Aboriginal Housing Management Association
Over 25 years of Indigenous housing expertise.

Operations Member Needs Assessment

Report Back

ABORIGINAL HOUSING MANAGEMENT ASSOCIATION

2024

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Executive Summary

Between June 2022 and November 2023, AHMA engaged in a needs assessment process with member organizations. Needs assessment participants included representatives from twenty-eight (28) unique For and By Indigenous housing and homelessness service provider organizations across the province. The needs assessment focussed on understanding AHMA members' experiences providing housing and homelessness services, with a focus on operational needs related to providing holistic, trauma-informed and culturally supportive programs and services. The project's objective was to identify and build in-depth understanding of member priorities, challenges and successes to enhance support and capacity building initiatives delivered by the AHMA Operations Team. The needs assessment responds to AHMA's Urban, Rural and Northern Indigenous Housing Strategy and accountability to AHMA member organizations.

The needs assessment used a mixed methods approach, which combines quantitative data to capture broader trends and qualitative approaches to understand the context, interconnections, and experiences. Engagement methods included one-on-one interviews, site visits and an online survey. Participation was voluntary, anonymous and confidential.

A key theme emerged from needs assessment findings: For and By Indigenous housing and homelessness service providers are working in a dynamic, and often inequitable, landscape. This landscape is characterized by chronic underfunding and increasingly complex and specialized needs experienced by those they serve. At a systems level, a lack of meaningful commitment, action and accountability to equity and human rights exacerbates new and existing challenges.

Organizations are responding to complex emerging needs in a resource-scarce environment that presents new challenges, while intensifying existing challenges. Providers are experiencing increasing complexity of needs among people served that are often related to, or concurrent with, adverse mental health and substance use. The intersection of health and housing is highlighted but resources are limited to effectively provide required support. Organizations frequently provide formal and informal holistic supports out of necessity. However, this work is often unfunded and beyond existing organizational resource capacity.

The needs assessment uncovered six core concepts that describe challenges facing AHMA members in the changing and complex landscape. The following themes are considered and discussed further in *Section 3. Key Findings and Discussion*.

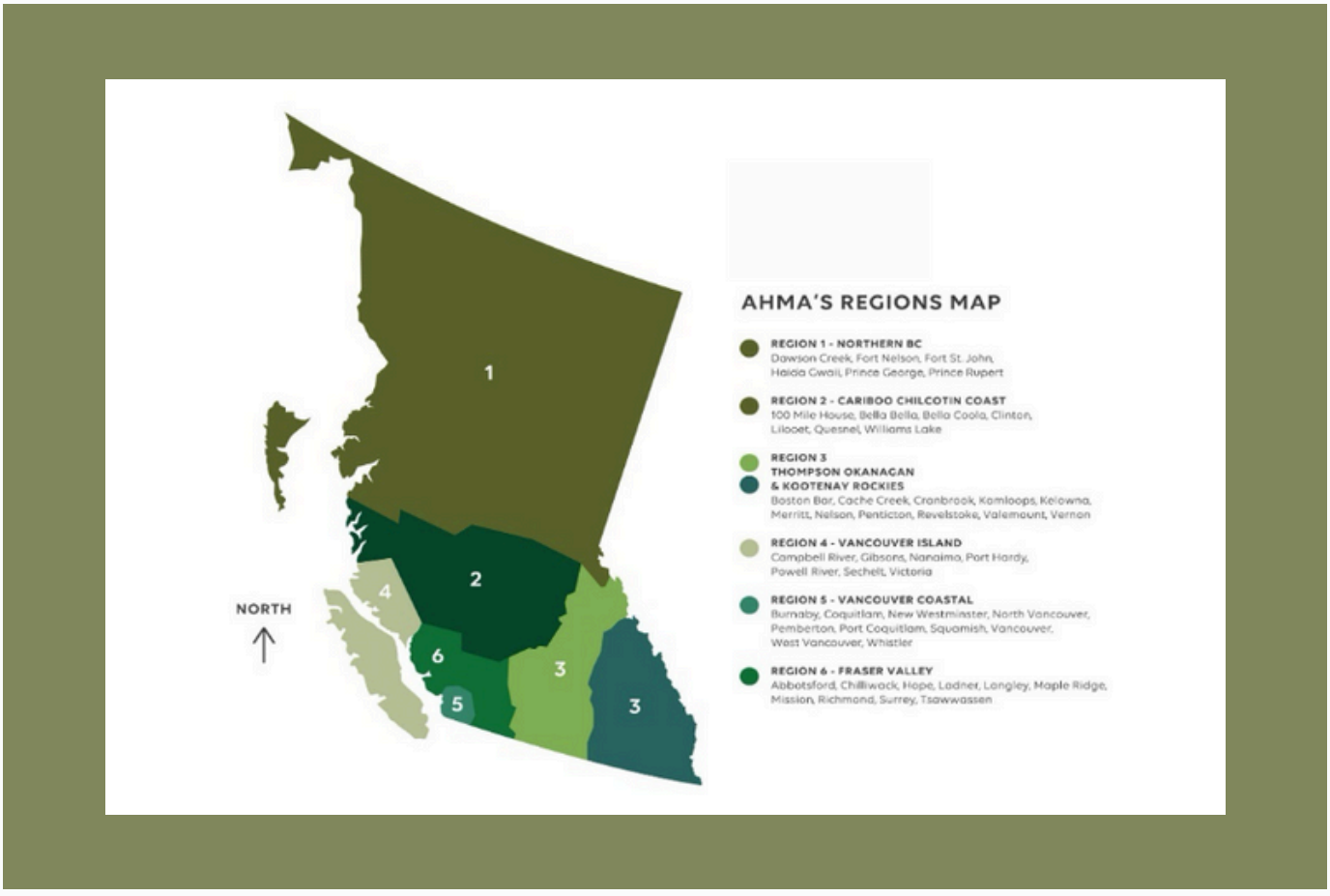
1. Equitable Access to Services
2. Safe Services and Pathways
3. Coordination and Accountability
4. Holistic Supports
5. Harm Reduction and Recovery
6. Staff Recruitment, Retention, Capacity and Wellness

