CIRCLE OF SUPPORT LESS BROKEN

ABBOTSFORD'S COORDINATED INTAKE AND REFERRAL PILOT PROJECT

EVALUATION REPORT

By
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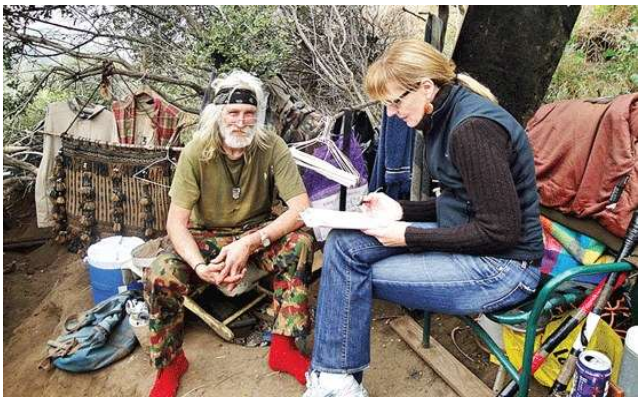

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January 2019

COORDINATED INTAKE AND REFERRAL PROCESS

Summarized Rationale

In an extensive evaluation of barriers to homeless persons accessing services, Burt et al (2010) determine that program fragmentation is one of the greatest impediments. A lack of standardized application forms, different documentation requirements, multiple service locations, and disparate eligibility requirements all create difficulties for people needing support. Hambrick and Rog (2000) write that "homelessness is a prime example of a problem needing policy and program coordination. The level of fragmentation of services is great, and the capacity of clients to navigate a complex system is weak" (p.254).

According to Burt (2010, 2007), the best mechanisms for improving homeless persons' access to service involve communication, coordination, collaboration, and coordinated community response with a central organizing structure – a single entity to "mind the store" in community response. As communities attempt to improve their responses to homelessness alongside the principles of housing first, coordinated intake and referral (CIR) emerges as a promising practice.[1]

Coordinated Intake and Referral refers to an approach by which multiple homeless-serving providers conduct intake and assessment from a standardized system. The system includes common screening measures and will often also include integrated case management. The centralization of the system enables providers to share information and coordinate procedures in order to increase efficiency and lessen the burden on homeless clients – particularly those with complex needs-who have more than likely already been shuffled through various disconnected systems, often to their detriment.

Coordinated Intake and Referral systems can allow for referrals, intake, assessment, service coordination, and program admission – depending on the particular system. Some systems involve a centralized hub or entry location; others simply use a common data sharing instrument, known as the Homeless Individuals and Families Information System (HIFIS). The level of authority in the system also differs, from providing referral and information only to offering first-level screening of full admission into a program.

Randolph et al (1997) suggest that coordination present multiple difficulties because of different funding restrictions, service eligibility requirements, treatment philosophies, and administrative policies. In addition

[1] Canadian Homeless Research Network distinguishes between best practice (proven by rigorous academic trials, reviews, studies), promising practice (realist reviews, encouraging case studies), and emerging practice (program descriptions, little outcome evidence). Coordinated Intake and Referral could be described as a promising practice when implemented in fidelity to Housing First core principles.

to the difficulties in coordination, communities also commonly lack the critical resources of affordable housing and assertive outreach and case management services. Additionally, while coordinated intake may be seen as a promising practice, it has not yet been extensively evaluated (Norman & Pauly, 2015). Scholar practitioner Turner (2014) maintains that in Canadian communities, coordinated access remains only partially developed and implemented. However, at its best, coordinated intake and referral avoids the discouraging and often humiliating process of people being passed on from program to program, telling their story over and over and jumping through multiple proverbial hoops, ultimately falling through the cracks of service delivery. It can also increase cross-sector collaboration, cost-effectiveness, and can provide data tracking for future programming improvements and support.

As with all "systems", however, without numerous key factors – such as genuine client engagement and choice, adequate housing options, empathy and respect from front door access points, effective case management practices, and vigilant follow-through – a CIR system could contribute to digitizing people to a series of labels and waitlists, and the system that was meant to support improved service could end up becoming another oppressive barrier.

The Role of Case Management

In a report on promising practice in homelessness case management, Nir et al (2011) found that both the literature and service providers offered differing and sometimes confusing information and definitions of case management. The National Case Management Network of Canada (2009) provides a definition of case management:

> Case Management is a collaborative, client-driven process for the provision of quality health and support services through the effective and efficient use of resources. Case management supports the client's achievement of safe, realistic, and reasonable goals within a complex health, social, and fiscal environment (p7).

This definition relates to case management from a clinical perspective, and homelessness involves more than just clinical support. Nir et al (2011) also provide a helpful definition of a case manager from a homelessness perspective: "The case manager is a navigator, an advocate, a coordinator, a collaborator and a communicator who balances service provision and systems navigation with short term and long term strategies to break the cycle of homelessness with individuals and families in a sustainable way" (p.20).

In case management support related to homelessness, Assertive Community Treatment (ACT) teams have been perhaps the most well-documented of effective case management models, although Intensive Case Management (ICM) and Integrated Coordinated Care (ICC) are also well supported and commonly in use (Nir, et al 2011). In particular, ACT and ICM when combined with Housing Fist principles, have proven to make a dramatic and cost-effective reduction in homelessness (Goering et al, 2014). However, ACT can also include requisites that remain in inherent tension with the more self-directed recovery-orientation and client choice provisions of the Housing First approach (Salyers, et al, 2013; Salyers & Tsemberis, 2007). Salyers, et al, (2011) observed that it could be difficult to balance a recovery approach with the needs for intervention that arise in working with chronically homeless individuals. Sayers et al (2013) suggest that employing nurses on the ACT team that work with clients to plan treatment can be vital in retaining recovery orientation and therefore Housing First fidelity.

In addition to the important role that nurses can play in an integrated case management approach, service recipients identified peer support as a key factor in their success (Nir,et al 2011). Wright-Berryman, McGuire and Salyers (2011) demonstrated that peer support workers do not necessarily improve clinical outcomes; however, they have a direct positive impact on outreach engagement, and peer support workers can act as a buffer to help develop therapeutic relationships.

A cross-cutting theme in the literature is one of ethical and compassionate care. No matter what model of case management employed, attitude matters. Milaney (2011) highlights the importance of positive engagement, and Davis, Tamayo, and Fernandez (2012) even link social support (genuine care through emotional support) to health outcomes. The social determinants of health have been solidly established in research and practice for some time. Davis, Tamayo, and Fernandez studied participants in a case management program for frequently admitted homeless public hospital patients. They found that the social support that case managers offered was equally as important and effective as informational and service support. Homeless participants had experienced profound isolation prior to the study. One noted: "There was no circle (of support). There was no help. There were no resources. There was just me and my asthma and General Hospital. That's it. That's all". Davis, et all (2012) write:

> Participants perceived that both the personal (feeling cared about and understood) and practical help (with medications, appointments, social services) aspects of the case management program led to improvements in their health. While participants differentiated the emotional components from the practical components of the case management program, they usually intertwined the two when discussing the impact of the program of their health. (p.8).

In the words of one program participant: "Because somebody cared about me. That's how it changed things" (4).

Another cross-cutting theme was the need for increased communication and collaboration between service providers, particularly via integrated teams accompanied by a coordinated system (Nir, et al 2011); Rosenheck, Resnick, & Morrisey, 2003: Milaney, 2012). Rosenheck, Resnick, and Morrissey (2003) found that increasing communication and collaboration among providers and delivery service in an integrated team helped to close pervasive service system gaps for individuals with a dual diagnosis. Milaney (2012) emphasizes the importance of a coordinated and well-managed system.

