Many Ways to Home

Coordinated Intake and Referral Research Project

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ABBOTSFORD

DISCLAIMER AND ACKNOWLEDGEMENTS

DISCLAIMER

Funded in part by the Government of Canada's Homelessness Partnering Strategy's Innovative Solutions to Homelessness

The opinions and interpretations in this publication are those of the author and do not necessarily reflect those of the Government of Canada.

ACKNOWLEDGEMENT

This project would not have been completed without the generous giving of time and commitment by so many. Collaboration, co-creating and partnerships require trust, honesty and a leap of faith that people in our community embraced. We are grateful to all who shared their time, expertise, resources, and encouragement along the way. A strong foundation has been laid as we continue to work towards our goal of housing security, health and well-being for all Abbotsford residents.

- Abbotsford Chamber of Commerce
- Abbotsford Christian School
- Abbotsford Community Foundation
- Abbotsford Community Services
- Abbotsford Downtown Business Association
- Abbotsford Police Department
- Abbotsford Regional Hospital and Cancer Centre
- Abbotsford Restorative Justice and Advocacy Society
- Abbotsford School District
- Affordable Housing Societies
- BC Community Corrections - Abbotsford
- BC Housing
- Bakerview Mennonite Brethren Church
- Buxton Consulting
- City of Abbotsford - Mayor and Council and staff
- Colla Films
- Correctional Service Canada - Community Corrections
- Cyrus Centre Services for Youth and Families
- Division of Family Practice - Abbotsford
- Dr. John Farley
- Drug War Survivors
- Elizabeth Fry Society of Greater Vancouver
- Fraser Health
- Fraser Valley Regional District
- Fraser Valley Regional Library - Abbotsford Libraries
- Greater Vancouver Regional District, Community Entity, Homelessness Partnering Strategy
- Gateway Community Christian Reform Church
- Government of Canada's Homelessness Partnering Strategy
- Greater Vancouver Home Builders Association
- Harvest Discovery Homes
- Healthy Aging Abbotsford
- Helpseeker

ACKNOWLEDGEMENTS *continued*

- Inasmuch Community Society
- Indo-Canadian Business Association
- John Howard Society of the Lower Mainland
- King Road Mennonite Brethren Church
- Kinghaven Treatment Centre
- Landlord BC
- Literacy Matters Abbotsford
- Lookout Housing and Health Society
- Mamela'awt Queesome & To'o Housing Society
- Mar Mar Pharmacy
- Mennonite Central Committee Community Enterprises
- Mennonite Central Committee of BC
- Metro Vancouver Community Entity-Homelessness Partnering Strategy
- Ministry of Children and Family Development
- Ministry of Social Development and Poverty Reduction
- Mierau Contractors
- Northview Community Church
- Pacifica Housing
- Prince George Nechako Aboriginal Employment and Training Association - BC Rural and Remote - Homelessness Partnering Strategy
- Peer Advisory Committee
- People with lived and living experience
- Positive Living of Fraser Valley
- R. Keith Jones and Associates
- Rain City Housing
- Raven's Moon Resource Society
- Residents of Abbotsford
- River Community Church - The Stream Ministries
- Salvation Army - Abbotsford
- SARA for Women
- Sikh Sewa International Society of Youth
- Surrey Housing First Collaborative
- Union Gospel Mission
- United Way of the Lower Mainland (frmly United Way of the Fraser Valley)
- University of the Fraser Valley
- Urban Development Institute-Fraser Valley
- Vancity Community Foundation
- Vancouver City Savings Credit Union - Abbotsford
- Vancouver Foundation
- Vibrant Abbotsford
- Wiebe, Al, Peer Engagement Specialist, Canadian Lived Experience Council
- Wolfe Auto Group
- Yates, Thorne Consulting Services
- 5 & 2 Ministries

LIST OF ABBREVIATIONS

ACT – Assertive Community Treatment

AHPRS - Abbotsford Homelessness Prevention and Response System

CIP – Community of Integrated Practice

CIR - Coordinated Intake and Referral

FVRD – Fraser Valley Regional District

HAAC - Homeless Action Advisory Committee

HAP - Homelessness in Abbotsford Action Plan

HARC – Housing with Abbotsford Rental Connect

HIFIS – Homeless Individuals and Families Information System

HPS –Homelessness Partnering Strategy

IACT – Inter-agency Care Team (formally name Integrated Inter-Agency Housing Allocation and Care Team)

MCCCE – Mennonite Central Committee Community Enterprises – community researcher

MOU Partners – Memorandum of Understanding Research Partners

PGNAETA – Prince George Nechako Aboriginal Employment and Training Association

P-I-T – Point-In-Time Homeless Count 

VAT - Vulnerability Assessment Tool

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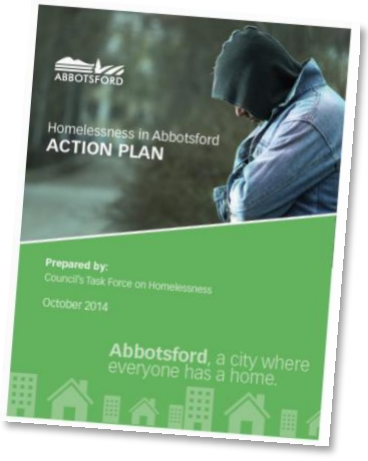
1 CHAPTER
BACKGROUND

The City of Abbotsford is located in Fraser Valley Regional District in British Columbia and is the hub of the Fraser Valley, boasting a diverse demography and global connectivity with its international airport, 2 US border crossings and the Trans-Canada Highway, a Regional Hospital, University of the Fraser Valley, and a vibrant agricultural and growing technical sector. Abbotsford is the largest municipality by population outside of Metro Vancouver and the fifth largest municipality in the province. In 2018, Abbotsford's estimated population is 141,397 people and is anticipated to grow in population to 200,000 people by year 2035.

In 2014, Abbotsford's population was estimated at 138,000 people. During this time, the Abbotsford community was experiencing significant issues related to homelessness and vulnerability in the community. The City of Abbotsford had partnered with BC Housing and local non-profit housing providers to construct affordable housing in the community; however, the demand for appropriately matched levels of housing, health services and support connections for vulnerable populations in the community were still required. The 2014 Homelessness in the Fraser Valley Point-in-Time Count revealed that Fraser Valley surveyed 346 people, who were experiencing homelessness. Of these individuals, 151 people reported Abbotsford as their home community. It was reported that Abbotsford had seen the greatest increase within the Fraser Valley since 2011, when Abbotsford representing 117 of the 345 surveys conducted in the region. In addition, in 2014, 51.8% of those surveyed in Abbotsford reported to have lived in Abbotsford for over 10 years. And, the growing number of youth experiencing homelessness was a reported trend. In addition, 75 percent of those surveyed, reported to be staying unsheltered (e.g. outside, car/camper, and couch surfing). The majority of individuals surveyed reported lack of access to affordable and appropriate housing as the primary barrier to becoming permanently housed.



In March 2014, Abbotsford City Council established a Task Force on Homelessness with the mandate to work closely with all levels of the community to design and initiate a comprehensive, community wide homelessness response plan. The Task Force consisted of a cross section of stakeholders including the Fraser Health Authority, BC Housing, Abbotsford Police Department, representatives of service providers, the business community and City Council. The Task Force work program was intensive and culminated in the Homelessness in Abbotsford Action Plan (APPENDIX A: Homelessness in Abbotsford Action Plan).

The Task Force held a number of public meetings which received numerous delegations and background materials. This information was synthesized into the Task Force's recommendations that informed the Homelessness in Abbotsford Action Plan (HAP) strategic directions and priority actions.

Abbotsford City Council adopted the plan with the goal of ensuring that everyone in Abbotsford has a home. While the importance of having emergency supports in place for people who have become homeless is understood, the focus of this plan is to also create conditions that prevent homelessness and quickly support those who have become homeless to again have a home.

In order to achieve this intention, the plan outlines five strategic directions to guide the Homelessness Action Plan (HAP).

The Action Plan provided strategic directions:

1. Facilitate a Housing First approach, rather than housing only.
2. Advocate for housing and wrap-around support.
3. Initiate a Prevention Program
4. Promote a culture of awareness, inclusiveness and respect
5. Foster collaboration between agencies, community, and government.

To implement the strategic directions of the Homelessness in Abbotsford Action Plan, 2 initial actions were undertaken in 2014-2015 to:

1. Establish a Homeless Action Advisory Committee (HAAC), and
2. Hire an experienced Housing and Homelessness Coordinator

The Task Force also collaborated to assist in informing an application to Government of Canada's Homelessness Partnering Strategy for contribution funding through its federal research and innovation stream, for the City and its stakeholders to research, develop, implement, test and evaluate a coordinated intake and referral model to support individuals who were experiencing homelessness to access housing and supports. Abbotsford presented a unique opportunity to pilot Canadian Housing First Toolkit, based on the experience of the Canadian At Home/Chez Soi project, as a current HPS non-designated community that:

- Faces significant issues related to street entrenched homelessness.
- Houses a significant number of correctional institutions within the region that discharge and release individuals into the community, who require access to transitional and permanent supports.
- Struggles with an increasing vulnerable youth population, who is at-risk of or experiencing homelessness.
- Experiences a relatively low rental vacancy rate (i.e. 0%-0.2%, 2017).
- Delivers innovative housing and community support measures that could support community infrastructure options for individuals experiencing homelessness to access transitional and permanent housing, health and community integration supports.

In May 2015, the City was successful in receiving the HPS contribution funding and was awarded $400,989 to commence this work.

The project's primary aim was to support the City to facilitate the multi-stakeholder creation of a coordinated intake and referral model and test it after one (1) year with the aim of demonstrating how

a community-wide systems approach can be implemented and achieve results in a mid-sized Canadian city.

The Coordinated Intake and Referral project stakeholder activities also informed and addressed the Homelessness Action Plan's Strategic Directions and Priority Actions through an on-going robust community planning and mapping process, multi-stakeholder research, design and mobilization greater collaboration to deliver programs, services, alignment of activities and multi-sectoral partners, and to develop and refine shared outcome measurements. These activities supported the development and activation of the initiatives and components that comprise the Abbotsford Homelessness Prevention and Response System, which includes the coordinated intake and referral model as the system's entry point.

The following report will outline how this HPS funded project has supported advancements by Abbotsford towards becoming the first mid-size urban centre in British Columbia to integrate housing and service agencies, health services, policing, and the community with Senior levels of Government and its agencies, including: BC Housing, Fraser Health Authority, Ministry of Social Development and Poverty Reduction and Community Corrections into its city-wide homelessness prevention and response system through the coordinated intake and referral model as its entry point.

2 CHAPTER
CIR RESEARCH PROJECT

The overall goal for the Coordinated Intake and Referral (CIR) system development was to support a community-wide systems approach to respond to homelessness; which would support Abbotsford to be the first mid-size Canadian city in British Columbia and perhaps Canada to fully integrate policing, community housing and service agencies, all levels of Government and their agencies, businesses and the community in a collective response to homelessness. The innovative response was to implement the following:

1) Centralized or coordinated intake system, and
2) Community wide response plan for individuals and families, who were experiencing homelessness, including newer Canadians, individuals identifying as Indigenous, and those recently discharged from institutions.

The City's role was defined as facilitating the collaborative research, planning, stakeholder engagement, community capacity building, and auditing of the project's deliverables, outcomes and shared learnings. For further information about the CIR project can be found at: https://www.abbotsford.ca/community/housing_and_homelessness.htm

The project's aim was through its collaborative research and development processes that would also advance the Action Plan and community-wide response plan in a way that it would create a sustainable foundation for the Housing First Approach to be implemented in Abbotsford.

The project's purpose built on the extensive work of the Abbotsford Homelessness Task Force to:

1. Implement the Homelessness in Abbotsford Action Plan (HAP) by working closely with its community partners, including but not limited to, community housing and service providers, Abbotsford Police Department, Fraser Health Authority, Ministry of Social Development-Poverty Reduction, and BC Housing.
2. Initiate a centralized or coordinated intake, access and assessment system and community-wide response system to be housed with partner organizations.
3. Work with partners to strengthen an innovative scattered site housing model, while continuing to encourage the development of housing options across the continuum.
4. Invest in an existing rent bank program as a pillar of a community-wide prevention and discharge program that works closely with all institutions, including the integrated offender management program.
5. Deliver a community Housing First training program including a partnership with University of Fraser Valley.
6. Design a careful research process with key community partners to integrate key indicators, benchmarking and video documents as a systems approach and learning tool for other communities.

The project had three main objectives, including:

1. Aligning exiting intake and referral activities to better connect populations, who were experiencing homelessness to appropriate services, including Housing First support services.
2. Promoting partnerships among key stakeholders, including landlords, and encourage the alignment of service delivery activities.
3. Generating formal connections with landlords.

The project included three phases, consisting of:

Phase 1: Developing a Coordinated Intake and Referral System model

Key activities: Housing First expert panel(s), with outcomes to inform population housing and support needs; community-wide formal landlord connections; and a community-wide data base to be created by the end of the project.

Phase 2: Pilot project testing of the intake and referral model and establishing sustainable Housing First Best (promising) Practices

Key activities: Monitoring and testing the launch of the coordinated intake and referral model over a one year period and report back to the Advisory Committee; Outcomes to report on number of clients assessed, number and type of referrals to appropriate services, duplication of services, reduction in the number of individuals experiencing homelessness, service outcomes and project learnings; and outcomes will inform the city-wide response, outcome measurement and database.

Phase 3: Dissemination of results to Abbotsford community, throughout British Columbia, across Canada and other jurisdictions (e.g. North America and Europe)

Key activities: Results of the project will be summarized in a report to demonstrate best practice of the development and implementation of a community-wide systems approach and will be disseminated broadly; will help to establish a sustainable foundation to expand the Housing First approach in Abbotsford; and will inform an e-learning component developed based on the project's learnings for collaboration and capacity building activities.