Section 1: Online Survey Results

1.1 Participant Profiles

The AHMA Needs Assessment Survey (online) generated 14 responses. Most participants (79%) were from a management, leadership, or board position within the housing and homeless sector. Less common roles were outreach worker (7%), support workers (7%), and administrative staff (7%), including no responses from peer support workers and healthcare professionals who work in housing. As such, survey responses are skewed toward the leadership experience in member organizations, as opposed to direct frontline experiences.

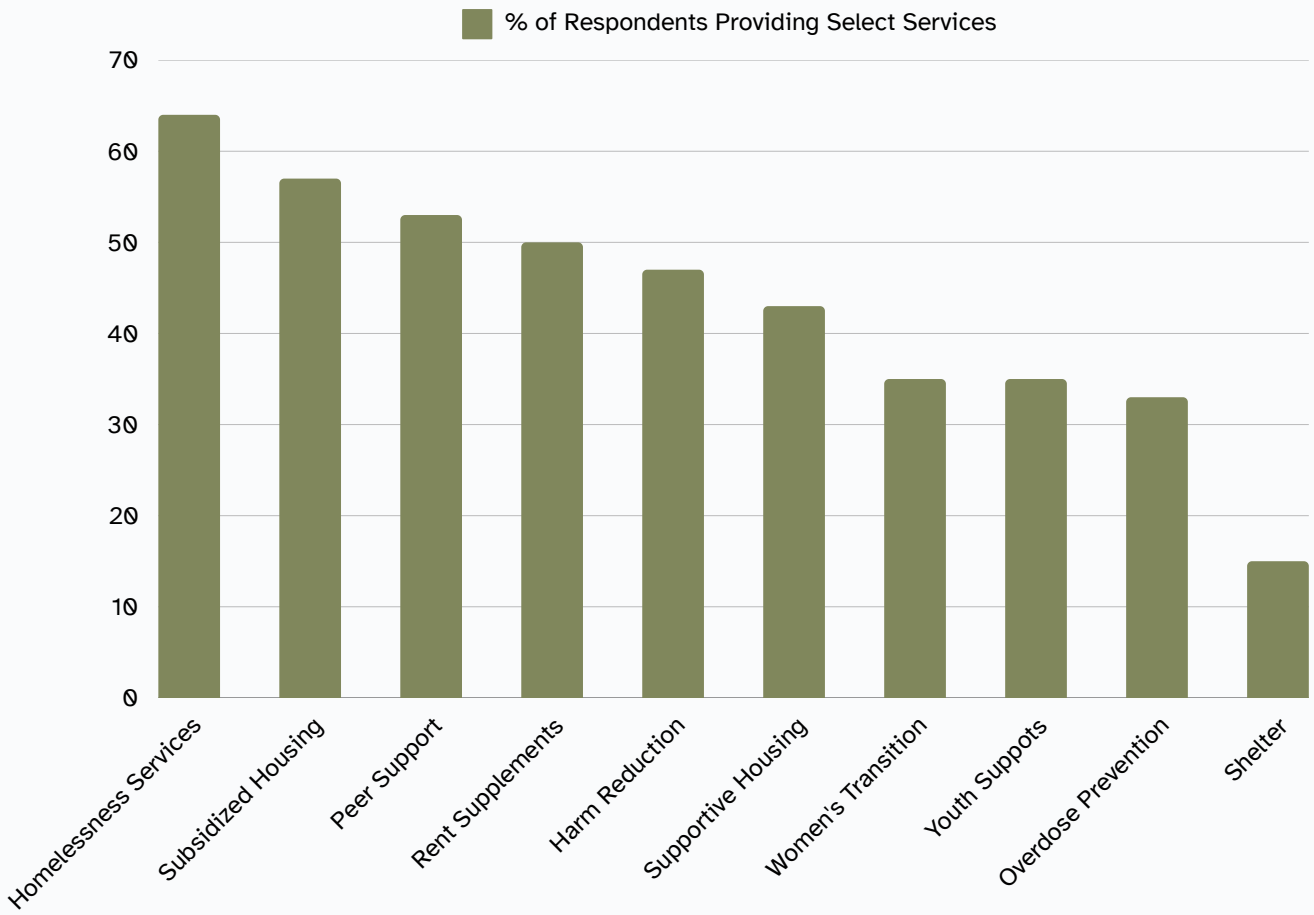
There was geographic participation in the survey from five of AHMA's six regions, with the highest engagement from Northern BC (36%) and Thompson Okanagan & Kootenay Rockies (29%) locations, followed by Vancouver Coastal (14%), Fraser Valley (14%), and Cariboo Chilcotin Coast (7%). We did not receive any responses from Vancouver Island.