Despite the importance of effective case management (Nir, et al 2011), case management alone is not enough for wellness; Nelson, Aubry and Lawrence (2007) found that the best client outcomes were matched with both housing and case management. However, without an adequate supply of affordable housing, even the best-designed interventions fail (Norman & Pauly, 2015).

Based on the above the following conclusions can be drawn:

- Defining case management is a difficult process. Existing research and information from service providers indicated variety and sometimes confusion in how it is described and administered. Clarity in language and definitions is critical to a coordinated community of care. The variance and confusion has led to different approaches, and therefore different outcomes, for people accessing services.
- Effective case management is potentially one of the best interventions for a sustained end to homelessness.

- Existing definitions for case management are often done by identifying its key activities, processes and principles, and the roles and core competencies of case managers.
- Local barriers to effective case management include: a complex, fragmented system that leads to staff burnout, rigid and complex resource accessibility, politics, and scarcity approaches to service delivery.
- Promising practices for case management include: collaboration and cooperation, right matching of services, ethical conduct, a coordinated and well managed system and continued professional and sector development.
- Overwhelmingly, peer support was identified by service recipients as a key factor in their success.
- Providing case managers with support to develop and maintain identified core competencies can help reduce staff burnout, ensure adherence to ethical codes and behaviours. Increase consistency in practices across the continuum of care, and improve the likelihood of success for service recipients.
- By following the advice and input of people experiencing homelessness in our community, we can ensure the interventions or actions we put into place directly reflect lived experiences. Continuous consultation with people who live homeless in our community will ensure that practices aimed at ending homelessness reflect individual needs including cultural supports, complex or multiple issues, and/or past histories of unsuccessful systems interactions.
- There are many solutions for the multiple of barriers we face to effective case management. This includes inter-sector collaboration through team based intervention, participation on advisory committees and consistent information sharing on emerging, promising and best practices.
- The use of evidence-based practices for case managed supports, in addition to processes and tools for coordinating, adequately resourcing and managing a case management system, is important and achievable. The critical aspect is ensuring the processes address both individual and systemic factors, and are guided by and done with community.
- There is need for ongoing research about case management and how it relates specifically to ending homelessness. This includes research specific to sub-populations, models of case management for ending homelessness, and client complexity and concurrent disorders. Given the heterogeneity of peoples' experiences, further research will also help indicate whether or not dimensions of practice are applicable, adaptable and continually relevant.
- Providing case managers with adequate support for training and professional development will help ensure that promising practices continue.

HOMELESSNESS IN ABBOTSFORD

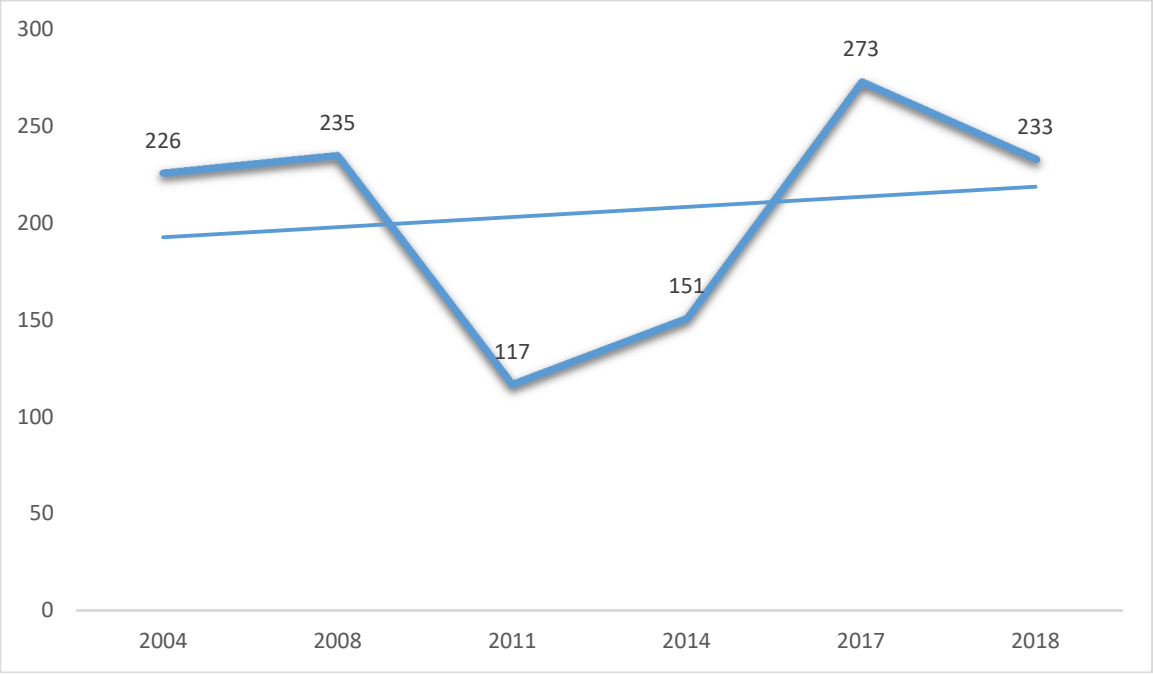
The presence of people who live homeless in Abbotsford was for the first time, systematically and empirically confirmed in 2004 when the first community based homelessness point in time survey was conducted. This was a collaborative effort involving a number of community based service agencies, i.e. Salvation Army, Abbotsford Community Services Society, University of the Fraser Valley, School of Social Work, and the United Way of the Fraser Valley. The project was coordinated by Mennonite Central Committee, British Columbia (MCC BC).

Since 2004 regular follow-up point in time homelessness counts have been conducted as part of the joint Fraser Valley Regional District (FVRD) and MCC BC tri-annual counts. These counts have always been done to coincide with the Metro Vancouver tri-annual homelessness counts. The most recent point in time count was completed March 8, 2017, again as a joint undertaking of the Fraser Valley Regional District (FVRD), and this time, MCC Community Enterprises Inc. Following the 2017 tri-annual count and as part of the Coordinated Intake and Referral Pilot Project (CIR) an Abbotsford specific survey or count was conducted in March 2018 for the purpose of setting a baseline of homelessness in relation to the implementation of the CIR project.

Table 1 below provides an overview of the number of homeless persons surveyed in each of these point in time counts in Abbotsford since 2004.

Table 1: Changes in the Number of Homeless Persons Surveyed in Abbotsford (2005-2017)

	2004	2008	2011	2014	2017	2018
Abbotsford	226	235	117	151	274	233



Homelessness can be categorized according to the time spent homeless i.e. chronic, episodic, transitionally or the state of homelessness i.e. absolute, hidden, relative. Chronic homelessness include those who are homeless for a year or more, episodic homelessness includes those who move in and out of homelessness, and transitional homelessness is short term, usually less than a month. Absolute homelessness indicates living rough, hidden homelessness includes those who are at risk of homelessness. This latter category is also reflected in the Canadian Observatory on Homelessness.

As part of the analysis of point in time survey findings for more than a decade, the presence of longer term and/or chronic homeless persons has been confirmed in Abbotsford. Through these analyses and several additional reports on housing affordability and housing and services needs in the Fraser Valley over the past 14 years, the shortage of affordable and suitable long term supportive housing has been confirmed.