The research methodologies employed for this project include: Community-based Action Research, Collaborative Mapping, Institutional Ethnography, and Best Practice review. The methods were utilized through a dual-track research and community development approach, which focused on a series of action-oriented, tangible deliverables and initiative to build stakeholder capacity, alignment

of activities and access to housing and support resources. The research design also included literature review, best practice presentations from other communities, and adaptation to local Abbotsford conditions

As the CIR model design was advancing, the research team recognized that structural alignment of activities were required across the housing, health, community integration and non-clinical services to mobilize effective referral and support. Thus, co-development of the Abbotsford Homelessness Prevention and Response System commenced to work through each structural component through a multi-stakeholder design approach. The Functional Zero Definition of Homelessness was utilized through a community infrastructure approach to activate the systems work to include: Intake Function, Inter-Agency Care Team, Housing with Abbotsford Rental Connect, Shared Outcome Measurement System, and integration between the shelter, housing, health, community support, prevention, discharge coordination, and justice systems. Additional funding was secured to mobilize these initiatives.

Monitoring was built into the CIR process as part of the on-going systems work. Daily monitoring by the Inter-Agency Care Team and Intake Function Coordinator were conducted to support seamless intake, referral and support of participants. Monthly monitoring and data reports were collected and reviewed for necessary adjustment to processes or trends or gaps that may be impacting the CIR model. Regular reviews were conducted with the Inter-Agency Care Team, Intake Function, Homelessness Action Advisory Committee and Working Groups and the Memorandum of Understanding partners.

Evaluation occurred at several points throughout the process. Pressure testing of the CIR model was conducted through journey mapping that utilized client archetypes and systems review of how the services would respond to diverse client needs. Third party evaluation of the CIR model was conducted at various points of its implementation phase, which included a 2017 and 2018 point in time count, qualitative interviews, and quantitative data and trend analysis. Finally, an evaluation was conducted to review the overall systems work and how it related to the CIR model.

Performance measurement was developed with stakeholder involvement to identify key indicators, shared outcomes, and collective impacts for each of the components of the system. These identifiers were embedded into the collaborative map that was developed by the community. This approach supported stakeholder investment in process, collaboration, alignment and shifted activities from singular agency input/output to a shared, person-centred, multi-agency approach. The key indicators and shared outcomes were also utilized as reference when applying for additional funding. Additional funding sources were applied through shared funding application processes with the stakeholder teams to allow for cornerstone agencies to be selected on behalf of the community to mobilize the funded initiatives. The funded initiatives mobilized as part of the Abbotsford Homelessness Prevention and Response System (AHPRS), a community-owned and invested resource that isn't owned by one agency or level of government, rather it is mobilized as a community collective with shared accountability for its outcomes, impacts and overall benefits.

3 CHAPTER
GETTING STARTED

Introduction:

The first phase of the research project focused on identifying the composition of the people experiencing homelessness and a shared understanding of their needs, and the services available in our community; adopting a structure to support and oversee the project, a shared understanding of best practices related to addressing and ending homelessness; and building partnerships and opportunities for collaboration in planning and implementing the Coordinated Intake and Referral (CIR) pilot project and development of the Abbotsford Homelessness Prevention and Response System (AHPRS).

PART 1:

Identify and survey needs of Abbotsford people experiencing homelessness

Throughout the research project, opportunities for engagement and input with persons with lived and living experience were pursued to ensure the voice of those accessing services was in the forefront of planning and implementation activities. Engagement and input took many forms from participating in the Best Practice forum, involvement with working groups, participation in focused dialogue sessions, participation in evaluation and towards the end of the project engaging in collaborative solutions. The following information was gathered on an on-going basis and was used to inform the CIR research project.

Qualitative: Survey results, conducted by the Community Researcher, with people experiencing homelessness stressed the need for housing that they can afford and respectful relationships with organizations providing services. Relationships between people experiencing homelessness with services providers and City of Abbotsford were strained due to prolonged conflict relating to lack of housing, lack of shelter beds, and lack of camping sites. Comments provided covered a number of themes: it's tough to get off the street due to drug use and health issues; lack of jobs or people willing to give them a chance; the stigma and judgement that is faced; need for support when the person is ready; the importance of trust and willingness to listen; the need for a place to be, just for us; and the need for respect.

Housing:

- You get clean and you have nowhere to live
- It's not just get a job, you need your health, you need to be clean, Abbotsford is the worst place. Where do you shower? There is one shower in Abbotsford for men
- I get $665 a month from welfare, my rent is $775.

Respectful relationships:

- Some people out there are so entrenched in homelessness that jumping through hoops is almost impossible for them. And they are looked down upon because they can't do something.
- Listen to what people say they need and not tell us what we need
- How are you going to know how to help- need to listen
- My thoughts seriously is that people running services and that, is how judgmental people are about the homeless people, that are poor, who are addicts.
- You don't necessarily have to agree with drugs - you just have to respect the person who does them

Summing it up:

> "I just don't want to see this municipality to give up. It's gonna be – it's a long, hard, road but It's doable… It didn't happen overnight, and it's not going to be solved that way. Right? So: Don't give up."

Through a series of other field observations and stakeholder input throughout the project, it was confirmed that many of the individuals who are chronically homeless or hard to reach have: persistent addictions issues, frequent utilization of emergency and community service systems and have underlying mental health challenges. Support with activities of daily living due to complex health care needs was also noted. Qualitative data also confirmed the health service data collected in the 2017 Point in Time report (below) regarding lack of access and barriers faced to receive necessary treatment and services to address health concerns.

Quantitative – The 2017 P-I-T report was the triennial homeless count survey update since data was first collected in 2004. The 2017 survey was conducted after the design of the CIR model (2016) was completed but before the model was launched in September 2017. The 2014 P-I-T report was used as the benchmark report for the research project, and the 2017 P-I-T provided an interim report.

The 2017 P-I-T surveyed 271 individuals, compared to 151 in 2014, representing an 81% increase, bearing out the concern of the CIR design group that affordability issues (high rent and low income) and lack of suitable housing (vacancy rate of less than 1%), would continue to be top causes of homelessness.

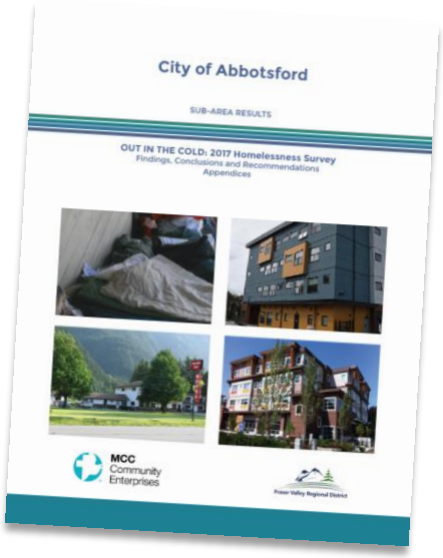
Reasons given for being homeless	2014 (N)	2014 (%)	2017 (N)	2017 %
Income to low	73	28.4%	161	16.6%
Rent too high	34	13.3%	160	16.5%
Lack of suitable housing			112	11.6%
Addictions	45	17.5%	81	8.4%

The above table also indicates the role of health issues relating to homelessness, where addictions was identified among the top causes for being homeless. In the 2017 P-I-T, the impact of health

issues was examined more closely when, for the first time, individuals were asked about access to treatment.

Reported Health Problems	2014 (N)	2014 (%)	2017(N)	2017(%)	Receiving Treatment (2017) only
Addiction	78	41.3%	183	73.5.%	18.2%
Medical Condition	39	20.6%	136	55.1%	28.8%
Mental Illness	42	22.2%	126	46.0%	15.2%
Physical Disability	30	15.9%	82	32.5%	13.4%

All reported health problems in 2017 saw significant increases from 2014. In 2017, when asked about receiving treatment, significant gap in treatment: 86. 6% of individuals with untreated physical disabilities; 84.4% of individuals untreated for mental illness and 81.8% individuals untreated for addictions. Access to health services and treatment was a priority of both the CIR design group and the AHPRS mapping design team. The addition of information about access to
treatment, supported the importance of including health services in the wraparound services of the Interagency Care Team



When asked about services that individuals had used in the past 12 months, shelter and health were in the top 2 of 3 services most used. (2017 results only)

Services used in last 12 months	Service Usage Percentage
Meals/Soup Kitchen	62.8%
Emergency Room	60.3%
Extreme Weather Mats	59.9%
Drop – in	54.7%
Outreach	49%
Harm Reduction	48%
Housing Services	29.1%

In 2017, respondents were also asked whether or not they had been impacted by a change or withdrawal in services, with 46.7% indicating in the affirmative. This is an increase from 2014.

Demographic Information:

In 2017 survey there was a similar proportion of individuals in shelter as living outside. The gender split has also remained stable. Compared to the 2014 count, individuals reported being homeless

longer, more are in the 50+ age group and youth experiencing homelessness are younger. People who were homeless more than one year increased in 2017, another indicator of lack of affordable housing and the entrenchment of homelessness. The 51.5% of people surveyed in 2017 reported always living in Abbotsford or 11 years+, comparable to 2014 51.8%, indicating that the majority of people experiencing homelessness have a temporal connection to Abbotsford.

	2014 (N)	2014 (%)	2017 (N)	2017 (%)
Total number of respondents	151		271	
Respondents - sheltered	24	17.4%	112	40.9%
Respondents – outside or vehicle	71	51.4%	120	43.8%
Respondents – Male	90	59.6%	166	63.1%
Respondents – Female	52	34.4%	95	34.7%
Respondents - Other			2	.7%
Age Distribution				
Adult – 30 – 49	74	54.8%	101	36.8%
Adults – 50-59	20	14.8%	59	21.5%
Youth 15-19	16	11.9%	34	12.4%
0-19	0		5	1.8%
Duration of Homelessness				
1 year +	55	42.6%	122	52.8%
6 month or less	52	40.3%	64	27.7%
Time lived in Abbotsford				
Less than 6 months	15	13.4%	27	11.8%
11+ years	58	51.8%	71	31%
Always			47	20.5%

APPENDIX B: 2014, 2017, 2018 P-I-T Reports

Part 2:

Structure for the Project

In early 2015, the City of Abbotsford appointed the Homelessness Action Advisory Committee (HAAC) to oversee the Homeless Action Plan. The committee consists of: one Council member and alternate; an appointee representative from each of Abbotsford Police, Fraser Health Authority and BC Housing; one appointee from service provider group – Abbotsford Community Services, Salvation Army and MCC BC; one appointee from an outreach service provider; one appointee between a housing service provider or an emergency shelter; one appointee from the Abbotsford Chamber of Commerce; and two members at large There is a City-vetted process for individuals and organizations to volunteer for Council appointment before selection is made.

HAAC also acted as the advisory committee for the CIR Research Project. HAAC used a working group model to assist with implementation of the Homeless Action Plan, development of the Abbotsford Homelessness Prevention and Response system and the CIR Research Project. Membership in the working groups was voluntary and had a cross sectoral mix. The HAAC reports their work to the Abbotsford City Council and to the community through an annual forum. Over the course of the project the working groups included Outreach Working Group, Shelter and Drop-in Working Group, Abbotsford Rental Connect Initiative. New working groups in development include prevention support and discharge coordination.

HAAC meetings are open to the public and are a means for keeping the community informed about the CIR research project, the systems development work, new trends, new services, etc. Focused, discussions were introduced into the meeting process as an opportunity for in depth discussion of a specific challenge or opportunity relating to housing and homelessness. Guest speakers were invited to attend to provide their perspective on the discussion topic from their experience, or area of expertise. Including guest speakers in the dialogue added new perspectives to topics, introduced other collaborative initiatives in the community and was an opportunity for inviting new partners to the table. (APPENDIX C: Example of Focused Discussion)

Part 3:

Best Practice Forum

Housing First rather than housing only was adopted as a key strategy of the Homelessness Action Plan. A Best Practice Forum was held in October 2015. The goals of the forum included introducing the Housing First approach to the community, to collective impact as a framework for change, integral strategy road mapping methodology for identifying collaborative actions, outcomes and impacts to effect social change. Participants also provided direct input regarding collaboration and Housing First through a world café dialogue. Participants for the forum included community service providers, housing providers, municipal staff and elected officials from across the Lower Mainland (Fraser Valley Regional District and Metro Vancouver), representatives of senior levels of government, community members and persons with lived and living experience. (APPENDIX D: Best Practice Forum Agenda)

Housing First Orientation and Training

Participants to the forum represented Council members of Abbotsford and neighbouring municipalities, city staff, provincial organizations (health and housing), service providers, faith groups,

business, persons with lived experience, students and residents. In keeping with best practice methodology, a panel of experts from other communities shared their expertise and experience in implementing housing first best practices. The panel was followed by a question and answer session. (APPENDIX E: Biographies for Panelists HF Training Best Practice Forum)

World Café

Through a world café process the participants of the forum provided input regarding a range of best practice topics relating to housing first, systems development and youth systems work. The following is a summary reflecting the top three priority areas for each issue explored –

Input for creating a system of care:

- The top priorities for supporting a collaborative effort for adopting a community-wide Housing First approach included: fostering communication and relationship between agencies and organizations; generating shared outcomes and creating climate of inclusiveness; support for establishing processes for information sharing within a system of care with specific person needing service. Other priorities referred to coordination, resource information sharing and policy changes to create flexibility and fast-track policies.
- To promote a culture of inclusiveness and respect for those currently experiencing homelessness: the importance of reducing judgement, understanding the needs of all parties advocacy and public education. Other priorities included promoting social responsibility, integration of social programs creating a culture of inclusiveness and respect.
- To engage more people in working towards an end to homelessness: have a plan and communicate success stories to give hope; demystify bias; and relationship building between all parties – policy, health, business, service providers. Suggestions for engaging individuals experiencing homelessness focused on incentives – more programs and economic benefit.

Input relating to service providers and individuals:

- Agencies and individuals identified ways that they participate in a Housing First approach: peers engaging to support referral; collaborative services to increase access to funding; and reference to all age groups. Regarding service delivery specifically: providing wraparound supports (social and professional); meeting basic needs and skills to stay housed; cultural sensitivity; and establishing landlord relations.
- The following strategies were identified for aligning current efforts with a City-wide, Housing First initiative: a) Efforts with landlords – using City as a liaison to mediate with large landlords in Abbotsford; creation of approved landlords willing to rent to homeless population (connected to City, policy creation and real estate communication); on-going support for landlord and tenant (relationship building, advocacy, establishing expectations); compensation/incentive for landlord (tenancy agreements, responsibility); communication/education for landlords on tenant needs (education, wrap around support approach, advocacy); b) Prevention strategies; and c) Bringing people into housing carrying their social networks and friends with them.

