) accredited with the status of special advisor to the Economic and Social Council of the UN.

Target Population

The residents of San Patrignano tend to be youth and young adults with drug and alcohol addictions, however they also accept families and older adults. Since the community takes a pedagogical/educational approach to recovery, it is not in a position to admit people with psychiatric problems that would require medical/psychiatric, pharmacological or containment care.

Funding Model

San Patrignano is funded in nearly equal parts by private donors and by vocational training school income generating activities performed by residents. The revenue generated allows for all residents to complete the program free of charge without the need for government funding.

Model of Care

Candidates can enter the program in two ways: Through recommendations from parents, volunteers, and people who have completed the Sanpa program or by directly contacting the facility

Service Model
Phase 1: Daily Structured Routine of Job Training, Socializing, and Education

Rehabilitation: The rehabilitation program is tailored to each resident and varies depending on the characteristics and needs of every individual. There are no rigid therapeutic steps, San Patrignano advocates a minimum stay of three years to ensure the long-term success of every resident and is a drug-free facility.

Mentorship and Community: Upon entering Sanpa, each resident receives a mentor (an existing resident) to provide guidance on their journey. After one year on the property, each resident also becomes a mentor and is assigned to an incoming resident to provide support and encourage accountability. This mentor-mentee cycle allows residents to support one another and share valuable learnings from every stage of the process.

Valuable Training and Work: Residents can choose from over 50 vocational trainings and are gradually given more responsibility over time. Through meaningful employment, they support the economic sustainment of Sanpa and learn skills that are transferrable for future full-time employment. There are also available opportunities to receive funding to start their own business, receive an educational degree and create a franchise of a Sanpa catering service. Doing work that is meaningful to each resident helps develop self-confidence, builds a sense of community, and provides a platform for personal accomplishment.

Reintegration of Family: After approximately one year in the community, residents are allowed to host a family member or friend. This is meant to help with healing from the past and working towards building strong relationships for the future.

Phase 2**:** Transitioning to Productive and Safe Work and Living Environments
San Patrignano partners with national and international associations to assist residents in finding housing and employment. Over the years, the track record of successful residents has built trust among low-income housing locations and business both locally and internationally.

Appendix – Service Provider Survey Results

Current State

Clients are generally referred to live-in treatment centers through a number of different pathways including:

- ✓ Central Addiction Intake Team (CAIT) at Vancouver Coastal Health
  - *Generally effective and efficient*
  - *Some reported errors on assessment*
- ✓ Access protocol involving all health authorities (provincial program)
- ✓ Self-referrals
- ✓ Referrals from Families, Unions, Employers

- ❑ Some individuals are excluded from live-in treatment centers
  - ✓ Based on various criteria such as violence, fire setting, mental health issues, criminal behavior, etc.

- ❑ Current programs often have waitlists, resulting in a waiting period between detox and treatment
  - ✓ Largely due to 5-day maximum stay at Vancouver Detox
  - ✓ Clients typically stay in their homes, shelters, on the streets, with family or others

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- ❑ Waiting periods can lead to dropping off waitlist and high risk of overdose

Appendix – Service Provider Survey Results

ARCH Feedback

Respondents agreed that ARCH would have a positive impact on the current system by filling a gap for clients awaiting treatment.

Other recommended ways that ARCH could be used include:

- Re-engagement into system of care
- Stabilization
- Connecting in person with clients to determine needs
- Social detox for clients that have relapsed

Ideal services to address gaps and minimize overlap would include:

- Supportive housing
- Community and outreach support
- Education and training for work
- Focus on motivation for recovery and improved quality of life
- Pre-admission assessment (medical and psychological)

Factors such as waitlists, bed availability, client readiness and health could potentially impact the flow in and out of ARCH.

Space for clients awaiting treatment → Preparation and support for treatment → Program success

Appendix – Service Provider Survey Results

- Survey Respondents were divided on whether ARCH should become a licensed facility under the Community Care and Assisted Living Act

Arguments For:	Arguments Against:
▪ Service Providers have restrictions on referring to unlicensed facilities	▪ Licensing regulations not currently appropriate for addictions care
▪ Safer considering population served	▪ Duplication of services
▪ Regulations and accountability	▪ Current facilities are inappropriately housed under the Community Care and Assisted Living Act

Appendix – Service Provider Survey Results

Supportive Housing Feedback

For programs that do offer supportive housing, factors that influence length of stay include:

- Set length of program
- Client engagement/commitment to recovery
- Behavior with others
- Treatment progress/risk of relapse
- Social supports and availability of safe housing

Service providers believe that the criteria for supportive housing should include:

- ✓ Expressed desire for and receptiveness to support
- ✓ Stage of change
- ✓ Viable care plan in place
- ✓ Emotional/physical/mental states
- ✓ Housing status
- ✓ Supports in place
- ✓ Employment readiness

Two thirds of programs surveyed do not offer supportive housing

Appendix – Service Provider Survey Results

Supportive Housing Feedback

To ensure smooth integration post-program completion, the primary components to be incorporated in Supportive Housing include:

- ✓ Employment (e.g., have career plan and/or a career counselor)
- ✓ Independent living skills
- ✓ Family and friends
- ✓ Professional supports and mentorship
- ✓ Education/training
- ✓ GP doctor
- ✓ Recreational/leisure activities
- ✓ Self-help programs

For respondents who track clients who have gone through programs, metrics used include:

- Quality of life and health
- Employment/volunteer situation
- Commitment to recovery
- Criminal activity

People with Lived Experience: Engagement Feedback

People with lived experience…

Overwhelmingly expressed that once they were put on a waitlist they are at their highest risk of overdose and increased risky drug use.

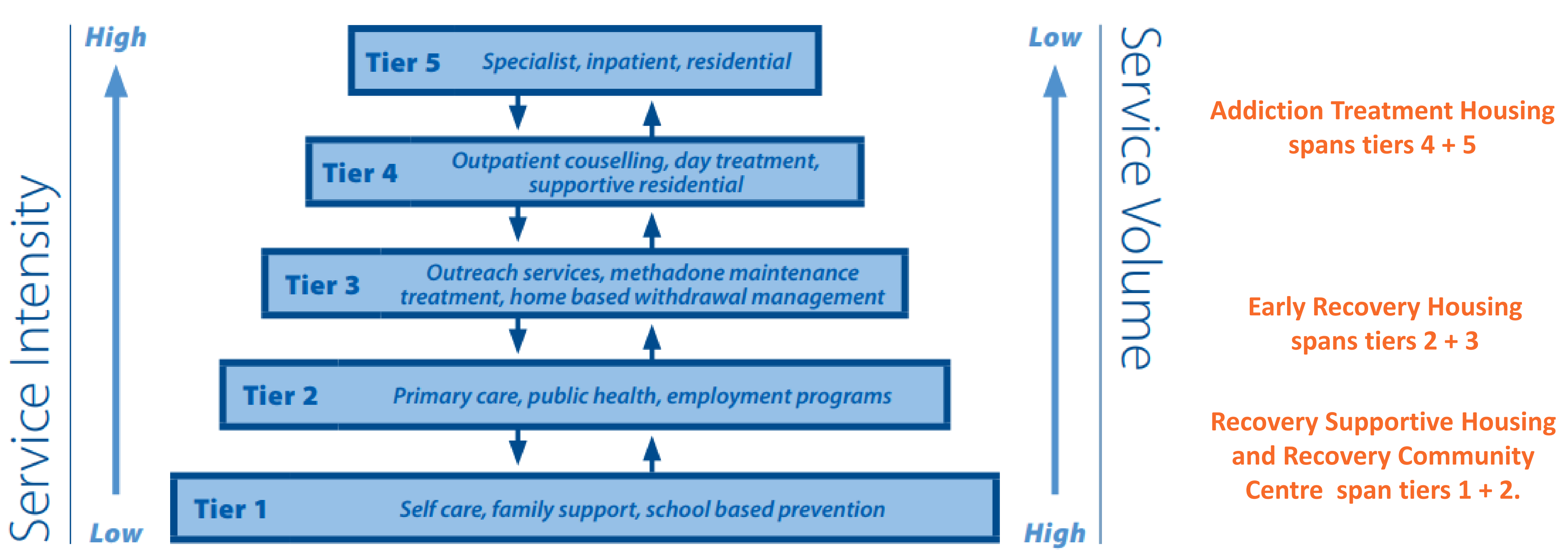
Are often hospitalized while on waitlists, and sometimes kept in hospital longer than required, in an attempt to keep them safe from overdose and other harms.

Strongly supported a early recovery housing model that would create safety for them, while on a waitlist or leaving hospital, and they also strongly voiced that early recovery housing needs to be abstinent-based.

Who were previously homeless expressed that once they were admitted into live-in treatment, that they spend too much time focused on housing post treatment rather than on their recovery.

They suggest that if post treatment housing can be sorted out prior to leaving early recovery, this would relieve them of significant anxiety and allow them to better focus on their recovery.

Appendix – Service Levels of Care



Adapted from, Smith, P. (n.d.). B.C. Tiered Model Adapted from the National Treatment Strategy. Electronic resource.

Do you have any unanswered questions?

For additional information, please contact:

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