As a result of the above referenced community based research into homelessness, housing affordability and housing needs, the City of Abbotsford has signed a Memorandum of Understanding (MOU) with BC Housing in 2008. This agreement between the city of Abbotsford and BC Housing, and in partnership with local service agencies, has resulted in much needed additional affordable and supportive transitional housing units having become available in Abbotsford over the past 6 years. Examples include:

- Christine Lamb Residences in partnership with SARA
- George Schmidt Centre and an expansion of units and services at King Haven in partnership with King Haven/Peardonville Treatment and Recovery Centres
- The Firth Residences in partnership with Elizabeth Fry Society
- Hearthstone Place in partnership with Abbotsford Community Services Society.
- Additional rent subsidies
- Increase in homelessness outreach staff
- Additional emergency shelter beds at the longstanding Salvation Army Centre of Hope and also at the Riverside Road shelter operated by Lookout Housing and Health Society
- Additional modular housing units totaling 83 are currently under construction in Abbotsford and should be ready for occupancy within the next few months (39 at E Fry site and 44 at Lookout Housing and Health Society site)
- Increase in temporary shelter beds during winter season for both youth and seniors.

The growing awareness about homelessness in Abbotsford coupled with policy, attitude and approach changes at municipal level have been instrumental in constructively addressing this matter, resulting in increased collaboration among service providers. Commitment from the City of Abbotsford to work collaboratively and constructively with service providers has been integral in persuasively engaging Fraser Health Authority, Ministry of Social Development and Poverty Reduction, and BC Housing. These strategic alliances have resulted in new momentum toward relative improvement to respond system wide to homelessness.

To this end the City of Abbotsford adopted a strategy in 2014 to address homelessness, the implementation of which is steered by the Abbotsford Homelessness Action Advisory Committee, a City Council appointed and resourced committee. The city of Abbotsford provided further impetus to its homelessness prevention and reduction strategy through the securing of funding in part by the Government of Canada's Homelessness Partnering Strategy (HPS) Innovative Solutions to Homelessness and the appointment of a Homelessness Coordinator.

Consultation with service providers, and borne out by the data from homelessness surveys (counts), confirm that there is a high percentage of chronically homeless people in Abbotsford. In addition, the homeless population in Abbotsford represents a diverse group with different needs including youth that have left home or have aged out of care, seniors on very limited income who cannot afford housing that is available, women who are more hidden, a large proportion of men 30-50 years of age, people of Indigenous descent, and even the occasional family. A variety of housing options are thus required to address the needs of people who live homeless in Abbotsford. For housing to be relatively successful, wrap-around support, pre-housing and post-housing, is necessary.

Homelessness thus remains present and is growing in Abbotsford. Some server providers refer to it as having reach a crisis. Community efforts in response to homelessness so far represent moving forward, but the progress is slower than what is needed and what service providers and business owners and residents would like to see. The situation is described by one servicer provider staff member as simultaneously horrible and heartbreaking. Some service provider staff continue to state that there is a greater degree of homelessness than what is being acknowledged by the tri-annual counts, officials and politicians.

Homelessness is a significant contributor to mortality and morbidity among persons with addiction and or mental health issues. There is the inherent danger of living on the street due to assaults, unsupervised overdoses and environmental hazards such as heat stroke and frost bite. Outreach workers report a higher incidence of aggressive and even violent behaviour among some people who live homeless. Some of the troubling behaviour is seen to be drug-induced and further aggravated by concurrent mental health issues. Improper use of sidewalks, bus stops, and streets is common in addition to the impact on businesses who have to deal with challenging “customers” or passers-by including erecting makeshift shelters and/or congregating at alcoves and entrances to offices. Littering, defacing and damaging buildings are also recurring. The community of Abbotsford also carries quite a bit of negative historical baggage, including a history of hurt, nastiness and ill-treatment of people who live homeless.

Data from the 2018 survey on homelessness in Abbotsford confirms the following:

- Of the 233 people who were surveyed as homeless the largest proportion (48%) or almost half were outside of shelters. Those who were sheltered on the night of the count constitute 28% following by 19% who couch surfed and 5% who were in hospital. Although shelters play and important role in terms of providing a warm and dry place to sleep, providing nutritious meals and serve as an important connecting point for clients, the solution to homelessness needs to go beyond shelters as is evident in adding more housing options for people who live homeless. Shelters are and should remain the connecting point, however it should never become an end in itself.
- Respondents who served in the Military or as First Responders constitute 10.2% (14 persons) of the persons who live homeless in Abbotsford, BC.
- As indigenous people constitute approximately 4% of the general population, they are disproportionately represented in the homeless population. In Abbotsford, 29.8% of homeless persons identify with some form of aboriginal ancestry.

- A significant proportion of homeless persons interviewed had experiences with foster or other institutional care, bringing to the fore the role of "system failure" as a cause of homelessness. Nearly half, 45.7% of respondents were in Ministry Care in some capacity.
- 58.8% of respondents (137 individuals) reported addiction; 43.3% (101 individuals) a medical condition; 39.9% (93 individuals) a mental illness; and 32.2% (75 individuals) reported a physical disability. In all categories mentioned, a significant number of people do not receive treatment.
- Gender breakdown is 64.5% male, 34.1% female, and 1.4% identified as bi-sexual or transgender.
- When it comes to how respondents identify sexually, 88.3% identifies as hetero-sexual and 11.7% identifies as bi-sexual, transgender, gay, questioning, lesbian or other.
- The biggest proportion of those who live homeless are in the age bracket 40-59 years (42.7%) followed by those 20-39 years of age constituting 35.5% with those who are between the ages of 15-19 making up 12.8% of the Abbotsford homeless population.
- The proportion of persons who live homeless in Abbotsford and rely on government assistance in the form of income assistance makes up 27.2%, representing a slightly higher proportion than the 22.7% reported in 2017. In 2018 there is also a bigger proportion of respondents who rely on disability allowance if compared to 2017 findings, namely 23% compared to 16%.
- The most used community services in order of largest number of people using it are: emergency room, meal programs/soup kitchens, extreme weather shelters, food bank, Drop-in, out-reach services, harm reduction, etc.
- The need for more affordable and supportive social housing is not a new issue and although progress has been made in Abbotsford in terms of an increase of options within the housing spectrum, not only should advocacy efforts in this regard continue, but creative funding solutions need to continue to be the focus in order to add housing options in Abbotsford especially housing supported by on-going wrap-around support for clients.
- In Abbotsford, 29.8% of respondents self-identified as having an Indigenous heritage. The findings and calls to action in the final report of the Truth and Reconciliation Commission is quite instructive. Special attention should be given to the content of this report and it will be an act of reconciliation by Abbotsford's municipal government to publicly recognize the multi-generational impacts of the residential school system and the manifestation among others of these impacts in the form of over-representation of Aboriginal people among those living homeless and to work collaboratively with First Nations communities to mitigate these impacts over time.
- There is an opportunity to consider policy and practice rethink because of the issues people living homeless are facing. The survey shows that 58.8% of homeless persons live with addictions, have medical conditions (43.3%), and are dealing with mental illnesses (40%).
- Future policy development would benefit from noting the diversity among homeless individuals and implementing strategies to target specific populations. What should be considered is the introduction of a multi-faceted approach related to securing housing and lengthening intense social service support. In doing so, street entrenched persons could move into stable, long-term housing, freeing up emergency shelter beds for temporary stays.
- Furthermore, housing resettlement and ongoing social support would assist the episodically homeless, while quick rehousing strategies can reduce transitional homelessness.