Input relating to youth homelessness:

- Housing – youth need as many support as adults in housing (choice and options); housing options are required (transitional housing, group homes, housing first and wraparound); Youth homelessness hidden and creates different barriers for housing that need to be identified, look at identified needs and create goals – short-term steps and support to find housing, a tool for assessing the risk of the youth for housing.
- Services/supports- a lot more opportunity for change with youth; connect regions for services, information and support; look for options for funding (youth agreement with social worker); collaborate with services (police, social workers, hospital, reconnect workers); supports for mentorship for youth aging out of care, let youth identify their own goals, have their own voice, have their own choice.

(APPENDIX F: World Café Dialogue Findings)

Collective Impact and Integral Strategy Roadmap

In addition to Housing First best practices the participants were introduced to the collective impact approach as a framework for communities tackling complex social issues in a cross-sectoral manner. The afternoon session was the introductory workshop for collaborative outcome mapping, the methodology that would be used during this project for developing a community response to homelessness (Collaborative Roadmap for the Prevention and Response to Homelessness – May 2016).

A ROBUST COMMUNITY PLANNING PROCESS CREATES- "A COLLABORATIVE ROADMAP FOR THE PREVENTION AND RESPONSE TO HOMELESSNESS IN ABBOTSFORD"

The Collaborative Roadmap for the Prevention of and Response to Homelessness in Abbotsford was developed with policy and evidence-based practice research, over 175 stakeholder perspectives and 20 key informant interviews, and a multi-stakeholder research design team. In June 2016, the Roadmap was presented to over 60 community members to identify ten (10) priority actions that informed the work program to respond to the Homelessness Action Plan's Strategic Objectives through mobilization of four key capability areas: 1) Prevention Support, 2) Discharge Coordination, 3) Housing First Approach, and 4) Support System Coordination and Sustainability. The Roadmap created a multi-stakeholder invested and informed architecture for the CIR model and Systems work.

The roadmap is a living document that is mobilized through the HAAC working groups and a status report on its actions is presented to stakeholders as part of a report to the Annual Community Forum and for input into the coming year's work program.
This process renews commitment and investment by stakeholders in the on-going implementation of Abbotsford's Homelessness Action Plan and the key strategic outcomes and actions as identified in the map. Accessible version can be found at: **www.abbotsford.ca/homelessness**

This initiative activated the following key capability areas:

- Prevention support
- Discharge coordination
- Housing capacity (intake and referral, outreach and wrap-around support, housing capacity, respectful delivery and community integration)
- Support system coordination and sustainability (coordination, funding and resources, best practices and continuous improvements, and aggregate information sharing).

Strategic Goal: Fewer people become homeless and the who community supports people who are experiencing homelessness or who become homeless

Ultimate Benefit: Abbotsford is a socially and economically vibrant community

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Municipal Leaders Homelessness Round Table

After the presentation of the housing first best practices, municipal leaders were invited to attend a co-occurring roundtable to discuss issues and opportunities related to homelessness and Housing First. The roundtable brought together elected officials and staff from the Fraser Valley Regional District and Greater Vancouver Regional District (Metro Vancouver). Metro Vancouver communities were already using housing first approaches were able to share experience and knowledge in the dialogue. They explored the context of homelessness in the Fraser Valley, local capacity to respond to homelessness and moving forward. Discussions regarding moving forward included: role of municipalities and regional district; opportunities for cooperation and partnership; role of BC Housing, Fraser Health and other partnering agencies; and priority areas for collaboration, joint positioning, advocacy and partnership. (APPENDIX G: Mayors' Roundtable Report)

Part 4:

Outreach Working

The outreach working group was formed to look at alignment of existing outreach services, identification service gaps and information sharing on changing trends to HAAC Advisory Committee. The timeframe of the Outreach Working Group was from June 2015 to March 2017 when the focus for community partners was on the pilot project implementation of the Coordinated Intake and Referral model and the activation of the Abbotsford Prevention and Response to Homelessness System.

Membership of the Outreach Working Group was cross-sectoral including social/community services, housing providers, social assistance, Indigenous-urban, health including addictions/mental health and recovery support. Persons with lived experience also attended meetings. The monthly meeting format included presentations, dialogues on study topics, development of a pilot project and work on a services inventory. The following chart provides the activities of the group as they pertained to the Homelessness Action Plan (HAP).

HAP Strategic Direction	**Activities**
Facilitate Housing First but not only Housing	• Presentation series of outreach programs in the community- information from non-profit, faith groups, government. The information shared provided a baseline about the service resources in our community, gaps in service and possibilities for integration of services • Presentations from Fraser Health Authority on topics of harm reduction and Home/Daytox services • Development of services framework for categorizing existing community services according to their focus – prevention, emergency response and accommodation/supports. As the framework is populated with community service information it will form the basis for service gap analysis,

HAP Strategic Direction	Activities
	generating real time information on program availability – both vacancies and wait lists for intake and the possibility of a digital resource directory.  http://homelesshub.ca/solutions/housing-accommodation-and-supports
Create a culture of inclusiveness and respect	• The member of the Outreach Working Group represented a range of philosophies and approaches. The regular meetings, presentations and discussions were opportunities for learning together and creating respect.
Foster collaboration between agencies, community and government	• Community Outreach Team – pilot- Dec/2015-Mar/2016 – a collaborative effort of several organizations to provide teams of outreach workers to visit camps/location of people who are experiencing homelessness and barriers to accessing services and connecting in real time to their immediate needs. Teams provided referral information, access to phones and care/food packages. The care/food packages were provided by students from local school and a local temple. The outreach team met regularly to plan their shifts and monitor the follow up for the people they assisted. • The outreach staff for this initiative came from different organizations with different mandates ranging from homelessness prevention, health services including ACT and harm reduction, and outreach to women. Working two-person shifts together provided a broader range of service access to persons living homeless. • Communications: Regular meetings of the Outreach Working group were a venue for information updates and discussions about current challenges, emerging issues and trends.

Through the work of the Outreach Working Group in 2017, it was concluded that Abbotsford was experiencing a critical gap in outreach services as it related to housing retention and homelessness prevention:

- The outreach services focused on housing for people experiencing homelessness are provided by two agencies with 3.5 FTE's combined. Additional outreach and rent supplements were provided to the community through another agency. However, overtime, the rent supplements available through outreach have not kept up with the increase in demand due to increasing rents and loss of market housing affordable for people on income assistance shelter rates.

- In July 2015, Ministry of Social Development and Social Innovation (now Ministry of Social Development and Poverty Reduction), placed an Integration and Outreach Worker in Abbotsford as an outcome of stakeholder engagement and City Council advocacy to the Provincial Government. The Integration and Outreach Worker fast tracked applications and reduce barriers to receiving income assistance for vulnerable persons, decreasing barriers to complete income assistance applications and personal identification applications, until this was restructured.
- A specialized community assistance program for individuals experiencing homelessness provided outreach and case management to help people find housing and retain it was wound down in March, 2017.
- In 2015, Assertive Community Treatment (ACT team) started in Abbotsford providing intensive case management with rent supplements to the persons served. This was an important development to increasing services to vulnerable individuals. But the criteria for admission is specific and as a result many people experiencing homelessness would not be eligible.

In addition to the services noted above, other organizations providing health services and women's services, provided outreach services to people experiencing homelessness. Through the Community Outreach Team pilot it was learned that working together with coordination and case management is an improvement for the person receiving service and those providing it. However, for it to be sustainable, there is a staff resourcing issue relating to the coordination of these activities that requires further consideration.

Part 5:

Rental Connect Initiative – understanding local conditions relating to rental market housing and establishing relationships with landlords

Through a focused dialogue approach, a stakeholders group including service providers, housing providers, landlords, tenants and persons with lived experienced identified challenges relating to finding and maintaining accommodation. Dialogue topics included: address the patterned cycle of homelessness (exit/barriers to housing), identify and survey housing options in Abbotsford; experiences of service providers engaged in landlord procurement; supporting successful tenancy; and components of a rental connect initiative – learning from existing programs.

The dialogue process identified that local conditions were rapidly changing regarding the rental market and this was supported by the following:

- Comparing October 2014 to the October 2016 Canada Mortgage and Housing Corporation Rental Housing data showed that the vacancy rate declined further from 3.1 to .5%
- The average private apartment rate for all unit types increased from $758 to $837.
- One bedroom rents have increase from $684 to $744.

- Income Assistance shelter portion remains $375 per month which increases barriers for low-income individuals to afford and retain housing in the Abbotsford private rental market without financial assistance
- Shelter to Income Ratio - with respect to renters in 2015 - of 11,870 renter house households in Abbotsford, 4,655 (39%) were Core Need Households (30% of income for housing expenses) ; whereas 2,295 (19%) were In Need and Spending at Least Half (INALH) of income on shelter. INALH households are precariously housed, at-risk of homelessness or episodically or chronically homeless.

From the experience of tenants, some landlord practices were making it increasing difficult to secure housing

- Many apartments introduced crime free multi-housing programs and require criminal record checks for all applicants
- Older private market rental stock is being purchased for redevelopment, which is decreasing availability of attainable rental options for low income households
- Due to low vacancy rates, when a unit becomes available, prospective renters are offering the landlord more than the asking rent to secure the unit.
- It is financially difficult for people to provide first month rent, damage deposit and pet deposit (if required).
- Problems relating to stigma and finding landlords willing to rent to people who have lived on the street with low income.

Other Observations:

- Scatter site housing, including congregate scatter site housing, using market housing, allows for individuals on social assistance to have affordable housing. It also meets the need in the community for additional transitional or supported housing to help people transition from street to home. For some individuals, given their health and mental health challenges there is also a need for permanent supported housing.
- The housing retention and eviction prevention approach that builds solid awareness about rights and responsibilities for both landlords and tenants and supports through active housing liaison services and successful landlord-tenant relationships.

4 CHAPTER
MOVING FORWARD

The shared learnings and collaborations established during the start-up phase of this project became the foundation for moving forward to create a Coordinated Intake and Referral model for the demonstration pilot project scheduled for 2017. To move forward with the desire to do things differently, multi-stake holder collaborative design groups were formed for the CIR model design, the systems collaborative road map design, the rental connect initiative and peer engagement For design groups to be effective it was important to ensure that the composition of the teams was representative of organizations providing services, allied services as well as sectors of the community that would be impacted by change and sectors that could provide expertise. Participation was voluntary but in order to ensure that the groups had cross-sector representation, invitations were extended to sectors missing from the table. Each design group was formed for a specific time period. In the case of peer engagement, at the request of persons with lived and living experience, they were specifically engaged to provide input into the design of a drop-in centre

Part 1:

Coordinated Intake and Referral model design process

The overall aim of the Coordinated Intake and Referral project was to establish the foundations for a sustainable Housing First recovery model that quickly houses individuals followed by supports as needed. Coordinated Intake and Referral includes elements of improving access to housing and support services and standardization of intake and referral processes. In recent years, CIR has come to be known as Coordinated Access in the broader homelessness servicing system.

The model design process was a synthesis of local service delivery information pertaining to intake and referral; compilation of the composition of the population of people experiencing homelessness and their needs; and a workshop series of best practice of CIR models from other communities. The information from presentations was reviewed and evaluated by the design group for adaptation and best fit with the local conditions and resources.

The membership of the design group was drawn from non-profit housing and service providers, and housing and health services of senior levels of government. The design group had 12-15 core members willing to participate in the workshop series. It was anticipated that for the pilot project and implementation of the model that organizations would self-select based on the fit with their mandate and programs with Coordinated Intake and Referral and Housing First approach. By the end of the model design process, six organizations volunteered to be Research Partners for the pilot project, and were formally approved by the HAAC Committee. A seventh organization joined during the pilot. All MOU partners signed on to a Memorandum of Understanding (MOU) with the City of Abbotsford The MOU was developed based on the Terms of Reference created by the CIR model design group. (APPENDIX H: CIR Research Partners MOU).

Abbotsford CIR Inventory

Mennonite Central Committee Community Enterprises was retained as the community researcher for the Coordinated Intake and Referral Research Project. The survey of intake processes and coordination was needed to inform the design of a coordinated intake model. Other activities for the community research included an evaluation process during the pilot process and conducting a 2018 Point-In-Time survey to compare with the benchmark Point-In-Time surveys of 2014/2017.

The methodology for information gathering included qualitative and quantitative approaches. The quantitative report was a survey of intake and referral used by agencies in Abbotsford. Qualitative interviews were conducted with the agencies involved in the CIR model design process including both front-line, supervisors and senior management staff. The researcher accompanied outreach staff on two walkabouts to observe the informal or "pre-intake" processes. In addition, four focus groups were held with people with lived experience in different service settings – drop-in centre, women's drop-in centre, youth drop-in and a peer-led organization (in this case a person with lived experience coordinated the group). Data regarding intake processes, data collection and services provided were collected through surveys of 14 organizations participating in the CIR model design process. For themes of the qualitative interviews and focus groups see APPENDIX I: Inventory Report of Intake and Referral; APPENDIX J: Qualitative Reports of People Experiencing Homelessness and Service Providers.

The survey of intake processes revealed a range of intake and data collection activities:

- Two agencies operating informally with no paperwork or data management system
- Three agencies were in the midst of moving from an informal to a more formal system of intake and data collection.
- Seven agencies operated on a semi-formal to formal basis with relationships outreach and "pre-intake" conducted before anything formal was introduced. Three in this group provide data to funder, BC Housing electronically but at the time it was not web-based which presented a limitation to understanding data from Abbotsford community.
- Two have highly formalized intake procedures (one has an assessment scoring tool) with organization wide data management systems.

In the absence of coordination of intake, at the time of the survey, people experiencing homelessness made individual applications for services and likely had to provide background information repeatedly. There was risk for duplication of service; however, on an individual basis staff between organizations formed collaborative relationships to facilitate connecting the person to appropriate services. High value was placed on these relationships and while there was an interest for more formalized collaboration there were reservations that would be addressed in the model design work.

