Downtown Eastside Second Generation Strategy Design Paper

Client Engagement Summary April 2015

INTRODUCTION

In February 2015 Vancouver Coastal Health (VCH) released the *Downtown Eastside Second Generation Strategy* (SGS) *Design Paper*. This is a vision document based on significant stakeholder engagement that outlines a road map for the future of health care on the Downtown Eastside (DTES). Before entering the implementation phase of this process the project team wanted to check back in with their stakeholders to make sure that they were on track. This paper briefly outlines what we heard from DTES residents and service users.

PROCESS

VCH's Community Engagement team led an engagement process in March/April of 2015 with 7 focus groups in the DTES connecting with 40 people, including:

- → 26 (65%) women, 10 (25%) men and 4 (10%) transgender persons;
- → 25 (62%) people over 40 and 4 (10%) people under 25;
- → 18 (45%) Aboriginal people and 1 other visible minority (Chinese); and
- → 21 (52%) who have lived in the DTES for 10+ years, with everyone having lived there for at least 2 years.

Participants were recruited through diverse agencies and provided with a meal and a $20 honorarium. They were asked to provide feedback on a condensed version of the report that summarized the proposed changes into 28 points, each presented in plain language and from a client perspective.

ONE WORD RESPONSE

At the end of the detailed discussion of the 28 points outlining the vision for the *Second Generation Strategy* participants were asked to offer one word that summarized their thoughts about the plan. Here is what we heard:

"Understanding"
"Positive"
"Impressed"
"Modernization"
"Think of the youth"
"Cautious" (x2)
"Inspirational"
"Heard"
"Hopeful" (X4)
"Vindicated"
"Accepted"
"Knowledgeable"
"Excited" (x3)
"Good"
"Supportive" (X2)
"Helpful"
"Fantastic"
"On the level"

HIGH LEVEL SUMMARY OF FEEDBACK

1. Participants were overwhelmingly supportive of the SGS paper.
2. Some clear and more universally supported, priorities are:
   - → more peer support and ongoing client engagement
   - → filling service gaps for people struggling with difficult transitions
   - → access to healthy and affordable food
   - → an integrated health care site
   - → staff training related to working with marginalized populations
   - → more supervised injection service
3. Areas where participants had the most cautions include:
   - → harm reduction, particularly low barrier, single-dose methadone
   - → an integrated health care site and coordinating clinicians
   - → women-specific health services

BROAD-BASED SUPPORT

Some of the *Second Generation Strategy* actions and goals presented to participants received more clear and widespread endorsement than others. We asked participants to identify their level of support for each action. Below are the ones that received the highest proportion of participants' support, starting with the highest and following in descending order.

1. Have peer support available in all VCH services in the DTES.
2. Create more and ongoing opportunities for clients to give their input and share their concerns about health services.
3. Have VCH outreach teams at all hotels, not just VCH funded hotels.
4. Create new place for people who are homeless to stay when they leave hospital or treatment and help connect them to more support while they are healing.
5. Set standards for the quality of the food served by the programs that VCH funds. Do research to see if providing healthy food improves people's health.
6. Put addiction services, mental health and home health into one building.
7. Work towards having supervised injection available at all VCH's sites in the DTES.
8. Help people to cook for themselves in community kitchens.
9. Create a plan for how we will work together to improve access to healthy food across the neighbourhood.
10. Train staff in how to work better with Aboriginal clients, people who work in the sex trade, people who have experienced trauma, etc.
11. Improve the way we support youth who are becoming adults (and getting too old for youth services).

CAUTIONS AND SUGGESTIONS

Participants were also asked to identify areas of caution or concern. Many times participants were supportive of an action at a high level, but with a caveat attached, or a suggestion for consideration during implementation. The following summarizes concerns and suggestions made by participants.

Harm Reduction

In general, the plan to build up harm reduction services received overwhelming support from participants. Concerns that were voiced related to a general worry that these services can enable addiction and/or be taken advantage of. This came up most frequently in relation to the single-dose methadone clinic – even many of the participants who were in favor of the service cautioned that strong safeguards, such as tracking and screening, need to be in place to limit abuse.

Similarly, while most were in favour of expanding harm reduction services for non-beverage alcohol users as well as research into prescription treatment for stimulants, a few participants worried that these could create barriers to sobriety and other health issues. Some participants stressed that harm reduction should make stronger links to abstinence-based treatment and were supportive of the action in the Design Paper related to this.