ABBOTSFORD'S COORDINATED INTAKE AND REFERRAL PILOT PROJECT

Background

Convinced by the promise of Coordinated Intake and Referral (CIR) Projects in other Canadian jurisdictions and flowing from the recommendations of the Abbotsford Task Force on Homelessness, adopted by Abbotsford City Council, and having secured a funding contribution agreement from Service Canada, Homelessness Partnering Secretariat, the community of Abbotsford, under leadership of the City's Homelessness Coordinator embarked on a process to conceptualize, design and implement a CIR pilot project. However, a great amount of skepticism had to be overcome at the start of the conceptualization and design of the project.

Some representatives from service providers felt this was once again a case of "reinventing the wheel". A strong sentiment was present among some service provider staff that instead of spending tax dollars on "research", it should rather be spent on services. Continuously time was spent on community discussions and discussions with individuals. Without minimizing the amount of skepticism, suffice to state here that over time service provider representatives and leaders started to demonstrate buy-in into the process. The perception of and attitude toward the project changed over time so that community involved conceptualization and design of an Abbotsford CIR project could proceed.

From April 2015 to August 2016, the City of Abbotsford, Homelessness Coordinator and Research Planner facilitated a series of multi-sectoral stakeholder engagement sessions regarding the barriers, needs, and opportunities to obtain housing by individuals, who are experiencing homelessness. This included the City of Abbotsford Homelessness Action Advisory Committee (HAAC) meetings, HAAC Rental Connect Initiative Focus Group, Housing First Best Practice Forum with over 170 attendees, the multi-stakeholder development of a Collaborative Roadmap for the Prevention of and Response to Homelessness in Abbotsford, and focus group sessions with individuals, who are experiencing homelessness. Through these initiatives the following key opportunities were identified for action:

- Address the patterned cycle of homelessness resulting from persistent barriers to obtain and sustain permanent, affordable, suitable housing options;
- Identify and survey rental housing needs and market factors in the community;
- Strengthen private landlord and tenant relationships;
- Build informed capacity with local landlords about BC Residential Tenancy Act requirements and best practices;
- Develop a pool of available rental options;
- Generate a clear and fluid intake and referral process;
- Explore the need of rental liaison and retention services;
- Advocate for adequate levels of rental subsidies in the community;

The HAAC work has focused on employing Collective Impact Conditions and Housing First principles to build local capacity, strengthen working relationships, and shift focus of service delivery agencies from a programmatic to a systems approach with shared outcomes. Through this work, key housing and support capability areas have been identified that:

- Require strategic planning,
- Commitment of agencies to collaboratively generate action-oriented solutions, and the

- Sharing and leveraging of resources and knowledge

The shortage of affordable and suitable housing options as a significant contributing factor to homelessness across Canada and also in Abbotsford is well documented. In Abbotsford there is consensus among service providers, homelessness advocates, persons who live homeless, and city officials that there remains a need for additional permanent supportive housing, coupled with ongoing wrap-around services and based on the principles of housing first.

The need to find an innovative way to obtain additional housing options in Abbotsford amid an almost zero percent rental vacancy rate during 2016/17 has been confirmed through consultation with stakeholders in the beginning stage of the Coordinated Intake and Referral design process. Community stakeholders have spoken loud and clear that affordable and suitable housing options are imperative for, not only the successful implementation of the CIR process, but to also find housing solutions for people living homeless in Abbotsford.

Based on feedback received through peer engagement sessions there is a desire for something tangible to happen in terms of housing options for longer term and/or chronic homeless persons that present with significant and challenging mental health and/or addiction related barriers. Given the presence of "chronic" homeless persons in Abbotsford who live with a substance dependency and or mental illness, housing options in and off itself is not sufficient. Housing plus support is necessary to facilitate housing retention, along with working through and resolving tenant-landlord disputes and facilitate rapid re-housing as needed.

The notion of designing and implementing a CIR pilot project was validated through a community stakeholder consultation meeting. Once designed, seven community agencies[2] signed on as community partners by means of signing a Memorandum of Understanding with the City of Abbotsford regarding the implementation of the pilot CIR project. The pilot phase ran from September 2017 to August 31, 2018. The implementation of Abbotsford's CIR pilot project encountered the following challenges right from the start.

- Low vacancy rate, rental increases and loss of rental housing stock and housing with rents that people can afford.
- Increase in homelessness due to a changing housing market such as people experiencing first time homelessness, including families and seniors.
- Limited housing supports to help those experiencing chronic and/or episodic homelessness acquire, maintain and retain housing.
- Increased chronic and complex health and social needs of vulnerable populations.

Purpose of Abbotsford's CIR

The Abbotsford CIR project has provided an opportunity for community agencies to build on previous initiatives and create a community-wide systems approach to respond to homelessness. The purpose is to provide more timely and effective options to prevent, interrupt and end homelessness for people in order to advance the Abbotsford Homelessness and Prevention and Response system by creating a sustainable foundation for the Housing First approach in Abbotsford.

[2] The seven agencies are: Salvation Army, Abbotsford; Lookout Housing and Health Society; Positive Living Fraser Valley; Raven's Moon Resources Society; SARA for Women; Cyrus Centre and Abbotsford Community Services Society.

The Abbotsford Coordinated Intake and Referral Pilot Project is described as a standardized systems approach to ensure those with greatest need are served first, matches people experiencing homelessness with best service available to meet their needs and to access services they need and are eligible for, without having to call or visit multiple social service programs.

Objectives of Abbotsford's CIR

1. Aligning existing intake and referral activities to better connect homeless persons to appropriate service, including Housing First Support services that are identified as being necessary.
2. Promoting partnerships among key stakeholders – including landlords and intentionally work collectively and collaboratively toward better alignment of services.
3. Establishing a community-wide tracking system or database and performance management system.

The stated focus of the CIR pilot project in Abbotsford is to employ a social-community infrastructure approach that shifts from programmatic/emergency response to a community-wide systems approach to prevent/divert people from becoming homeless and focus on bringing people into service that have not historically been connected e.g. chronic/episodic homeless persons. The assumption being that coordination will improve access and support for system navigation and that the assessment process will prioritize individuals with the highest need, with referral to the Interagency Housing Allocation and Healthcare Team.[3]

Building blocks of Abbotsford's CIR

The components or elements that constitute Abbotsford's CIR include:

Coordinated Access – Seen as processes that facilitate access to housing and services for people experiencing homelessness or are at risk of homelessness.

Coordinated Assessment – Include processes to determine the appropriate level, intensity and frequency of supports. Using the Vulnerability Assessment Tool (VAT) as a part of the process to assess the need of individuals at intake for matching to level of support.

Assignment – Within the pilot project term, assignment will be a referral to the Interagency Housing Allocation and Health Care Team for final decision.

Data Systems – Within the pilot project, data systems will be used to collect information for referral management, progress tracking, system monitoring and performance management.

Intake Function – a single point of entry to access housing and health and social supports, prevention and diversion services and liaison to Assertive Community Treatment.

Interagency Housing Allocation and Health Care Team [4] – a cross-sectoral team providing case planning and wraparound supports to people who are hard to reach and most vulnerable among those experiencing homelessness.