Workshop Series for the CIR Model Design Group:

Community	Model
Orientation to CIR Research Model Design process Greater Victoria Regional District – presented January 2016	Street 2 Home Coordinated Access to Supported Housing
Interval February to April to complete Inventory of CIR models in current use in Abbotsford	System Collaborative Roadmap design group meeting during interval
Research Validation – qualitative research People with lived experience/service providers re proposed CIR model Forms distributed for collection survey data re existing I&R in Abbotsford May 2016	Presentation by CIR researchers survey themes regarding current system & proposed changes People with lived experience in attendance
Calgary Homeless Foundation Self-study June 2016– due to unforeseen circumstances the Calgary staff not able to present	Coordinated Access and Assessment
Surrey Housing First Collaborative July 2016	Coordination of intake, Memorandum of Understanding and assessment tool
Orange Hall, Vancouver August 2016	Coordinated Access and Assessment
Dialogue and Review of Models August 2016	Design group identified the elements needed for Abbotsford model
Rain City, Surrey Sept 2016	Intensive Case Management (wraparound support)
Adapting CIR Model for Abbotsford Oct 2016 November 2016	For the October meetings a discussion framework document identifying key considerations was used for adapting a CIR model for Abbotsford. The November meeting focused specifically on securing shared data management - HIFIS (Homeless Individuals and Families Information System) and CAMS (Case Management Administration System)
VAT workshop February 2017	Orientation to use of Vulnerability Assessment Tool

Task Groups for Terms of Reference and Finalizing Model - subcommittees of Design group

Task	Results
Terms of Reference July/August 2016	Created terms of reference for the Design Team, this document was used to create the Memorandum of Understanding (MOU) for the Pilot Research Partners
Third Party Evaluation with mapping consultants September 2016	Using the Abbotsford Homelessness Prevention and Response Road map and scenario archetypes, the design team walked the scenarios through the CIR process and the map.
Finalizing Model November 2016/January 2017	MODEL FEATURES: • Research Partners self- identified - development of Memorandum of Understanding for participation in CIR pilot project and wraparound support with IACT. Six organizations signed on at the start of the pilot period and a seventh joined later. • Access – centralized but mobile Intake function, using drop-ins, shelters and camps as touch points for referrals. Pre-screen form developed for initial service request, Assessment – Common intake form developed including written consent for release of information to MOU Partners (for wraparound support). Vulnerability Assessment Tool (VAT) would be used to align with use by BC Housing funded organizations in community • Assignment – referred participants to the IACT – outreach and wraparound support. Composition included core health care workers, Intake function staff and staff of MOU agencies where indicated by participant. • Data Management – based on HIFIS, recorded data using spreadsheets. No access to HIFIS software anticipated during the pilot. Exploring other shared information management systems. The data collected would anonymous and aggregated for systems work

Recommendations to support implementation of the CIR model in the pilot project

1. Given that there were no formal Housing First programs in the community at the time, and a lack of on-going housing retention supports, the design team recommended that the pilot focus on one program for testing access, assessment and referral. With the intention that the pilot model would be scalable for adding additional services as they are developed, funded and implemented
2. CIR process to be used as the means of referral to one wraparound support service (to become known as the Inter-agency Care Team), based on Housing First principles to provide housing stabilization and service supports to the most vulnerable people in the community. To ensure most benefit of the supports offered during the pilot project period, participants with a connection to Abbotsford and an intention to stay in the community were a priority.

3. The referrals for the pilot limited to 30 participants who are chronic or episodically homeless with medium to high vulnerability based on Vulnerability Assessment Tool. The Canadian Definition of Homelessness, Canadian Observatory on Homelessness for 2016, was adopted for purposes of the pilot project.
    - Chronic homeless referring to individuals who are currently homeless and have been so for 6 months or more in the past year.
    - Episodic homeless referring to individuals who are currently homeless and have experience three or more episodes of homelessness in past year.
4. Participation is voluntary and it was understood that due to chronic illness and relapse that a participant would be able to step away from the program and when ready to return, would re-engage without having to be reassessed or be put on a wait list. The file status would be inactive, not closed and IACT would stick with the individual as long as it takes.
5. Secure funding for CIR staff (Coordinated Intake)
6. Secure funding for a wraparound support team.
7. Six organizations will be directly involved as MOU Research Partners, a seventh joined during the pilot
8. To address housing market concerns, secure additional rent supplements for participants referred to Abbotsford Inter-agency Care Team (IACT)
9. During the pilot project, continue to explore an electronic data management model to support the CIR that is easy to use, web-based and has tiered levels of access control, to address client confidentiality needs, relatively flexible and well-supported including training

Monitoring, Testing and Evaluation for Implementation of Pilot CIR

The community researcher conducting the pilot study evaluation had also conducted the P-I-T studies for Abbotsford, since homeless counts started. The evaluation plan for the pilot project was designed to evaluate the effectiveness of the pilot project based on success indicators.

- The quantitative component was a P-I-T report conducted in March 2018
- Monitoring of the pilot study was qualitative. consisting of interviews and focus groups of MOU partner agency staff and participants who had accessed IACT through Coordinated Intake and Referral

The P-I-T count was to document any reduction in homelessness and provide an analysis of the homeless population. It was decided to conduct the count March 19/20 of 2018, despite the date being at the midpoint of the pilot study. March is the month that tri-annual P-I-T counts are conducted. It was decided that for consistency and the ability to compare results with the 2014/2017 reports holding the count In March, at the same was the best option. The qualitative study for monitoring effectiveness of the CIR process and IACT wraparound supports included interviews and focus groups with staff of the MOU Partner agencies and participants who were referred to IACT through CIR.

Through the duration of the pilot project the researcher provided two progress reports and a final report to HAAC committee. The progress reports were conducted at the six and nine month interval. The six month interval included preliminary finds of the P-I-T along with qualitative findings. At the nine month interval, the research compared the P-I-T results to the referrals to IACT. The final of the 2018 P-I-T report was presented to the HAAC committee in November 2018 and the final evaluation report was presented in March 2019. (APPENDIX K: CIR Pilot Study Progress and Evaluation Reports)

Performance Measurement Framework Development

Phase One of the Performance Measurement framework development was completed to flesh out a complete performance measurement system for measuring, monitoring and reporting on progress achieved with respect to the intentions described in the roadmap and mobilized through the components of the Abbotsford Homelessness Prevention and Response System. As with each component, key performance indicators were identified, specific to CIR, as well as shared outcomes that link to the overall system effectiveness and cost saving.

Key outcomes for CIR:

- IR-12 Intake and referral for people experiencing homelessness are smooth and efficient as they are provided appropriate housing
- IR-1 Access is well-coordinated across all service providers
- IR-2 Intake and referral clients have their needs addressed quickly and efficiently
- IR-4 A personalized care plan is developed with each person experiencing homelessness
- IR-10 An integrated planning approach is established

Key indicators of success:

- Number of persons housed
- Housing retention at 3, 6, 9, 12 month mark
- Number of persons rapidly re-housed
- Number of persons prevented from becoming homeless
- Progress toward community/social integration

Part 2:

Structural components to address service gaps and support Coordinated Intake and Referral pilot project

In the model design process it was emphasized by participants, that it could not be done off the sides of the desks of staff and support services that were already over extended. The following were also confirmed through community research and dialogue:

- The capacity to provide housing retention services was limited
- Organizations with rent supplements for people leaving the street could help with housing set up but on-going supports, including wraparound support, was not available.
- Concern was also expressed about the changing rental market situation, the drop in vacancy rate below 1% combined with rent increase that were to people experiencing homelessness for the first time and was a continued barrier for people homeless for years.
- The system for referral did not existed before the CIR pilot project implementation and for the pilot to go ahead, funding and staffing was required for the Intake Function, the Inter-agency Care Team (for wraparound support), and the Housing with Abbotsford Rental Connect (HARC) HARC would focus on building relations with landlords willing to rent to vulnerable and at risk individuals, couples and families and provide support for tenants.
- The system required shared outcome measurement to supplement monitoring, evaluation and continuous improvement to the overall system.

Intake Function

The intake function for the Coordinated Intake and Referral model comprised of an Intake Function Coordinator and a Housing Placement Liaison Worker. The City of Abbotsford on behalf of the community applied and received, contribution funding from PGNAETA through the Government of Canada's Homelessness Partnering Strategy's Rural and Remote Homelessness funding stream to run concurrently with the CIR Model Pilot.

The CIR model design team dialogue and the intake and referral research survey confirmed that intake processes varied widely among service providers based on funding source and requirements, mandate and capacity of the organization and individual program requirements. Access to services was not integrated and made it difficult for individuals experiencing homelessness with complex care

issues and or multiple barriers to housing and supports. The Intake Function was designed to address centralized access, with capacity for a mobile service, to assist individuals to navigate the system of care through three streams of support– prevention and diversion, emergency response and accommodation with supports.
The goal of coordination of intake is to quickly identify requests for housing and service that could be referred for prevention supports and to simplify the process for an individual with chronic or episodic experience of homelessness. For individuals experiencing chronic homelessness, the intake process included assessment (Vulnerability Assessment Tool) identifying services to best support the priorities of the individual and coordinate the wraparound supports. From a systems perspective the Intake Function Coordinator facilitates integrated outreach meetings of the MOU partner agency staff, for identifying new community trends, finding solutions for specific situations and identifying referrals for the Inter-agency Care Team. This approach builds on existing relations that persons experiencing homeless may have with service, providers and comes alongside in support of the relationship. It also builds on collaborative working relations established among staff of agencies with one another.

Inter-agency Care Team (IACT)

The findings of the CIR model design team identified that there was a gap in outreach supports to assist individuals to retain their housing once it was secured. Particularly for individuals who are experiencing homelessness with: addictions, mental health challenges; barriers in accessing traditional health and social services; require assistance with activities of daily living; and have high utilization or impact to services (e.g. police, jails, hospitals). Fraser Health Authority provides funding for three staff to form the core of IACT consisting of a Registered Psychiatric Nurse, an Outreach Clinician and a Nurse Practitioner. Unfortunately, the Nurse Practitioner role was not filled during the period of the pilot project. IACT is a partnership initiative between Fraser Health Authority and the City of Abbotsford and MOU Partner agencies.

IACT is an outreached-based, multi-disciplinary health and social service, person-centred approach that focuses on building relationships and wraparound support for some of the community's most vulnerable individuals. The CIR Intake Function Coordinator provides coordination for the team and the Housing Liaison Placement Worker helps with landlord recruitment and housing retention supports. In addition, the IACT and CIR staff will work in collaboration with existing non-clinical outreach and social service agencies in Abbotsford to provide wraparound support and stabilization to move participants towards recovery from substance dependence and provide intensive engagement and link participants to housing and treatment.

Prior to the implementation of IACT, staff from Fraser Health Authority facilitated a collaborative focused dialogue series of multi-sectoral stakeholders to design the criteria for IACT, aligning it with existing services, defining the referral process through CIR and the collaboration to provide wraparound supports. New stakeholders became involved in this collaborative process and as a result a potential partnership with a Community Court process was identified. An opportunity presented itself with the imminent construction of a new provincial Court house for an exploratory initiative for a Community Court in Abbotsford to align with the initiatives of the Abbotsford Prevention and Response to Homelessness.

CIR INTAKE FUNCTION AND INTER-AGENCY CARE TEAM

The **Intake Function** for the Coordinated Intake and Referral model comprised of: An Intake Coordinator and Housing Placement Liaison worker. The City applied and received Service Canada contribution funding through Prince George Nechako Aboriginal Employment and Training Association (PGNAETA), the BC Rural and Remote Homelessness Partnering Strategy Community Entity, to run concurrently with the Coordinated Intake and Referral model. The Intake Function oversees all referrals into the CIR and works as part of the Inter-Agency Care Team to provide health-centred, wrap-around support to vulnerable individuals. BC Housing provided rental supplements for the program through Lookout Housing and Health Society.

The **Inter-Agency Care Team** was informed by CIR project findings that revealed that many of the individuals who experience chronic, entrenched homelessness in Abbotsford are experiencing addictions, mental health challenges, barriers in accessing traditional health and social services, require assistance with Activities of Daily Living, and have high utilization or impact to services (e.g. police, jails, hospitals). The Inter-Agency Care Team is a partnership initiative between Fraser Health and the City of Abbotsford and received contribution funding from Fraser Health. The Care Team is an outreach-based, multi-disciplinary health and social service, person-centred approach that focuses on building relationships and wrap-

The Inter-Agency Care Team consists of: A Nurse Practitioner, Registered Psychiatric Nurse, an Outreach Clinician, and the City's Intake Function (Social Worker/Intake Coordinator and Housing Placement Liaison Worker).

These initiatives activate the following shared outcomes and key performance indicators:

- IR-1-Access is well-coordinated across all service providers
- IR-2-Intake and referral clients have their needs addressed quickly and efficiently
- CO-2- The Assessment system is more streamlined and integrated
- HC-25-More rental supplements become available for clients
- HC-28-The supply of available housing is known
- HC-29-Housing demand can be matched with supply
- DC-A-1-Establish resources needed for well-coordinated discharge from institutions
- RD-A-2-Develop and implement equitability principles in caring for individuals
- OW-1-Individuals have an advocate to help navigate the systems
- OW-6-Individuals experiencing homelessness are able to acquire the life skills they need to be more self-sufficient
- OW-10-Individuals receive wraparound and outreach services when they need them

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Housing with Abbotsford Rental Connect (HARC)

Housing with Abbotsford Rental Connect is a collaborative, community-invested housing and support resource that was developed through a multi-stakeholder research design team process. As a precursor to HARC, a rental connect dialogue emerged from community engagement efforts and stakeholder input received from the 2015 Regional Best Practice forum.

A collaborative submission by the City of Abbotsford on behalf of its cornerstone agencies – Raven's Moon Resource Society and Mennonite Central Committee; Fraser Health Authority and a collective of non-profit housing and service providers was developed. Contribution funding for the development of a project framework and implementation of HARC was received from PGNAETA through the Government of Canada's Homelessness Partnering Strategy's Rural and Remote Homelessness funding stream.