Other suggestions:

→ Expanded supervised injection capacity be limited to clinical buildings

→ Harm reduction supplies and services be made more accessible to youth

→ Supervised injection facilities be established outside of the DTES

Integrated Clinics and Coordinating Clinicians

While participants were in general very supportive of the idea, some suggested caveats to integrated clinics and a few felt they were not worth pursuing. One concern was that having all services in one place centralizes "power" and gives clients no alternatives for care; that convenience and navigability need to be balanced with the ability to choose care providers and venues. Another concern was that combining harm reduction and abstinence services would be triggering for people trying to stay sober, particularly because it would mix populations. Similarly, serving mental health consumers alongside those with addictions and concurrent disorders would lead to abuse of the mental health consumers by "addicts".

While participants generally supported the notion of a most-responsible clinical staff member coordinating their care, there were also concerns. Many participants identified this as a powerful role and that it is therefore important that this be optional and that clients have choice about who this worker is as well as recourse in the event of conflict.

Women's Specific Health Services

There was relatively low support from participants, mostly women, for women-specific health services. Participants noted that there are already sufficient dedicated women's

health services. A few participants noted that in contrast there are almost no dedicated health services for men on the DTES, such as The Dudes Club (at Vancouver Native Health Society), or LGBTTIQ residents. Other clients were concerned that clinics exclusively for women may exclude transgender people.

Interestingly, mobile clinics for women received a lot of support from participants, particularly the notion of a van. In these conversations many participants identified other populations who would also benefit from mobile care, such as men and particularly sex-working men and people who identify as LGBTTIQ.

Gaps in current services for women were also identified, such as support for women on Sundays and Mondays as well as at night, and for women who do not have addiction or mental health issues.

<u>Accessing Care</u>

There was widespread support for changes to allow more people to get care when and where they need it. Participants stressed how critical it is to increase clinic hours to fit client needs. Many shared stories of DTES clinics not accepting new patients and of wait times and restricted hours at clinics creating significant barriers for people who need care. Similarly, participants supported extending the hours of Insite and even suggested 24/7 access, which would reflect demand and curb the violence and other problems that begin as soon as Insite closes.

Several participants raised issues around eligibility criteria and accessing care during life transitions such as moving out of the DTES or when children reach certain ages. Participants voiced the need for more leeway and/or support connecting to other agencies when they have to exit specific services.

Other points:

- → Those who voiced support for improving treatment for people suffering from chronic pain felt it was *very* important and identified training for doctors as critical.
- → End of life care was a concern for several participants, some of whom noted that tenant support workers need to be better trained to help dying residents.

<u>Housing</u>

There was low overall support for clients having the option of tenant support workers (TSWs) working with health care teams. Participants identified that TSWs are not trained to be part of a medical team, and had particular concerns related to confidentiality.

Tailoring housing to people who need special supports was more broadly supported. However, there were safety related concerns about the potential of mixing vulnerable populations with others who might take advantage and specifically that people in palliative care need special protection. The second concern about tailored housing was that maintaining family units whose members might have different needs be prioritized when determining eligibility and placement.

Healthy Affordable Food

Participants almost universally endorsed making healthy food more available on the DTES. Their more detailed suggestions include:

- → Educational components that should be included in food services are: basic health and nutrition education and strategies for cooking with limited supplies and amenities.
- → Take into account accessibility of both food and water at non-traditional times – particularly at night and during the winter when water fountains are off.
- → Food lineups are prohibitively long for some, including those with children. Food programs should make healthy food accessible to take home and cook rather than just focus on community kitchens and "soup lines".
- → Many clients have no capacity to store food at their homes and disabilities can preclude participation in community kitchens.
- → Youth-friendly or youth-specific meal options are important and lacking on the DTES.

Youth

Despite efforts, few young people participated in these focus groups. Those who were engaged were in favour of supporting both youth who are transitioning out of youth-specific services and adult-focused services at being better at working with youth. They also highlighted the need for more youth-specific or youth-friendly services, particularly related to harm reduction for young drug users.

There was some concern from adult participants about supporting adult services to be better at working with youth. A few felt that youth are too vulnerable to safely access adult services. Youth-specific services were suggested as a way to protect youth from potential harm and a mobile health van as a way to provide services while not requiring youth to be on the DTES to access them.

Filling Service Gaps During Difficult Transitions

Participants supported the need for greater services for vulnerable people being discharged from hospital and treatment. One participant suggested making it mandatory for hospitals to ask if clients have a safe place to go before they are discharged.

Next Steps

This feedback will be presented to the appropriate VCH working groups to consider where and how suggestions can be implemented. VCH's DTES Redesign team is currently working with the Community Engagement team to establish a plan for continuing client engagement about health services on the DTES.

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