Streams of Service - Abbotsford's CIR

The Abbotsford CIR project has identified three steams of services to respond to homelessness during the pilot phase of the project, i.e.:

[3] This team is also referred to as the Interagency Care Team (IACT). For the remainder of the report the acronym IACT will be used in reference to the Interagency Housing Allocation and Healthcare Team.

[4] See footnote 3.

Prevention – This refers to policies, practices and interventions that reduce the likelihood that someone will experience homelessness. It also means providing those who have been homeless with the necessary resources and supports to stabilize their housing, enhance integration and social inclusion, and ultimately reduce the risk of the recurrence of homelessness.
Emergency response – This includes providing emergency supports like shelter, food and day programs while someone is homeless.
Housing Accommodation and supports – This encompasses the provisioning of housing and ongoing supports as a means of moving people out of homelessness.

Abbotsford's CIR Guiding Principles
The Abbotsford CIR Pilot Project recognized that pathways that lead into homelessness are as varied as the people who experience homelessness and pathways out of homelessness are unique to each individual. Thus, there is a need for strategies to interrupt homelessness through flexibility, responsiveness and support of the goals and desires of the person experiencing homelessness and sticking with them however long or how many times it takes. The housing first philosophy and principles that support the Abbotsford's CIR (CIR) include no wrong door approach, immediate access to housing with no readiness conditions, a person's right to self-determination and choice, individualized person driven supports, recovery orientation, including harm reduction, and social and community integration.

Values guiding the work of Abbotsford's CIR:
- Continuity and consistency in the spirit of collaboration
- Inclusionary language
- Collaborative in nature and action
- Use of collective impact conditions – common agenda, shared measurement system, mutually reinforcing activities, continuous communication and backbone organization
- Covenant of relationships/mutual engagement
- Sustainable cultural shift to systemic approach
- Alignment of service activities
- Shared client-centered outcomes
- Client's voice and personal agency are acknowledged and incorporated
- Voluntary participation by people who live homeless

Focus, Assessment criteria and intake function of CIR Pilot
The focus of CIR was on hard to reach individuals of moderate to high acuity level who will likely experience:
    - Complex care needs that include persistent addictions
    - May have concurrent mental health disorders
    - May have frequent utilization or impact to services such as hospitalization, police, city services, business and community
    - May require support with activities of daily living (social integration/self-sufficiency)

The BC Housing Vulnerability Assessment Tool (VAT) has been used to assess client need. The VAT was used in conjunction with the history of homelessness of the person, suitability of person and program match, and the person's preferences. Persons with low acuity has been referred or diverted to other services in the community.

Clients referred to IACT were provided with client-based case planning and wraparound supports for housing, health care and social integration.

The intake function of CIR included the entering, tracking, monitoring and reporting of data related to housing placement rates, housing retention rates, health support connections, income stabilization, and social integration connections. Data was maintained on the number and type of referrals, as well as, client-centered outcomes regarding the engagement and retention rates of the housing, services and support connections.

Shared Outcomes of the Abbotsford Prevention and Homelessness Response Roadmap
Abbotsford's CIR project is contributing to the realization of the following shared outcomes:

- Access is well-coordinated across all service providers (IR-1)
- Intake and Referral clients have their needs addressed quickly and efficiently (IR-2)
- Intake and Referral are managed in a seamless and integrated manner (IR-3)
- A personalized care plan is developed with each person experiencing homelessness (IR-4)
- Care for each person experiencing homelessness is tailored to their individual needs and situation (IR-5)

The following are the key indicators related to the above stated shared outcomes:

- Number of persons housed
- Housing retention at 3, 6, 9, 12 month mark.
- Number of persons rapidly re-housed (how quickly CIR was able to re-house)
- Number of persons prevented from becoming homeless
- Progress toward community/social integration

Roles of Memorandum of Understanding (MOU) Partners
The following roles have been identified and agreed upon for MOU partners:

- Continue to be a connecting point for clients as is current practice
- Identify individuals for referral
- Apply pre-screening checklist to clients with moderate to high acuity
- Administer VAT and include in referral if VAT is used by agency
- Provide additional background info for assessment by CIR
- Participate in wrap-around supports of IACT
- Accept referrals for service to clients not referred to IACT
- Participate in pilot project evaluation

The following organizations (in alphabetical order) have signed up as MOU partners for the pilot project:

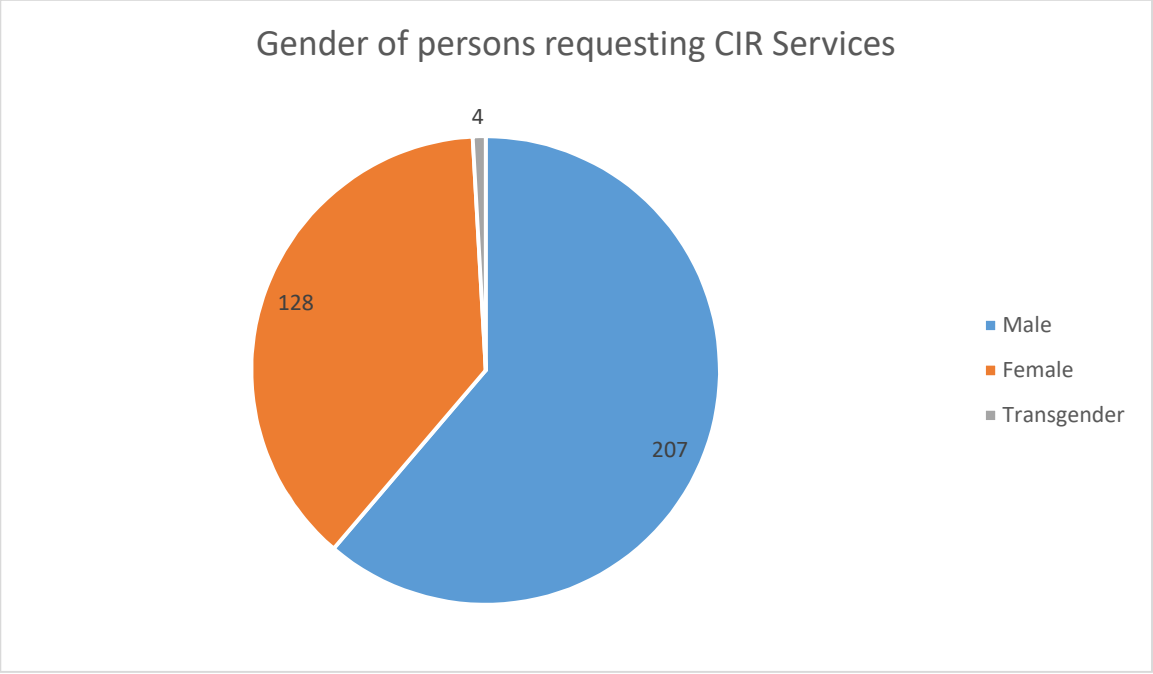
1. Abbotsford Community Services
2. Cyrus Centre
3. City of Abbotsford
4. Lookout Housing and Health Society
5. Positive Living Fraser Valley
6. Raven's Moon Resource Society
7. Salvation Army - Abbotsford
8. SARA for Women

It is also important to note that during the pilot project, organizations other than the MOU Partners started to work much closer with the CIR process. Examples include Fraser Health, Ministry of Social Development and Poverty Reduction, Abbotsford Regional Hospital, and Elizabeth Fry Society. Adding MOU partners could be a matter for further consideration as the CIR process continuous beyond the pilot phase.