The project framework focused on addressing:

- the patterned cycle of homelessness (exiting homelessness and barriers to housing);
- identified and surveyed housing needs and markets factors in the community;
- strengthened private landlord and tenant relationships; and
- informed capacity with local landlords about BC Rental Tenancy Act requirements and best practices.

The collaborative looked at components that considered the input of homeowners, landlords, tenants; other services both local and from other communities such as housing retention support, rent supplements and vacant houses programs, landlord tenant registry and a host agency for the program. The proposed housing model was based on the successful scatter site, congregate living model of Raven's Moon, a local housing provider. Exploratory consideration was also given to sustainability through the development of an Abbotsford Housing Foundation. (APPENDIX L: HARC Development Framework Report)

The purpose of HARC is to secure a pool of rental units in the private and social housing sector with appropriate tenant matching, wraparound support connections and landlord-tenant liaison support. HARC formally launch in May 2018. The City oversees the initiative, which includes a Program Coordinator and Housing Liaison Worker with direct oversight from Raven's Moon Resource Society and Rent Bank offered through Mennonite Central Committee. It is a community resource that is not owned by any one agency, rather it is a collective initiative of the Abbotsford Homelessness Prevention and Response System, which all agencies, community organizations and community members can access for support, provide offers of secured units, donations or services in kind.

A steering committee was formed to research and conduct a feasibility study through funding received from VanCity Community Foundation to explore the formation of an Abbotsford Housing Foundation to address the sustainability of the CIR project and systems work beyond the pilot project. The steering committee comprised of representatives from: Mennonite Central Committee Community Enterprises, Van City Savings and Credit Union, Abbotsford Community Foundation, Raven's Moon Resource Society, and City of Abbotsford. As a result, Many Ways to Home Society has been formed to mobilize the housing foundation with the purpose to financially sustain the operations of Housing with Abbotsford Rental Connect, which is a function of the Intake Function and Coordinated Intake and Referral and to acquire, secure and leverage housing units for tenant placement through the systems work. As of February 2019, initial funding has been received through a community donation to launch this phase.

HOUSING WITH ABBOTSFORD RENTAL CONNECT AND MANY WAYS TO HOME SOCIETY

Housing with Abbotsford Rental Connect (HARC) is a collaborative, community-invested housing and support resource that was developed through a multi-stakeholder research design team process; which emerged from stakeholder input received from the 2014 Regional Forum, a HAAC Focus Group, and collaborative submission for Service Canada contribution funding through PGNAETA, Designated Entity, for BC rural and remote communities, by the City on behalf of its Cornerstone Agencies- Ravens Moon Resource Society, Mennonite Central Committee, and a collective of local non-profit housing and service providers and Fraser Health Authority.

The purpose of HARC is secure a pool of rental units in the private and social housing sector with appropriate tenant matching, wrap-around support connections, and landlord-tenant liaison support. HARC was formally launched on May 8, 2018. The City oversees the Service Canada funded initiative, which includes a Program Coordinator and Housing Liaison Worker with direct oversight from Raven's Moon Resource Society and Rent Bank connections administered through Mennonite Central Committee. This is a community resource that has been incorporated into the CIR and Inter-Agency Care Team and is not owned by any one agency, rather it is Collective initiative of the Abbotsford Homelessness Prevention and Response System, which all agencies, community organizations, and community members can access for support, offers of contributions of secured units, donations, or services in kind.

The Many Ways to Home Society (Abbotsford Housing Foundation) Sub-committee has finalized research and has launched to provide a financial and administrative sustainability mechanism for HARC and the on-going implementation of the Coordinated Intake and Referral model. This is a community-owned and invested resource that will also purchase, secure, leverage and acquire housing units for the HARC program. This Society is open to participation by interested financial institutions, all levels of government, community agencies, community organizations, and community members who have a vested interest in supporting the development and continued implementation of the Abbotsford Homelessness Prevention and Response System and housing access in the city.

These initiatives activate the following shared outcomes and key performance indicators:

- HC-10- More private rental and market units are available and suited for people experiencing homelessness
- HC-23- More housing units are available more quickly from a wider range of sources throughout the city
- HC-A-14-Design and implement innovative approaches to increasing housing unit supply
- HC-A-15-Develop and implement a scattered site housing policy
- RD-A-O4- Adopt a harm reduction approach if appropriate
- FR-A-8- Adopt, adapt or develop a social/community investment instrument to support action on homelessness
- FR-A-13- Develop a systems-wide funding and resource plan for homelessness
- FR-A-15- Identify and seek strategic partnerships to strengthen homelessness support system

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Part 3:

Peer Advisory Committee – engaging with people with lived and living experience of homelessness

To ensure that individuals with lived experience of homelessness are engaged in meaningful ways to participate in the development of the CIR model and systems planning, the model of engagement utilized the following levels of engagement: informing; consulting; involving; collaborating; and empowering. Incrementally, introducing collaboration into the work that was conducted ensured a sustainable, supportive structure was in place to provide an integral mechanism for power sharing, respectful relationships cooperation and trust to be fostered.

Over the course of the project, involvement has been explored in a number of ways with persons with lived experience and groups that represent them. There was a series of dialogues, involvement, consultation and collaboration with peers at various stages of the CIR project and systems development work, which included:

- peer involvement with the Regional Best Practice Forum, as community ambassadors;
- peer engagement in the CIR population demographics and service inventory report completed by MCCCE;
- a series of hosted coffee house dialogues regarding Abbotsford Homelessness Prevention and Response system (e.g. housing, health, transportation and support needs);
- participation in a harm reduction dialogue series, co-facilitated with a peer researcher and a University of Fraser Valley practicum student;
- Participation in annual community forums including guest speakers with lived experience, Jolene Greyeyes, Peer Researcher and Al Wiebe, Peer Engagement Specialist;
- Capacity was built with a Peer Advisory Committee (PAC) to design and conduct a survey with 115 individuals experiencing homelessness to assess what type of support services are required in a drop-in or hub centre and to be involved in providing input into the project's feasibility study. For details of the PAC Survey report. See (APPENDIX **M:** PAC Survey Report).

ENGAGING PEOPLE WITH LIVED AND LIVING EXPERIENCE OF HOMELESSNESS

Engaging with people experiencing homelessness was built in to the CIR Project to ensure opportunities for people with lived experience to give voice in the design, planning and implementation of services and systems that impact their lives. Engagement took many forms throughout the project, from informal dialogues, participation in focus groups for evaluation, presentation at the annual community forum to the Peer Advisory Committee work to plan and conduct a survey about drop-ins and prepare a report on the findings.

Considerations when planning for engaging with people with lived/living experience:

- Honorariums: An honorarium is recognition of the individuals' expertise and the time they are committing to the project.
- Meals: Providing a meal or nutritious snacks supports involvement
- Location/time: Ask for input regarding location and time. If possible, go to where people are or pick a location that is near to where they stay. Keep in mind the challenges that people face about
- Transportation: Arrange for carpooling or bus fare to facilitate attendance
- Planning the dialogue or consultation: invite people with lived/living experience to be on the planning team to ensure that consideration is given to the concerns of people participating.
- Recognize the diversity among people experiencing homelessness and make plans that ensure engagement is inclusive and all voices are heard.

This initiative activates the following shared outcomes and key performance indicators:

- RD-A-07- Engage people who have recently experienced homelessness as educators for service delivery staff and volunteers
- RD-08- Service delivery agencies and volunteers learn from those with actual homelessness experience directly
- CI-A-10 Recruit speakers who have first-hand experience with being homeless
- BP-1- Factors that contribute to homelessness are better understood

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Part 4:

Abbotsford Homelessness Prevention and Response System (AHPRS) – sustainability

The Homelessness Partnering Strategy contribution funding provided the impetus for collaborative multi-stakeholder research design work that informed and developed an "Abbotsford-specific" response to homelessness and a number of multi-stakeholder initiatives. Concurrently, design teams worked on creating a system of care as well as a coordinated intake process to support individuals to access the housing and support services they required.

From Fall 2015 to June 2016 the Collaborative Roadmap for the Prevention of and Response to Homelessness in Abbotsford was developed with policy and evidence-based practice research and included over 175 perspectives and 20 key informant interviews, and a multi-stakeholder, multi-sector research design team of 25. In June 2016, the Roadmap was presented to over 60 community members to identify ten priority actions to inform the work program to respond to the Homelessness Action Plan's Strategic Objectives through mobilization of four key capability areas of the map: Prevention Support; Discharge Coordination; Housing First Approach; and Support System Coordination and Sustainability. The Roadmap created a multi-stakeholder invested and informed architecture for the CIR model and Systems work. The community forum has become an annual event for reporting out to the community and seeking input for priorities moving forward. The attendance at the forum has increased each year and the number of organizations and sectors of the community becoming more diverse.

The Collaborative Roadmap is an evolving action-oriented implementation tool, which offers a proactive planning approach for designing a suitable course of action in anticipation of likely changes, decision making in advance. This is in contrast to a more common reactive planning approach whereby future action is dictated as a response or mitigation of impacts. Since the creation of the Roadmap there has been action in the following areas:

- Housing capacity
- Intake and referral
- Respectful delivery
- Community integration
- Prevention support
- Wraparound and support
- Funding and resource mobilization
- Aggregate information and data
- Best practice and continuous improvement

(Appendix N: Top ten priority actions and outcomes from May 2016 community forum)

These capability areas have been mobilized to support enhancement of the built, social and community infrastructure components of the AHPRS, including but not limited to:

- Built infrastructure – shelter, men's low-barrier housing, supported housing, access to market rental
- Social infrastructure – Coordinated outreach, access to health, income and service supports, capacity building and awareness, the development of an Integrated Hub Centre, and linkages to discharge coordination and integrated court process
- Communication – CIR/IACT procedures, City policy, public communications, senior government support and activation of HelpSeeker, Abbotsford Stories Project, Community of Integrated Practice, On-line Curriculum and utilization of restorative justice approach in community engagement and second generation systems work. (Appendix O: Abbotsford Community Hub Centre)

THE ABBOTSFORD COMMUNITY HUB CENTRE

The **Abbotsford Community Hub Centre** is an inter-agency hub that provides respectful delivery of services and supports for individuals experiencing health and social challenges. Services include: essential services (laundry, showers, and meals), housing services, health care, employment and training opportunities, access to community services, social connections and volunteer opportunities.

The Centre is a partnership project and is operated through a shared service delivery agreement with the City of Abbotsford, Fraser Health's Mental Health and Substance Use services and Inter-Agency Care Team, Public Health, and Primary Care, Abbotsford Police Department, Abbotsford Fire Department, Ministry of Social Development-Poverty Reduction, Positive Living Fraser Valley (local cornerstone agency), Inasmuch Refugee Society, Healthy Aging Abbotsford and commercial anchor tenants, Dr. John Farley and Hub Pharmacy.

This initiative activates the following shared outcomes and key performance indicators:

- CI-A-7- Develop ways for Not-for-Profits and people experiencing homelessness to work together that are mutually beneficial
- OW-A-6- Design, build and operate a hub facility
- OW-A-16- Develop innovative approaches to the delivery of primary health and mental health and addiction services to people experiencing homelessness.
- CRM-IR-2- Intake and referral clients have their needs addressed quickly and efficiently
- CRM-IR-3- Intake and referral are managed in a seamless and integrated manner.
- CRM-CI-A-10- Develop and implement strategies for community-based social integration

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5 CHAPTER
MAKING IT HAPPEN

In addition, the collaborative mapping process informed the City's Affordable Housing Strategy update and has supported the City to meet its strategic directions and priority actions outlined in the 2014 Homelessness in Abbotsford Action Plan.

Coordinated Intake and Referral (CIR) for the Abbotsford Homelessness Prevention and Response System was launched in June, 2017 and the period of the research pilot project was from September 1, 2017 to August 31, 2018. The pilot project was evaluated both quantitatively and qualitatively. The Community Researcher conducted the formal evaluation and the Intake Function Coordinator provided process reporting on the implementation of the design model.

Implementation was phased in during the period of June to August 2017. At the annual community forum in June, the community was informed of the start of the CIR pilot project, were provided with information and contact information. During this period the CIR staff and the Inter-agency Care Team (IACT) were hired and introduced to the community. Due to logistics and timing the staff started at different times during this interval. As staff started they began introducing themselves to the MOU partner organizations' front-line staff. They accompanied outreach teams on their visits to camps and spent time at the drop-ins and shelters. They were introduced to individuals who were not strongly connected to services who tended to be high users of emergency services and were experiencing chronic or episodic homelessness. Engagement with individuals included: building relationship, service connections and addressing immediate needs, such as health services. There was also opportunity for program planning by reviewing the presenting needs of the hard to reach individuals that they were meeting.

Part 1:

MOU Research Partners

During the phasing in process, the memorandum of understanding was formalized with the MOU Research Partners that came forward during the CIR model design process to be a part of the wraparound supports and participating in CIR. The MOU partners represented key homelessness serving agencies providing shelter services, drop-ins, day to day essential services, housing, rent supplements and health social service supports included:

- Abbotsford Community Services
- Cyrus Youth Ministries
- Lookout Society Housing and Health Services
- Positive Living of Fraser Valley
- Raven's Moon Resource Society
- Salvation Army, Centre of Hope
- SARA for Women

Seven organizations agreed to work collaboratively with CIR and IACT with the goal to providing seamless, wraparound supports and access to housing for medium to high acuity individuals experiencing chronic or episodic homelessness and prevention/diversion referrals. Other terms included eligibility for IACT, scope of service, the roles and responsibilities and shared outcomes. (APPENDIX H: CIR Research Partners MOU)

The goal for the CIR project was to shift from a first come first serve approach to an intake and referral process into a system of services and supports matched to individual need and level of vulnerability. Through the CIR process individuals would access prevention/diversion services or housing with service supports for individuals experiencing long-term homelessness. The pilot project focused specifically on the referrals for IACT established for rapid response with wraparound supports including strategic housing placements and retention supports. The intent was to ensure that those who are vulnerable could be referred to the IACT quickly, without having to go through multiple intake processes to reach the services most aligned with their needs. (APPENDIX P: CIR Process Graphic for the flow chart that illustrates the CIR process)

The following is a review of the pilot project based on process reporting and statistical reports provided by the Intake Function Coordinator. The process reports documented the implementation of the CIR compared to the model developed by the design team. Summaries of these reports were also presented monthly to the Homelessness Action Advisory Committee, as part of oversight for the project.

Part 2:

Single access, mobile service

Abbotsford is a large geographic area that includes both an urban centre and rural areas. Coordinated Intake and Referral, as a mobile service, combined with the connecting points of shelters and drop-ins, operated by MOU Partners, facilitated access for individuals in need of housing and support services. The mobile service allowed for connections to be made with individuals living in camps and on the street, particularly those not accessing services. Visits to camps were made routinely throughout the project to establish and maintain relationships and keep an eye out for the most vulnerable individuals, especially when they had not been seen for a few days. The single access point provided a centralized point for the community to connect individuals for service. Communication options included phone and e-mail. There was also some capacity for after-hours response during the week and on weekends by the CIR team.

Initially, agency site visits and information sessions were held to introduce the CIR pilot project staff and familiarize staff of community organizations, hospitals, police, bylaw staff about the role of the CIR team and the process for connecting individuals to housing and supports and services. Site visits continued throughout the project for the purpose of networking, providing updates, and hearing feedback and providing orientation to new staff.

Service requests were received from multiple sources – City Bylaws/Police and Corrections, MOU Partner agencies and community agencies, hospital and health care services and families or self-

referrals. A total of 339 requests for service were received during the pilot period. CIR staff processed the service requests received, locating and connecting with the individual to determine the nature of the service request to make appropriate referral.

- Prevention and Diversion referrals were made for individuals recently homeless or at risk of homelessness were referred to services of MOU partner agencies or other community services
- Emergency Responses – MOU partners provided shelter and drop-in services for shelter and needs of daily living
- Housing and wraparound supports – for individuals who were prospective participants for IACT, the staff would engage with the individual, provide support and service navigation for health care needs and other supports while completing the intake process.

A pre-screen tool was designed to assist the CIR staff to quickly identify individuals for housing and wraparound supports:

- Individual had complex presentations – mental health diagnosis, addictions, and complex health issues.
- Individual was being underserviced by traditional community programs (i.e. anxiety too high to stay in shelters).
- Willing to voluntarily work with a support team
- Willing to work towards housing and connection to various resources
- Individual had been in Abbotsford for 6 months and intended to stay in Abbotsford

Disposition of service requests:

By the end of the pilot period, 339 service requests were received by the CIR team. Forty-two individuals assessed and referred to IACT and 21 were in the process of referral (18.58%) and 146 (43.06%) were diversion/prevention referrals. The remaining 161 (47.49%) either refused service, were unable to locate, unknown, leaving the area or violence was present. Because the CIR team is mobile, there was opportunity to continue connecting with individuals refusing service, establishing trust and relationships for future service opportunities. They might also locate individuals, previously not found. On-going CIR staff connections with this group were an opportunity to identify specific service needs and gaps to be addressed as the Abbotsford Homelessness Prevention and Response system grows.

Part 3:

Intake (assessment process including the Vulnerability Assessment Tool

In the CIR design process, it was a recommendation that the CIR process should be scalable, and the pilot project would test the CIR process by introducing a new and needed wraparound support service, that had not previously existed in the community. The pilot project would be the opportunity for making adjustments and improvements to unanticipated results before adopting it more broadly. Therefore, the focus of the intake process, during the pilot project, was to assess and understand the strengths and vulnerabilities of the individual and prioritize those with the highest level of need and vulnerability for referral to the Inter-agency Care team (wraparound support). Referrals were also made for prevention and diversion.

Prevention/Diversion Referrals

Individuals or families at risk of homelessness or recently homeless were referred to prevention and diversion supports or emergency response provided by MOU Partners or other community services. When a service was not available at the time or service coordination was needed, the CIR team would engage with prevention/diversion activities. Diversion was highly utilized to assist in service enhancements for other organization that were already connected in some capacity to the individual.

In many instances the diversions were a single request for a specific service, such help with identification, completing a form, etc. With a few hours of work CIR staff is able to successfully divert a person from homelessness. For example:

- An afternoon spent with a male who had been unsuccessful at applying for income assistance for 2 months due to low computer literacy. After spending a few hours with him, he was assisted to successfully apply for income assistance. The Intake Function Coordinator was also able to advocate for him with his landlord which prevented his eviction from being followed through on.

Example of service coordination for prevention/diversion:

- CIR staff met a youth (under 19) on the streets and they worked directly with the outreach workers from the youth shelter/drop-in to bridge the gaps for the youth who was aging out of youth services. In another instance CIR was able to provide support to a youth who had stopped engaging and they also accompanied youth outreach workers to visit a few youth and bring them food and other supplies

Prevention and diversion responses were strengthened through the implementation of Housing with Abbotsford Rental Connect (HARC) in April 2018, mid-way through the pilot project. HARC was able to assist with housing to prevent individuals or families from becoming homeless. HARC focuses on securing private market rental units affordable for people with fixed or low income, matching tenant to landlord and providing supports and landlord liaison. HARC has 2 two staff who recruit landlords, assist tenants with locating housing and assist individuals ready to leave congregate housing and

supported housing. Referrals through CIR to HARC are seamless and staff work collaboratively regarding landlord engagement and housing retention supports.

Four practicum students from the University of the Fraser Valley, School of Social Work were deployed during their practicum to assist with requests for service for prevention and diversion support. The Intake Function Coordinator delegated tasks to the students and they were able to follow through and report their activities in a timely manner. The Coordinator provided a minimum of one hour each for one to one clinical supervision. The students would also submit daily summaries as needed and weekly summaries (process recordings). The involvement of students helped significantly with the workload for the Coordinated Intake and Referral team. The students assisted with administering the pre-screen or diversion and prevention work. They also assisted with regular check-ins and community inclusion activities. During the extreme heat, they assisted at a community water station, distributing water and sunscreen aids.

Assessment Process

The IACT referral criteria focus is on vulnerable and homeless individuals with limited service connections or support. The assessment process for identifying individuals included an application form with a signed release of information between the CIR team and MOU Partners (for collateral information and information sharing) and the Vulnerability Assessment Tool (VAT). The VAT assessment was used as the standardized assessment tool to determine vulnerability (level of risk or stability). The VAT score for an individual would fall in the medium to higher acuity level. The application form aligned with the VAT domains of assessment and together with the VAT score, formed the basis for an individualized client-centred case plan. With consent of the participant, third party collateral information was collected where indicated.

The VAT was chosen by the CIR model design group as the assessment tool to use as it aligned with the decision by BC Housing to use the VAT as part of supported housing applications or by case planners in the shelters. At the start of the pilot project, training to administer the VAT was provided by staff of BC Housing for the CIR staff. Staff representatives of the MOU Partners attended the training for orientation and a better understanding of the assessment process. The VAT was administered by CIR staff unless the person had completed a VAT assessment in the year previous, through a shelter or for a housing application. In which case, with consent, the VAT assessment score was secured from the agency and the CIR staff did an update interview.

The Intake Function Coordinator observed that it took several contacts with most participants to build trust and rapport before the individual would sign the forms to complete the assessment process. This was attributed to the innovative approach of the coordinated intake and referral process as many participants stated they were accustomed to programs of exclusion not inclusion so it was a new way of thinking about accessing supports.

The use of a standardized assessment tool as part of intake was new to the community. The decision to use it was not fully embraced initially as it was felt that the homeless population was small enough in Abbotsford and those experiencing chronic and episodic homelessness were known. Over the course of the pilot project, the VAT came into practice with CIR, the shelters and for supported housing. By the end of the pilot project the assessment tool was administered to 21 participants for

referral to Inter-agency Care Team, 13 participants were unavailable, 1 person refused and 7 will be completed as time permits. If a participant did not wish to complete the VAT, it was not a barrier to a referral for the Inter-agency Care Team. In some instances, a provisional VAT assessment was completed.

Administering the VAT was challenging if the participant to be assessed was homelessness and not sheltered. Challenges included, keeping appointments, private space to conduct the interview and ability to maintain focus for the duration of the interview. In 2019, the Abbotsford Community Hub will be opened and the CIR staff will have office space for interviews and this will help address some of challenges.

The Intake Function Coordinator was concerned about the degree to which the content of the VAT questions could trigger an individual based on their life experience and trauma. Important to building relationships is the awareness of individual triggers and having the time to respond appropriately in the event of a triggered memory. This factor could significantly extend the time needed to complete an assessment. For planning assessment sessions, the Intake Function Coordinator took this into account. Use was made of the provisional assessment in situations such as this. Due to profoundly mentally ill individuals encountered, the Intake Function Coordinator noted the need to develop a clinical assessment tool designed specifically for CIR to be used where individuals lack self-awareness for VAT assessment which is a client self-report tool.

The Intake Function Coordinator managed all the requests for service: pre-screens, prevention/diversion referrals, assessments, case management and oversight of referrals to the Inter-agency Care Team As the pilot project proceeded the Intake Function Coordinator also facilitated integrated outreach meetings with MOU Partner agency staff, held case management meetings with lead organizations for coordination of services, provided coordination with Housing With Abbotsford Rental Connect (HARC) and liaised with BC Housing Coordinated Access and Assessment for supported housing. This workload points to a future need for the additional CIR staff, including administrative support for the CIR team. An administrative position could address issues relating to paperwork, collecting data and data entry, annual updates of consent forms, booking spaces for interviews and meetings, CIR service request phone calls and email responses, etc.

Part 4:

Assigning a referral to Inter-Agency Care Team (IACT)

The CIR design team recommended a caseload of 30 participants for IACT. By the end of the pilot project 42 individuals were referred to the IACT, with an additional 21 individuals in the process of assessment. The assignment process took into consideration if the participant identified with a particular agency where they felt they had an established a relationship. IACT services were direct towards individuals who:

- May struggle with persistent addictions,
- May have mental health challenges,

- May require assistance with activities of daily living,
- Experience high impact or utilization of services (Police, jails, hospitals, Bylaws, other City services/or community), and
- Face barriers when accessing traditional services.

Of the 42 participants, 24 identified a lead agency. In these cases the IACT would come alongside the lead agency to support the work and provide additional supports as determined between the participant, the lead agency and IACT. For the remaining 18 participants, IACT became the lead for coordinating housing and wraparound supports, expanding the team to include other MOU partners and community/health services as needed. Recognition of the relationship keeper role of the lead agency was intentional so as to preserve and strengthen established relationships, and not disrupt them by a referral to a new organization. When IACT comes along side there is the opportunity expanding the client-centred care plan to incorporate access to housing and retention services, needed health, addictions, mental health treatment support as well as case management coordination, with consent of the participant.

Part 5:

Housing Placements for Inter-agency Care Team Participants

The CIR model designed team identified the lack of housing retention supports to assist individuals to find and retain housing. A Housing Placement Liaison Worker was included in the Intake Team to engage with landlords, assist participants with determining their housing preference, finding housing and provide housing retention supports. Initially, considering affordability, the Housing Placement Liaison Worker searched for basements suites. In particular, two bedroom suites that would allow for shared accommodation - better accountability for the individuals and safer for people with opiate misuse histories. But it became apparent, early the pilot study, due to the growing rental housing shortage and lack of affordability in Abbotsford, for participants relying on a fixed income, affordable accommodation would be rooms for rent or shared accommodation, with limited other housing options. As part of case planning people were asked about their housing preferences and those that accepted housing were willing to try living with a roommate for affordability and companionship.

Securing a wider variety of housing options would assist in more meaningful, long-term housing placements where people can have a level of both support and independence that would make the most sense for the individual. Living with their significant other, or having a pet are a few of the barriers that many participants contend with in boarding homes or low income housing options. There was acknowledgement among service providers that with the increase in rental rates, the number of rent supplements available through BC Housing no longer met the local need. BC Housing, through one of the shelters provided additional rent supplements and the shelter provider reserved five supplements for use by participants with IACT.

By December of the pilot project, all housed participants were in shared accommodation - boarding house or congregate living in scatter site housing. The staff came to the conclusion that this accommodation was the safest, quickest and most affordable solution for participants. All spaces

were fully furnished so that removed a barrier for participants seeking housing (furnishings provided by donations from local thrift stores and the community). At the time that the pilot project started Abbotsford was in the middle of an overdose crisis and in October, there were 5 overdose deaths in a 9 hour period. With this crisis, safety became an important housing criterion that shared accommodation could address.

At the end of the pilot project, 10 participants were housed, 3 were in treatment and 28 participants remained homeless while receiving outreach support with stabilization. In total, during the period of the pilot project, 17 were housed, 7 lost housing due to challenges with the fit of accommodation to their needs. Of the seven who lost their housing only one is still engaged with the team and the other six have left the area or are no longer receiving services.

Of the 10 individuals housed by the end of the pilot project, two were living in supported housing and one was in residential care and the remaining in shared accommodation. In the case of the individuals in supported housing, the Inter-Agency Case Team provided enhanced services to prevent an eviction. The Care Team was able to fill a gap as the complex care needs of the individuals exceeded the level of support provided in the housing. In the case of the individual in residential care, while on the street the individual was cycling between the hospital, street and local jail, his complex issues fell outside of all organizational mandates and his health was rapidly deteriorating. As a result of advocacy by CIR staff, he was held in hospital and stabilized and a residential placement was found for him.

In working through housing and supports with participants and MOU Partners, the need for enhanced housing retention services to help hoarders and those who experienced psychosis or other complex mental health presentations was identified as an important need as the resulting disruption, mess and chaos would lead to eviction.

Despite the small number of people housed during the pilot, it was obvious that securing housing was an important first step for participants to stabilize their situation, feel hopeful and start to gradually make plans for their future. In some situations it took more than one try.

The following are examples of incremental steps to wellness that were observed during the pilot project when a participant was housed:

- Male participant struggling with poly substance use and very complex physical issues for several years. Referred by an emergency room social worker because he was presenting at the hospital daily. He has been housed for a few months, and now receives disability benefits. He has cut back on his substance use and requested to go to treatment. It is expected that he will have a treatment bed within a few weeks. He has asked to be moved to clean and sober housing when he finishes treatment.