Client Service Requests to CIR

Based on data obtained from the CIR Coordinator, the CIR Team received 339 service requests over the 12 month period of the pilot project i.e. from September 1, 2017 to August 31, 2018.

Of these 339 requests, 207 or 61% were males and 128 or 38% were female and 4 or 1% were transgender.

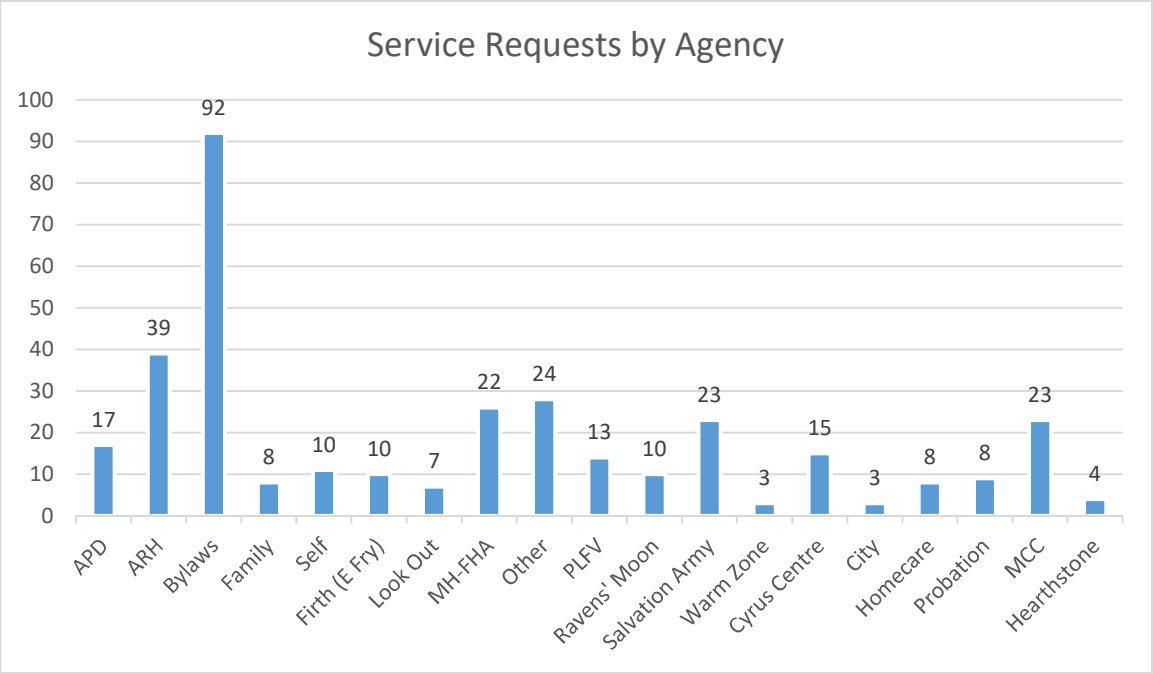


The ages of persons for whom services were requested from CIR ranged from 17 – 92 years of age.

Service requests came from the following organizations:

- By-laws City of Abbotsford
- Abbotsford Police Department
- Abbotsford Regional Hospital
- Elizabeth Fry Society
- Lookout Housing and Health Society

- Mental Health – Fraser Health
- Positive Living Fraser Valley
- Raven's Moon Resources Society
- Salvation Army
- SARA for Women
- Cyrus Centre
- City of Abbotsford
- Homecare
- Probation
- MCC
- Hearthstone

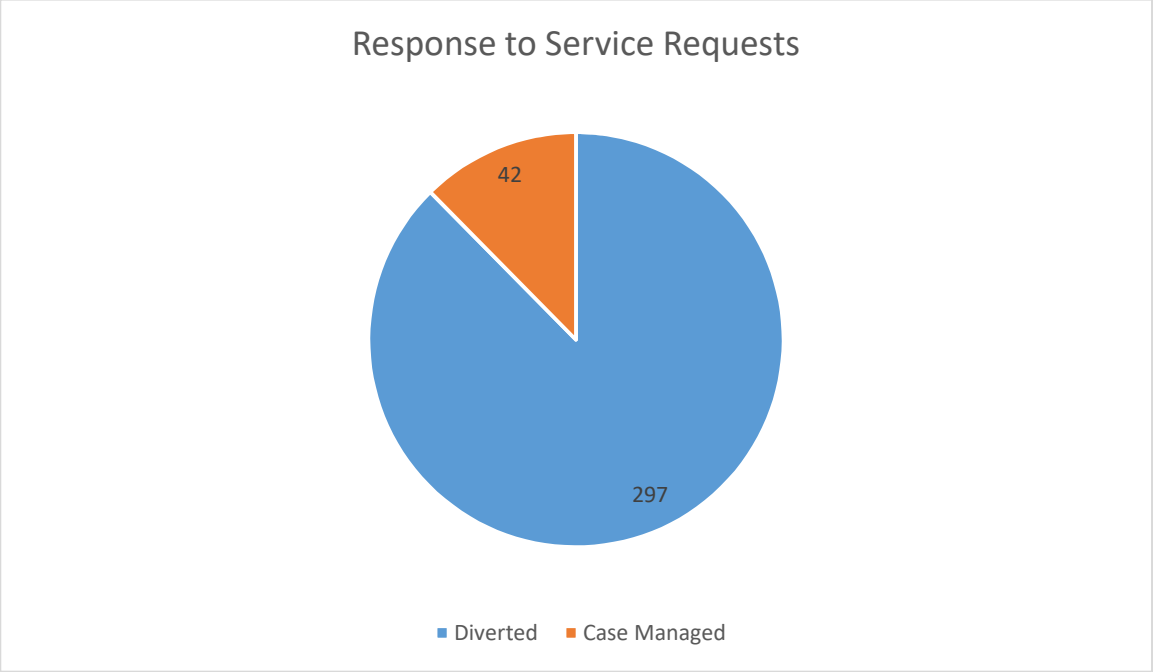


Of the 339 service requests, 297 were "diverted"[5] and 42 received enhanced case management and wrap around support from the CIR Team with support from local homelessness services agencies. Of the ones "diverted", 182 or 61% were males; 111 or 37% female and 3 or 1% transgender.

Of the 42 persons who received enhanced case management and wrap around support services through CIR, 25 or 60% were male and 17 or 40% were female. A similar gender breakdown than the gender breakdown of the 339 persons for whom services were requested.

[5] The term "diverted" in the context of this report encapsulates the following: Persons receiving short term case management resulting in receiving prevention and diversion services, including most importantly connecting with medical services; those still in process of being assessed and those for whom no service was offered as they did not meet the eligibility criteria for the pilot project. This included having lived in Abbotsford for at least 6 months, planning to remain in Abbotsford, being assessed "most vulnerable" using the BC Housing Vulnerability Assessment Tool, etc.

For the 42 persons who received enhanced case management and wrap around support services, the Salvation Army was the care agency of 4 persons; Lookout the care agency for 3 persons; Raven's Moon the care agency for 5 persons followed by Inter-Agency Care Team 4 persons; Cyrus Centre for 3 persons, Hearthstone for 2 and Abbotsford Mental Health and The Warm Zone 1 person each. The remaining 18 persons were primarily cared for by the CIR team.



Of the 42 clients who received enhanced case management and wrap around support through CIR, 10 were housed, representing 24% of clients, 3 went to treatment and 28 remain homeless of which only 4 are in shelter. One person passed away. Housing was provided through Raven's Moon, Steve Simpson Housing, Hearthstone, Residential Care and one person is housed with a friend.