- Male participant recently completed alcohol residential treatment. When he was referred to CIR/IACT he was living under a bridge and was not known by local service providers. He was housed in a low barrier congregate living house with housing retention supports and health stabilization. He was assisted with completing application for permanent disability income and was successful. At his graduation from the alcohol treatment program he was visited by his

mother and son. He attended treatment for substance misuse and successfully completed treatment. He did not return to homelessness and his chronic medical conditions stabilized so his hospital presentations were reduced to zero.

- Senior-aged female participant housed in supportive housing with enhanced wraparound support from IACT. She had some complex health issues including seizure disorder and in the past had walked away from housing due to mental health issues. The Care Team worked through her health issues in partnership with Doctor at the Salvation Army medical clinic to determine an appropriate assessment. She is enjoyed her home and maintaining her personal space in a tidy manner. Subsequently , she continued to deteriorate but is still connected to the Care team and she is going to be transferring to residential care in the near future.

Due to chronic alcoholism, incontinence and high-risk behaviors there was only one organization that agreed to house a male participant, long term. He used a walker and was also almost completely deaf. He had cognitive impairments due to repeated head trauma from falling and assaults while homeless. He could not stay in a shelter because his needs exceeded capacity to care for him. He would go from city jail cells to the emergency room to the streets. After being housed, he continued to need a high level of care and support due to his deteriorating health from chronic alcoholism. At the end of the pilot period, he had remained housed for 4 months, his alcohol consumption was reduced to intermittent usage and he managed to stop when it became highly problematic (health and hospitalization).

He stayed sober for weeks at a time. What worked well was that he lived in clean and sober housing so there were no people around him using substances. His meals were provided and he received help with budgeting of his money which ensured he had incidental items like cigarettes which made him less inclined to walk to the store and risk falling. Housing improved his quality of life and resulted in significant savings to the emergency response system. This participant retained housing for further 4 months after the pilot project when he died in his sleep. The CIR/IACT were saddened by his passing but took comfort that he had a home for the last months of his life and died with dignity in his own bed, with a roof over his head and people around him who cared.

Part 6:

Interagency Care Team (IACT) - wraparound supports

Structure

The Fraser Health clinical staff and the CIR staff became the core staff for IACT. The Intake Function Coordinator provided coordination of case management and the Housing Placement Liaison provided housing supports. Depending on the case plan, MOU partners or other community or health services would be included as part of the team providing warp around supports. Participation of individuals is on a voluntary basis.

On an outreach basis, the Inter-Agency Care Team uses a wraparound support approach to provide individualized service plans that meet people where they are at. The recovery orientation includes housing, clinical, non-clinical and social integration supports. Wraparound support is a collaborative interagency team-based, client-centred case management approach. Staff focus on the individual's self-identified goals as they pertain to housing and retention support, complex health issues and access to health services, social and financial situations, service connections and community integration. Through this process the participant is not a client of a specific agency but of the team which works together to achieve the shared outcomes of the participant.

Participant Profile

The CIR model design group identified the target group as including individuals of medium to high acuity in terms of vulnerability with specific outreach to individuals not accessing services. Participation would be voluntary and the supports are participant driven and client-centred. The following participant profile, comparing IACT participants to 2018 P-I-T indicates that referrals to IACT were reaching intended participants based on the recommendations of the design team and P-I-T results. All participants reported a history of chronic/episodic homelessness. Regarding health status, participants of the IACT reported a higher occurrence of mental health and addictions compared to the P-I-T survey, while the access to treatment for the P-I-T survey is low, through IACT, participants will be supported to access the health services they require. The profile shows that the gender breakdown was close to that of the P-I-T survey. The age range of the pilot began at 19 and the P-I-T survey data captured a small number of youth under 15. Source of income is similar but it is noted that with the help of CIR/IACT staff, individuals are able to access government benefits for which they are eligible.

	Pilot Participant Data Sep/17 to Aug/18	P-I-T 2018 Comparison	Comment
Gender	Male – 25 (59%) Female – 17 (41%) Bisexual/Trans - 0	Male – 136 (64.5%) Female – 72 (34.1%) Bisexual/Trans- 3 (1.4%)	The gender mix was similar. P-I-T studies have acknowledged that women are among the hidden homeless.
Age	19-84 years of age	All age groups are over represented compared to general population, except older adults which is not as large a disproportion	The 2018 P-IT- study surveyed youth under 15 years of age
Indigenous	5 (12%)	57 (30%)	There is an over-representation of Indigenous homeless compared to the general population

	Pilot Participant Data Sep/17 to Aug/18	P-I-T 2018 Comparison	Comment
			Indigenous individuals underrepresented in Pilot Project in comparison to the P-IT- survey
Income	Income Assistance-28 (66.6%) Disability – 9 (21.4%) Pension – 3 (7.1%) Employment – 1 (2.3%) None – 1 (2.3%)	Income Assistance 7(27.2%) Disability – 67 (23.3%) Pension – 5 (1.7%) Employment – 15 (5.2%) None – 20 (7%)	3 individuals receiving income assistance were determined eligible for disability assistance during the pilot. Given the complexity of health issues of participants, there is a new focus to assist more individuals with disability application in collaboration with local doctor.
Health Status	Disability – 17 (40.4%) Mental Health – 38 (90.4%) Addictions – 37 (88%) Chronic Disease 18 (42.8%)	Phys. Disability 75 (32.2%) Mental Health 93 (39.9%) Addictions 137 (58.8%) Medical Condit.-101 (43.3)%	In the PIT study a significant number of people did not receive treatment. In the Pilot project all participants were offered treatment

Wraparound Supports

Wraparound supports were tailored to the individual participant in recognition that every person's journey is unique with respect to the experience they encounter and the steps that are taken along the way. Whether experiencing homelessness or being housed, a range of supports are provided to start addressing challenges and barriers and build hope. The following is a list of activities included in the wraparound supports offered during the pilot as part of the stabilization process.

Housing Supports	Health Supports (Clinical)	Income Supports (Non Clinical)	Social Integration
- attaining housing - assistance with housing applications for transitional or second stage housing, including transportation to/from intake interviews - housing readiness	- attaining General Practitioner -medication stabilization - transportation to/from appointments, including specialists, or dental appointments -liaising with case managers	- assistance with completing disability applications and social assistance applications - transportation to/from Ministry of Social Innovation and Poverty Reduction office - visits to bank to set	-reunification with family members -relocation to home community - attending Court - considering return to work – training or upgrading -referrals to

and retention education and support, including life skills - advocating for emergency transition beds -liaising with shelters to obtain beds for participants	- applications for treatment, mental health and addictions, including, detox - health system navigation	up account - money management - replacement identification - income tax forms for back years	community programs and support groups to assist in creating individualized peer support networks.

Collaboration

Integrated Outreach meetings were held monthly with the outreach staff of the MOU partner agencies and CIR/ Care Team. The meeting space was provided by MOU partners. The meetings were started for the purpose of strengthening collaborative working relationships of the front line workers who were most likely to refer vulnerable individuals or work collaboratively with IACT to provide enhancements as required by the participant. Changes to existing programs, updates about new programs and community trends were also discussed. The Intake Coordinator facilitated the meetings to enhance the collective responsiveness of the system and to provide support and awareness building among the MOU Partner agencies. The meetings were an opportunity for information sharing regarding vulnerable individuals in the community and shared participants. Other activities included problem solving and debriefing. Case management meetings were held with specific organizations to coordinate the wraparound supports. For example, where a participant is a resident of a supported housing facility and the Care team provides enhanced wraparound support to prevent a possible eviction. Another example, where a shelter or drop-in has a medical clinic, the shelter/drop-in staff, doctor and nurses and CIR/ Care Team meet monthly to review shared participants and identify vulnerable individuals who could benefit from housing and wraparound supports.

Because the CIR/Care Team is mobile, team members are frequently at the sites of the MOU Partner agencies. These frequent visits were opportunities for regular updates regarding the progress and developments of shared participants.

The following examples show how supports were provided in collaboration with MOU Partners and/or other service providers:

- A female participant, homeless for many years, referred by bylaw staff, eventually presented at hospital with drug induced psychosis. After stabilizing for a week when she asked for treatment, the Inter-agency Care Team and hospital staff worked collaboratively to get her to treatment for drug dependency, and while in treatment she was planning to seek second stage housing outside of Abbotsford so she can enhance her changes of maintaining sobriety long term.
- A young female participant initially refused service when a service request was received from Bylaws staff. She went to transitional housing and once she discovered she was pregnant was referred to Inter-agency Care Team. She completed her stabilization and moved into

supportive housing where she gave birth to a healthy baby and is maintaining sobriety, housing and health.

Incremental Steps to Wellness

When designing the CIR process, the design team stressed the importance of supporting people experiencing chronic and episodic homelessness to find a home that works for them, with no preconditions for housing and willingness to continue support through failed or unsuccessful attempts to be housed (in recognition that for some people securing housing takes time). It was also acknowledged that building a trusting relationship would take time. The design team stressed the importance of acknowledging the incremental steps to success that a participant makes towards their best life.

Some individuals have remained homeless since their referral to the Care Team and some would not access shelters or drops-in services for a variety of reasons personal to their situation. Engagement through the Care team was an opportunity to start accessing services and finding housing. Engagement took the form of moving at the pace of the participant as trust is built and the staff showing that they are reliable, empathetic and person-centred towards the participant. Support focused on making small incremental changes.

- One participant who typically refused his injection, was agreeable that Registered Psychiatric Nurse help him with his injections in the community and as a result his mental health remains stable and he has not presented back in hospital since being connected to the Care Team.
- Some participants expressed that they are tired of being homeless and tired of using drugs/alcohol. Some of this maybe in part due to the winter weather conditions at the time, but staff also attributed some of this shift in thinking to the rekindling of hope that participants are articulating.

Example of expanding the wrap around support to meet changing needs:

- Housing placement, provided by an MOU partner was in jeopardy when a participant had an episode of psychosis and ended being admitted to hospital. Initially, she was not going to be able to return to her housing but a case conference gave IACT the opportunity to advocate that she be allowed to return due to her high level of vulnerability until another place for her to live was secured. IACT provided enhanced health supports and the wraparound supports were expanded to include her family and the mental health team. Working closely together created better outcomes for this participant.

Example to reinforce the value of using inactive status instead of closing a file:

- Female participant was in transitional housing when she signed up for IACT. Shortly after, she left the transitional housing and was reported as a missing person by her family. After a few weeks she was found safe and acknowledged that she had experienced a very significant relapse. After reconnecting with IACT she re-entered the transitional housing, got back on

agonist treatment to assist with opiate withdrawal. She chose to reengage with CIR/IACT and reengage with sobriety. The above example is also an illustration of the transient nature of people experiencing homelessness. This participant was moving between Abbotsford and other nearby communities. An area of future work development is inter-community collaboration.

Understanding Incremental Steps to Wellness

The Intake Function Coordinator mapped the incremental steps to wellness by comparing the stage of change with level of engagement of the participant and current housing status. All the participants referred to IACT experienced chronic or episodic homelessness. However, at the point of initial contact they were varied in terms of where they were regarding the stages of change and taking the step to transition from homelessness to being housed. The chart below illustrates that the synergy of stage of change, level of engagement and moving from homelessness to housing and maintain housing.

- The stage of change was identified based on theory of change work
- The level of engagement referred to building of relationship, moving at the pace of the individual and regularity of contact – continual, irregular or inactive. Inactive participants included individuals whose locations were currently unknown or they were in treatment, in care or unwell.
- The third category was current housing status – housed, shelter, outside,

See chart below, based on the August report for the pilot project.

Stage of Change	Level of Engagement	Current Housing Status
Action and Maintenance Stage - 20	Active - 13	Housed - 7 Shelter - 3 Outside - 2 Couch Surfing -1
	Intermittent Contact - 2	Housed - 1 Shelter - 1
	Inactive - 6	Residential Care - 1 Shelter - 1 Treatment -1 Moved - 1 Outside - 1 Unknown - 1
Action Stage- 8	Active - 5	Housed - 1 Second Stage Housing - 1

Stage of Change	Level of Engagement	Current Housing Status
		Outside - 3
	Intermittent Contact - 2	Treatment - 2
	Inactive -1	Shelter - 1
Contemplating – 8	Active - 2	Outside - 2
	Intermittent Contact - 2	Shelter - 1 Outside - 1
	Inactive - 3	Outside - 2 Unknown - 1
Pre-contemplating– 5	Active - 0	Moved - 1 Unknown - 4
	Intermittent Contact -0	
	Inactive -0	

* the 42nd participant is an individual referred on to Assertive Community Treatment Team, due to severity of mental illness, the file remains open but inactive in the event the ACT Team is not a fit.

Part 7:

Data collection, data systems and information management

The CIR design team acknowledged the importance of an integrated data management system to allow client-level information in real time, system wide (with consent) for providers working with the same participant to access client information for purposes of coordinating services. At the systems level, the availability of anonymized, aggregated data to understand participant service use patterns and the inflow and outflow of people into homeless level is important for improving system function and services. Due to a policy decision in British Columbia, it was not possible to access Homeless Individuals and Families Information system (HIFIS). Other options were explored with no success. During the pilot project data was collected by the Intake Function Coordinator, spreadsheets developed by Metro Vancouver for Housing First programs and support programs, based on HIFIS were also used, in the hope that HIFIS would someday be available.

Work is in progress to create a web-based application for outreach workers to collect and enter data as they work, starting with an initial service request that can be entered on line from anyone needing help, disposition of the request, including tracking the assessment process. The City of Abbotsford is also participating in a project with two other cities to roll out the Helpseekers mobile application that provides up to date information on housing and support services available in the community. The analytics from this initiative will provide information to better understand the requested and provided services, gaps in services, etc.