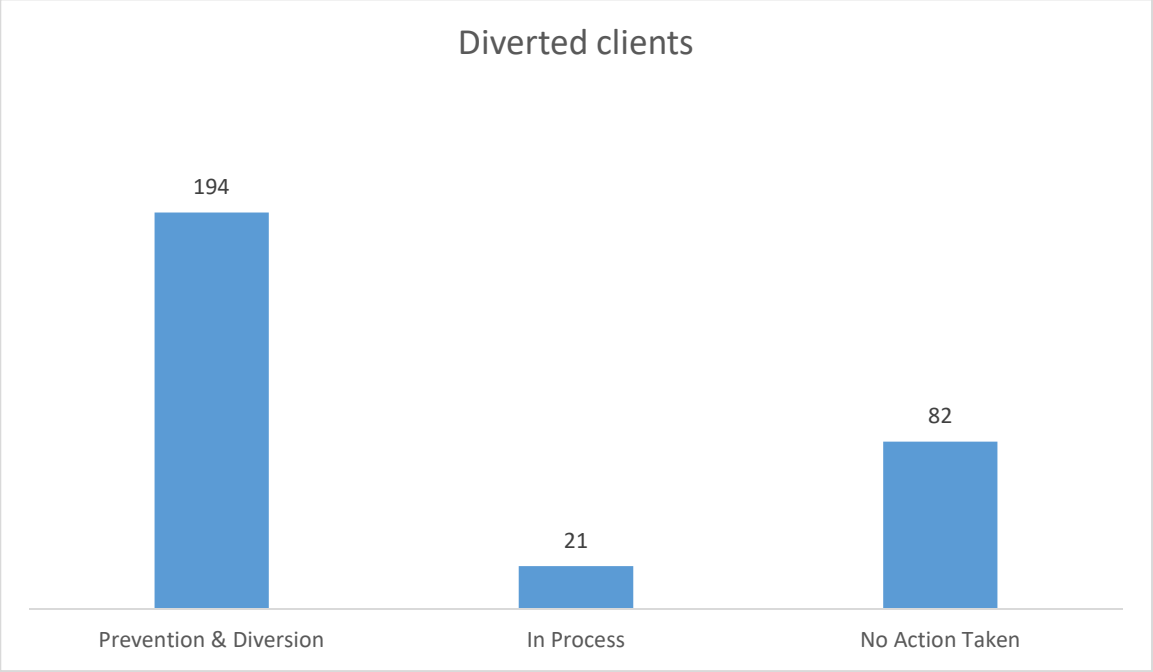
Of the 42 clients who received services through CIR, 15 have become "inactive" for the following reasons:

- Location unknown
- Referred to Assertive Community Treatment Team
- In treatment
- In Residential Care
- Unwell
- No longer engaging in the process

The result of the above is that these individuals are no longer able to participate in working on a pathway out of homelessness. (One person passed away).

With regard to the 297 persons who were “diverted” by CIR the following can be reported:

- 194 – Received prevention and diversion interventions - Persons in this category did receive short term case management to be connected with resources including medical services i.e. physician care, mental health services, addiction treatment services, prescription medication, additional medical appointments, etc., finding housing or in some cases persons were already in receipt of adequate support and services in relation to criteria of being “most vulnerable”; others were in process of being assessed.
- Included in this category are persons who did not meet the criteria of “most vulnerable”, or they did not meet the pre-screen criteria including living in Abbotsford for the past 6 months and planning on remaining in Abbotsford for foreseeable future. Nevertheless, 21- In process of assessment
- 82 – No action was taken - Reasons include having left the area; not engaging at time of contact; violent behaviour; staff unable to locate the person, etc.



ASSESSMENT OF CIR BY REPRESENTATIVES OF PARTICIPATING AGENCIES

Two rounds of qualitative interviews were conducted with staff of agencies who participated in or interfaced with CIR during the pilot period. In total 24 interviews were conducted; 13 during the first round and 11 during the second round.

Below is a summary of responses to key questions put to staff of participating agencies.

What has worked well?

- Connection clients to health care services
- Approachability of CIR/IACT Team
- Responsive
- Good skill set and knowledge in team
- Professional team– do not give false hope
- Open to dialogue appreciate other opinions/views
- Connecting on regular basis with service providers
- Making connection to health services
- Front line staff sharing information/informing one another
- Facilitate wrap around support
- Good response to mental health challenges
- Timely response to crisis intervention
- Coming to site
- Team has flexible approach to criteria for assistance
- Amount of autonomy and being able to be flexible in daily operations.
- Building organizational operations
- Excellent relationships in the field working together
- Agencies worked closer together – learning from one another
- HARC finding housing
- Collaborative team work
- Being able to refer to an entity
- Response to homelessness has become more efficient
- Team has an excellent understanding of the issues facing homeless people.
- They are not afraid to go where they are most needed.

What can be improved?

- Team needs to be expanded; more staff is needed both as it relates to health workers and referral function; referral function needs support
- More focus on getting people housing ready.
- Expanded hours including weekends
- More feedback to referring agencies; speaks to increasing capacity of intake function
- Clarifying roles; intake in relation to outreach and lead organization
- More access to designated doctors; fast tracking to doctors for medication for stabilization; faster response to those needing stabilization

- More regular communication on process, achievements, challenges, intervention – also clarification of roles CIR-IACT-HARC, etc.
- Bridging to mental health and bridging to Abbotsford Addictions Services; still some disconnect
- Discharge practice from psych ward and prison needs further improvement
- Access to psychiatrist is imperative given the number of people who present with complex mental health issues
- Increase detox capacity (To use Riverstone you need to be housed)
- Create a Substance Use Services Access Team

What has been the impact of the CIR project on Abbotsford's response to homelessness?

- Better access to health care including mental health services, addiction treatment, etc.
- Put a positive face on good changes coming down the road
- Positive relationship with people and agencies
- Improved and more focused collaboration
- Opportunity to share information and views at interagency outreach team meetings and at CIR table
- Improved wrap-around support
- Increased flexibility with regard to services and responses to homelessness
- Connecting and sharing on a regular basis.
- Some people were housed
- Beginning of a new approach that shows promise of working collaboratively
- More subsidies available
- Mutually respectful relationship re. team; open dialogue
- One call is the right call – one call gives you action
- Clients feel cared for
- Providing a much needed service in a great way

Rating of CIR project's operation

Those interviewed were asked to rate CIR in terms of how it operated, on a scale of 1 – 10 with "1" being "poorly" and "10" being "very well". The mean rating was 7.5 and the average was 7.4. Therefore, the CIR pilot project has been rated favourably as it relates to the way it operated. Below are some of the comments linked to the how interviewees rated CIR.

- exceeded expectations
- still some confusion as to where is correct port of call – refresher on process
- open to be helpful, receptive to work outside the box
- good place to refer too. There is a reply and action is being taken although result is not necessarily solving the problem
- responsive; outside the box – referral process still unclear. Feedback on what has happened.
- has not really worked that well other than a place to refer to; has not had any significant impact on preventing and reducing homelessness
- need access to psychiatrist; team is not big enough; demand outstrips supply
- same as above

- small team; some frustration with system; slow progress and "insurmountable" challenges innate to people who live homeless. Makes for slow progress and difficult to measure; clarifying roles and responsibilities.
- achieved cross-sectoral buy-in to collaboration

What outcomes have been achieved?

- Much improved connection to health services
- Housing appropriately
- 10 – 15 of my clients have been housed, partly due to CIR; not all remained housed but those are the challenges
- Support from the team extends beyond given information
- Relationship building – clients can see that genuine effort is made; caring is palpable in the approach
- The implementation of HARC and thus access to market housing
- Team is professional yet approachable; team is able and successful in making connections
- Provides opportunity to trouble shoot and brain storm
- People who have lived homeless have moved forward. Some are housed; some have been re-connected to family; some have completed treatment successfully
- Role played by Salvation Army low-barrier clinic is very powerful and plays a very important role in connecting people with services, including connecting to CIR/IACT that otherwise would not happen.
- Emerging and growing community of service providers working together
- Establishment of the HUB at Positive Living Fraser Valley
- Establishment of Housing through Abbotsford Rental Connect (HARC) and thus access to market housing
- The initiative toward establishing a Housing Foundation for Abbotsford
- Fraser Health's mapping project
- Securing modular housing units
- The circle of support is less broken
- Improved and stronger relationships with people in the field.
- Evidence of authentic relationship building that is emerging underpinned by respect, trust and dignity
- The fact that the City of Abbotsford has stepped forward and came to agreement with Fraser Health and BC Housing to bring more resources and services to the community is a tremendous step forward
- People who live homeless now have practitioners and professionals in the community who can interact with them where they are. Trust is slowing being built.

Has CIR Pilot being a good initiative for Abbotsford?

- Very good – exceeded expectations
- Very good – seeing positive changes in attitude and increase in options with growing support
- Very, very good – Make CIR/IACT a standing program
- Yes – better responsiveness
- Yes – there is a referral process; a place to call

- Very good – improved and focused collaboration between organizations; follow-up improved too.

CONCLUSIONS

It is clear from the preceding pages, especially the feedback from staff of agencies who participated in the CIR pilot project, that the one constant theme is one of improved or better collaboration. The CIR pilot project has, based on feedback from participating staff, definitely succeeded in bringing about improved and more focused collaboration, most notably the marked improved linkage to health services, including mental health services. However, it should be noted that increased capacity regarding health services and mental health services related to homelessness need further attention.

It is also clear that the team that constitutes CIR/IACT possess and demonstrate knowledge, skills, know-how, attitude, commitment, and resilience that are imperative for the success of such a process. The commitment, know-how and professionalism demonstrated by the team and experienced by staff from participating agencies cannot be emphasized enough.

Most, if not all of the areas identified for improvement in the first round of evaluation were confirmed in the second round of evaluative interviews. These are:

- More clarity is needed regarding the intake and referral process, assessment tool and assessment criteria and how these all relate to outreach and the role of the lead organization and an improved feedback loop to referring agency as and when appropriate.
- The team needs to be expanded. More staff is needed both as it relates to health workers, including mental health, and very important, access to a psychiatrist given the increasing number of persons who present with challenging mental health issues, further compounded by high incidence of concurrent disorders.
- The referral function needs added capacity too.
- Expansion of the team to include access to team's services after hours and weekends.
- Process to discuss clients' situation and prognosis and decide on best response present significant room for improvement. This point relates to the need to assess the CIR model used for the pilot project against the literature grounded overview of what a CIR process, including case management, should entail. The CIR model going forward needs to be more robust and based more closely on emerging practices and lessons contained in peer reviewed scholarly assessments or evaluations of CIR including the importance of a robust case management system with all what is required to undergird a robust client centered case management and CIR process.
- Role clarification regarding linkage between CIR, IACT, HARC and ACT is needed.
- Discharge policy and or practice as it relates to the hospital in general, emergency room, the psych ward and the prison system continue to present challenges and requires further dialogue or conversation to enhance collaboration involving the mentioned entities and CIR and IACT.
- Housing outcomes were low. This speaks to the challenges related to scarcity of appropriate housing options, need for further expansion of wrap around services and what wrap around services really entail, the need to determine what more can be done and how best to get people housing ready and how to motivate clients to follow through, balanced with a client's right to choose to participate or not.

- Better access to designated physicians that has knowledge of and understands and have empathy regarding addictions in order to fast track medication for stabilization
- Improve bridging to mental health and Overdose Access Team at Abbotsford Addictions Services to mitigate some "disconnect" that still occur from time to time.
- Improve bridging to recovery houses in the community
- Increase detox capacity (in order to use RiverStone the person needs to be housed)
- Explore the value that the creation of a Substance Use Services Access Team may add to ongoing and expanded CIR/IACT
- Consider ways and means to motivate clients to follow through
- Give serious consideration to ways in which community integration can be facilitated especially as it relates to persons who experienced pro-longed marginalization, and/or are coming out of treatment.
- It is imperative that the CIR design become more robust and include a robust case management system and that a robust project evaluation system be designed and implemented in order to augment qualitative evaluation with quantitative evaluation based on tracking of key performance measures in order to demonstrated, based on hard data, efficiency and better return on tax dollar investments.

It is apparent from this evaluation process that piloting CIR in Abbotsford was a big and meaningful step forward. Although it could be argued that not much has been achieved in terms of preventing and reducing homelessness when conditions "on the streets" are looked at, the significance of the CIR pilot project lies in the fact that collaboration has been more formalized and has become more focused. Furthermore, the CIR pilot and the knowledge, skills, attitude, commitment, respect and professionalism that the members of the CIR/IACT Team demonstrated brought about responses to the needs of people who live homeless that previously was simply not available or possible. The presence of CIR has buoyed front line staff. CIR/IACT represents the addition of a much needed service capacity that involves rapid response and much improved and timely connection to health services.

The CIR/IACT pilot project has also brought into the emerging repertoire of responses to homelessness the tremendous value of services already present in agencies who participated in the CIR/IACT pilot project. Cases in point are the low barrier medical clinic at the Salvation Army and leveraging the services and facility at Positive Living Fraser Valley toward the creation of the Community Service Hub.

CIR/IACT has certainly demonstrated how a coordinated system response can bring about greater efficiency and result in people being housed, treated and receiving much needed medical care. The CIR/IACT team has not achieved much in terms of achieving tangible outcomes, but it certainly demonstrated the benefit to be had from collaboration, coordination of interventions or operations, and has identified areas where further work is required.

The CIR pilot involving the city of Abbotsford and 7 participating agencies has further solidify the importance of a coordinated response to homelessness prevention and reduction. To this end the partnering and collaboration involving the City of Abbotsford, Fraser Health, BC Housing and relevant Federal Government Ministries need to continue in order to build out the CIR team and bolster its capacity. The Coordinated Intake and Referral Project has contributed to laying a solid foundation upon which the Abbotsford Homelessness Prevention and Response System can be further strengthened.

The Abbotsford Homelessness Prevention and Response System is a manifestation of much needed community infrastructure that over time should be maintained and expanded. Sustaining what has been achieved to date and further expanding it, requires ongoing funding partnerships with all levels of government i.e. Service Canada, Province of BC, specifically continued partnering with BC Housing, Fraser Health, and Ministry of Social Development, Innovation and Poverty Reduction among others.

In closing. The beauty or significance of the CIR/IACT pilot project is that it contributed, in the words of one staff member from a participating agency, to "the circle of support being less broken". Building on the foundation laid by this pilot project, has the potential to improve the circle of support and making it stronger, resulting in better outcomes as it relates to preventing, interrupting and reducing homelessness in Abbotsford.

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