For the duration of the pilot project, there was an effort to “stitch” together aggregate data for shared outcomes and understanding systems through sources such as Abbotsford and FVRD P-I-T reports, comparison of FVRD P-I-T results to Metro Vancouver results, local emergency shelter system reporting (usage and service outcomes), aggregate data from IACT for demographics,

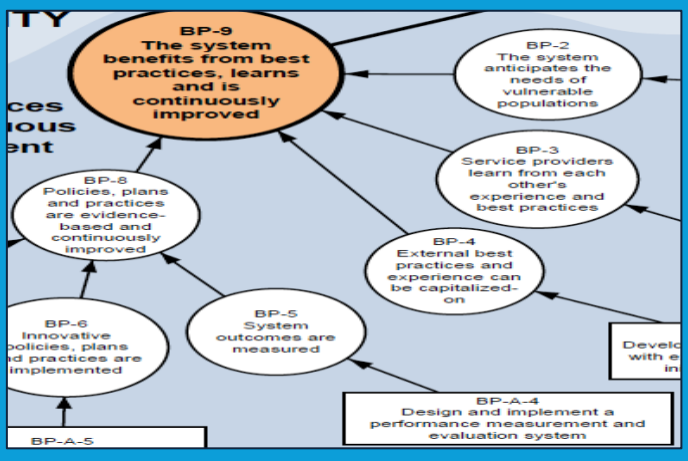
housing/services, return on investment analysis comparing costs relating to emergency services for a person who is homeless compared to costs when housed through CIR/IACT. Information from the service requests to CIR provided a better understanding of prevention/diversion services and gaps

Running the pilot study without use of real-time data has reinforced the importance that local communities have access to local data. Real-time data is critical for case planning, decision making and tracking participant outcomes. At the systems level, aggregate information on participant service use patterns can be assessed to determine how system components function on their own and as part of the system and for tracking shared outcomes.

SHARED OUTCOME MEASUREMENT

The development of a **Shared Outcome Performance Measurement Management and Reporting Framework (PM2R)** has been recognized as a key element in the overall efforts to prevent and manage homelessness in Abbotsford. This was first identified in the process to develop the collaborative roadmap and became an action with downstream outcomes in that map.

It should also be noted that the federal government in its 2019/2024 HPS program revision *Reaching Home* has further emphasized the importance of what they are referring to as the 'annual performance report'.



The development of the framework in Abbotsford has been undertaken in two phases, with each phase assisted by a research design team.

Shared Outcome Measurements support system integration to achieve client-centred outcomes, systems transformation and cost-saving across sectors and the in the community.

This initiative monitors, measures and activates the following priority outcomes and actions:

- HF-1- People experiencing homelessness are responded to respectfully, have a choice of appropriate housing, and are supported by wrap-around services and the community
- PS-17-People are more aware of and receive the prevention support they need
- DC-6-Discharge of people from institutions is coordinated closely with support service organizations
- SS-1- The homeless prevention and response system is well-coordinated, high functioning and sustainable

Enabling Impacts:

- Resources are used more effectively to support people experiencing homelessness
- The community well-being of Abbotsford is increased
- The cost to the community is reduced and savings invested in the local economy

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Part 8:

Community of Integrated Practice

A Community of Integrated Practice (CIP) was developed as part of the Coordinated Intake and Referral project and systems work with the aim to foster practice standards and integration across sectors, multi-sectoral knowledge sharing, collective awareness of issues related to vulnerability in the community, and circles of support for practitioners and service providers in the field. The CIP launched with an "Evening of Care" for first responders, front line workers, service providers, and community volunteers to provide information and resources about self-care, trauma-informed practice, and mindfulness/meditation. Throughout the pilot, the City's Housing and Homelessness unit hosted lunch and learn dialogues, integrated practice sessions, and knowledge sharing opportunities. The CIP has also launched the Abbotsford Stories Project, a series of videos that provide an overview about the CIR project, systems work, and highlight individual's stories of transformation. The videos and systems learnings have also informed an on-line curriculum that has been developed by the City and University of Fraser Valley. It is hoped that the CIP expands to reach a broad audience and supports community awareness, engagement and acceptance for diverse lived and living experiences in Abbotsford.

6 CHAPTER
KEY LEARNINGS

Key learnings from the Coordinated Intake and Referral project include:

1) **The importance of systems integration and adopting a community infrastructure approach.**

The alignment of activities across sectors, agencies, and all levels of government is critical to the understanding of the needs, gaps, and opportunities. The project supported the mobilization of community-invested resources to activate a community infrastructure approach to identify, produce and advocate for adequate levels of resources across systems.

For example, there continues to be a critical lack of rental, supportive and specialized housing options in Abbotsford. The CIR project highlighted the value of an evidence-based approach to identify the housing need demands and further systems integration required to respond to the housing needs of the most vulnerable in our community. For example, this informed the advocacy and development of over 80 units of supportive housing, enhanced capacity of Housing with Abbotsford Rental Connect, the formation of Many Ways to Home Society (Abbotsford Housing Foundation), the City's Affordable Housing Strategy update, and continued development of affordable housing options (e.g. 60 units of affordable rental housing for elders, family, and youth is currently underway).

2) **Cultural transformation is a fundamental component of systems work.**

The CIR project provided the opportunity to not only develop a systems approach to the delivery of service and support connections, but it also provided the conditions to foster alignment of activities across sectors, new ways of working together, deepened collaboration, and fostered a community of integrated practice centred in respectful delivery, Housing First principles, and a harm reduction approach.

For example, the collaborative mapping process allowed for multiple perspectives to be listened to, mobilized through priority action development, and invested in shared outcomes that has emerged as a 'community-owned and invested resource' across sectors, systems, and agencies. The Abbotsford Community Hub Centre is an initiative that has emerged as a direct result of the cultural transformation work, which is an inter-agency collaboration to offer housing, health, and community integration support to vulnerable individuals. The hub partners include Fraser Health Authority (Mental Health and Substance Use, Primary Care, and Public Health), Ministry of Social Development and Poverty Reduction, City of Abbotsford, Positive Living Fraser Valley, Inasmuch Refugee Society, Healthy Aging Abbotsford, University of Fraser Valley, Hub Pharmacy, and Dr. John Farley.

3) **A coordinated entry point for intake and referral strengthens the Abbotsford Homelessness Prevention and Response System's effectiveness and response**.

The co-creation of the CIR model was an opportunity, as a community, to address the challenges identified by people experiencing homelessness and service providers. Service silos, fragmentation and duplication were identified as barriers to accessing services for people experiencing homelessness, particularly for vulnerable individuals with complex needs. Scarcity of services resulted in a first come first served approach. Introducing a coordinated intake process shifted the focus to referrals based on needs and vulnerability. Matching services to best address identified needs, and prioritizing referrals to ensure that those most vulnerable were able to access housing and wraparound support that resulted in a seamless integration of services to meet needs specific to highly vulnerable individuals. Increased coordination and strengthening components of the system led to increased effectiveness and responsiveness.

Increased coordination:

- The CIR process provided a single access point, standardized assessment for vulnerability for best service matching to address the individual needs and housing people appropriately. Single access provided one point of contact to make a service request without the worry of where to find a service or eligibility criteria – the Intake team helped them to connect to services.

- Other areas of coordination undertaken by CIR Intake Function Coordinator:
    a) Coordination and facilitation of monthly integrated outreach meetings of MOU partner agency staff and others.
    b) Case management meetings with lead organizations for coordination of services..
    c) Coordination with HARC for housing placements in market rental housing, landlord recruitment and support for landlord-tenant relations.
    d) Liaising with BC Housing Coordinated Access and Assessment for supported housing placements.
    e) Coordination of diversion planning and discharge coordination
    f) Improved connections between community services and health services

By strengthening components of the system, the system is more effective and responsive to individuals experiencing homelessness:

- In keeping with client-centred services and intentional trauma informed practice, when a participant had an established relationship with a MOU Partner, the participant selected the organization to be the lead organization and relationship keeper for wraparound supports. In this case the IACT team came alongside the participant and the agency to ensure seamless and continuous support.
- Prior to the CIR project, coordination and collaborative practice was done off the sides of people's desks. In addition to coordinating intake, the CIR Coordinator provided coordination for IACT team and case management meetings for wraparound support. For communities that struggle with funding, combining the CIR function and case management coordination could improve integration for more seamless service delivery.

- Embedding HARC within CIR created the opportunity for strengthening the response to prevention/diversion referrals. Staff from CIR/IACT and HARC work together on landlord recruitment efforts and supporting landlord-tenant relationships. Housing placements are secured to prevent evictions, divert a person discharged from hospital, treatment or aging out of foster care. HARC can also place individuals ready to rent in the private market after residing in supported housing, freeing up the supported housing unit for another.
- Improving communications and working relations among front line staff across agencies
- Improved and more focused collaboration between service providers

4) Intentional, on-going collaboration and capacity building is essential to develop and sustain systems continuity and effective outcomes.

Intentional and on-going collaboration was outlined in the Memorandum of Understanding (MOU) between the City of Abbotsford and seven service providers that agreed to be research partners for the CIR pilot project. At the completion of the project the MOU was extended for the transition period while stable and long-term funding is secured for CIR and the Abbotsford Homelessness Prevention and Response System.

Collaboration as outlined in the MOU referred to the CIR process and service delivery coordination and included agreements to: prioritize vulnerable individuals for referral to the Inter-agency Care Team; staff participation in delivering wraparound supports with IACT, where indicated; drop-ins and shelters, operated by MOU partners would be service contact points for CIR staff to people experiencing homelessness; accept referrals for supports for individuals not referred to IACT; and to avoid duplication, if a VAT assessment was previously administered by a partner, the assessment score would be shared.

The MOU agreement facilitated the level of collaboration needed to provide wraparound supports. The CIR/IACT staff came along side to support the existing relationship between service provider (relationship keeper) and participant, provided supports to complement the participant's plans and goals, enhanced supports that prevented evictions or kept participants housed while waiting for a higher level of care such as residential care. In the case of individuals with very complex health and social needs that could not be addressed by a single organization, through collaborative efforts of MOU Partner agencies and IACT, they were housed, provided supports, helped with applications for disability support, assisted with access to home supports or residential care.

Capacity building:

Housing coupled with on

-going supports for people of high vulnerability was not available in Abbotsford prior the CIR Research project. The implementation of IACT and wraparound supports provided by health and together with community/social service organizations provided integrated services for vulnerable participants for housing retention.

Integrated data management was acknowledged by the CIR design group as an important investment to support a systems approach to responding to homelessness at the service delivery and systems

level. But for the pilot project, data collection was done without the benefit of a shared information management system. However, with regular communication and case conferencing, the wraparound teams worked together effectively with shared participants. At a systems level, the aggregated, anonymized data was used to inform systems planning. In one instance, four client profiles were used to illustrate the return on investment that providing housing for individuals realized, resulting in additional rent supplements for the community. Other examples of initiatives that emerged from shared aggregate data were the formation of the Inter-agency Care team and the Abbotsford Community Hub Centre.

As an example of capacity building on the systems level, the collaborative mapping process has been mobilized not only as a community engagement tool, but also as the architecture for the System and infrastructure for its on-going activation, monitoring and evaluation through the shared outcome measurement system. This is a living process that is continually updated through stakeholder engagement and input, Community of Integrated Practice sessions to incorporate best practice, systems learning, and continuous improvement. It is critical that all levels of systems stakeholders, systems users, system implementers, institutional organization stakeholders, and elected officials are aware, engaged and invested in the shared outcomes. It takes a multi-sectoral, multi-level approach to ensure shared outcomes that achieve systems and community level outcomes and benefits. There is great benefit and perseverance required to ensure on-going intentional institutional and community capacity building is embedded into on-going processes of systems implementation and transformation.

5) Sustainable funding and a greater understanding of the value of systems-based funding are required beyond pilot project and time-limited funding.

The HPS contribution funding towards the CIR model was a critical impetus to mobilizing the efforts of the Abbotsford community to develop and invest in a systems approach to prevent and respond to homelessness in Abbotsford. With this said, additional funding was secured, a deepening of collaborative relationships, and new partners were secured to develop the additional components of the Abbotsford Homelessness Prevention and Response System. This created both opportunities and challenges in systems continuity. Although, this is precarious in the sense it is project-based versus continuous, on-going funding.

Overall, the pilot project emerged as a critical and key learning in the significance in ensuring that community have access to sustainable, on-going funding to build capacity to effectively resource, leverage shared funding, and to secure adequate levels of community infrastructure to respond to factors of vulnerability in local communities.

The Coordinated Intake and Referral project has been deemed a significant and successful community-invested process that exemplified strong collaboration and the strength of community working together. This was mobilized through Community-based Action Research to develop and implement a systems-wide approach by local housing and service agencies, multi-sectoral stakeholders, community members, and all levels of government.

Concluding thoughts and Future Directions

Homelessness, housing, and opioid emergencies have been deemed as crisis issues at an international, national and provincial scale. Abbotsford is not alone in facing its challenge to manage and mitigate local impacts of these issues or to secure adequate amounts of infrastructure funding to respond to its current and ever-increasing community housing, health, income support and accessibility needs.

Although, local government doesn't have the mandate for housing, health, or income assistance, the City utilized the aggregate level data from the CIR project and systems work to help inform policy advocacy and development, community infrastructure planning and evidence-based data to inform local conditions, interventions, and to secure leveraged and shared funding to meet these local impacts and conditions throughout the pilot project duration.

This approach further mobilized the ***Functional zero definition of homelessness***, which means that a community has a sufficient amount of resources and infrastructure to meet the current and future housing, health, and social support demands in the community for those who are experiencing homelessness, who are at-risk of experiencing vulnerability, and to ensure access and equity for all Abbotsford residents to these resources to foster housing security, health and well-being.

The first generation systems work has focused on the research, design and implementation of the CIR model and Abbotsford Homelessness Prevention and Response System. The second generation systems work will focus on operationalizing real-time data, performance measurement and HelpSeeker to support evidence-based funding, planning, and policy decisions. In addition, further work will be conducted to enhance the City's housing, health, and food security infrastructure, as well as, the systems linkage to public safety, discharge coordination and prevention and upstream supports. It is hoped that the increase in understanding of the data and outcomes will support the ability to achieve cost-savings that can be reinvested in community infrastructure and prevention and upstream supports.

When you can create a systems-approach to respond to the most vulnerable in your community, community infrastructure emerges to foster health, well-being, and social and economically vibrant community for all Abbotsford residents.

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