Source: https://www.ahma-bc.org/list-of-aboriginal-housing-providers

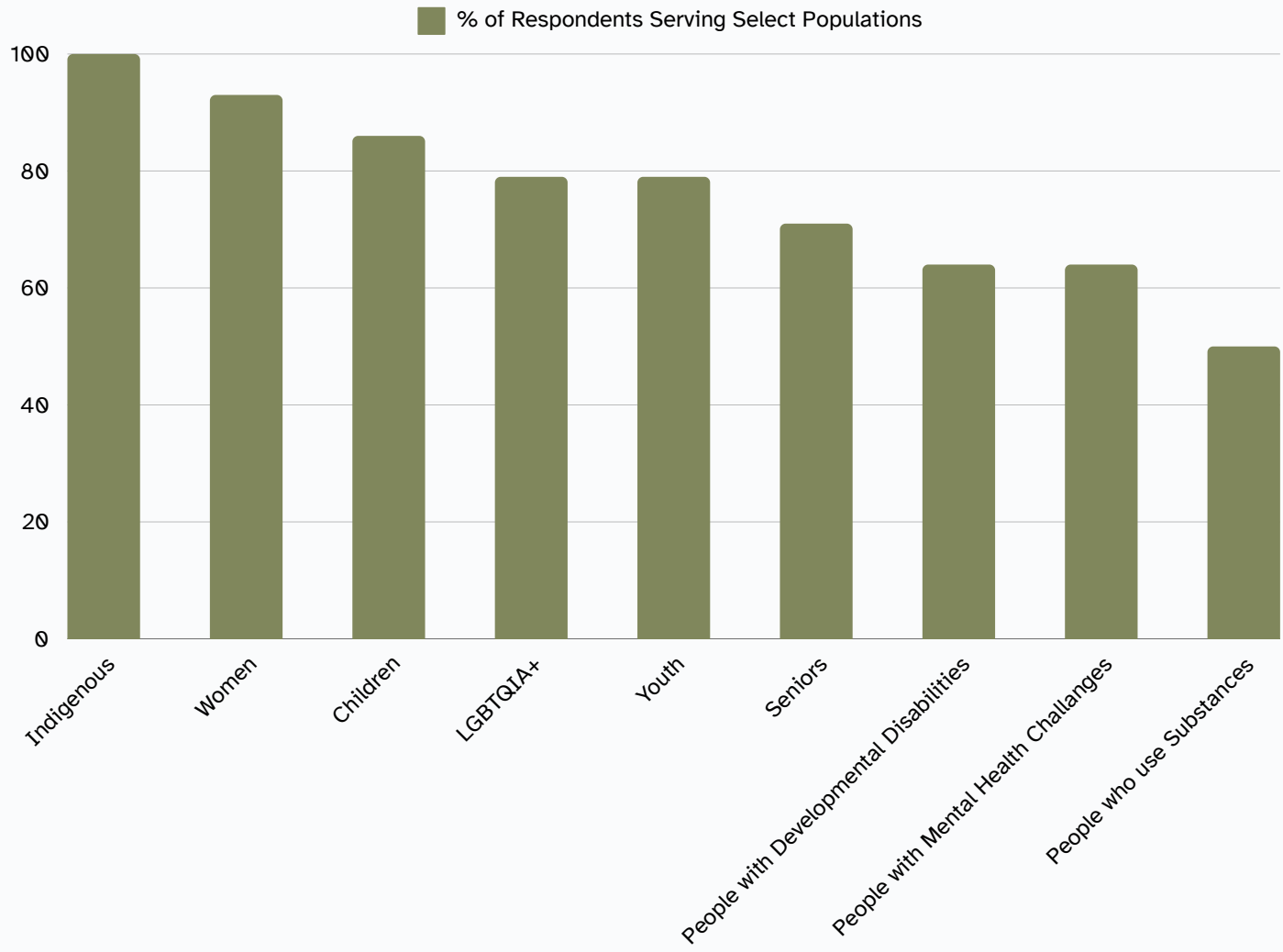
The survey asked participants to identify all housing and homeless services provided at their organization. The following was reported:

- Homelessness services (64%)
- Subsidized housing (57%)
- Peer support (53%)
- Rent supplements (50%)
- Harm reduction (47%)
- Supportive housing (43%)
- Women's Transition Housing (35%)
- Youth supports (35%)
- Overdose prevention (33%)
- Shelter (15%)



When asked who the client population is in their housing and homeless services (check all that apply), participants reported the following:

- Indigenous (100%)
- Women (93%)
- Children (86%)
- Youth (79%)
- Seniors (71%)
- Two spirit people and LGBTQ+ (79%)
- People who use substances (50%)
- People with mental health challenges (64%)
- People with developmental disabilities (64%)



There is a broad and diverse population served, many with specific program and infrastructure needs. Of note, people who use substances comprise the smallest proportion of priority populations directly served through respondent programs and services.

When asked to estimate how many unique/individual clients are supported in housing and homeless programs, there was a wide range of answers. The smallest reported number was 10 people and largest was 600, with a median (middle) number of 100.

These data indicate significant variation in the type and scale of AHMA member organizations. Some are large with many programs and services in addition to housing. Other organizations may only be involved in one or two housing services (e.g., women's transition housing, rent supplements).

When asked to estimate what percentage of clients were Indigenous, the median response was 87.5%, with a low of 50% and high of 100%. Half of respondents reported 90% or more Indigenous clients.

1.2 Complex Needs Related Funding

The survey asked several specific questions related to complex needs. Complex needs are defined as challenges and considerations related to mental health and/or substance use.

Overall, 100% of respondents have clients with mental health and substance use needs in their programs.

Participants had a wide range of estimates when asked what percentage of clients experience complex needs, ranging from a low of 9% to high of 70%, with a median of 38.5%. Half of this group reported 30% or fewer clients with complex needs, while three participants reported 68% or more.

Survey data indicate that all (100%) respondents have clients with mental health and/or substance use needs in their programs and services. The size and scale of that population varies from moderate to high.

When asked if their organizations provide formal services to support complex needs, 50% of respondents said they support complex needs experienced by clients. A smaller number of organizations did not support complex needs (36%) or didn't know the answer to the question (14%).

What needs or gaps do you have supporting people with complex needs?

There is a large gap between complex care needs and currently available resources and services. As one participant observed, "So many needs. Housing and health have never aligned due to legislation. It's nice to know we are now, at the very least, talking about this openly."

Gaps and needs included:

- Complex care housing: "More effective and sustainable homes for people with complex needs. More supports for complex needs people. More training and staff available for the needs."
- Integrating healthcare and addiction services into housing.
- Policies and funding to support clients who have not yet received complex needs designation.
- Proper training and funding for staff to manage complex needs, not just in designated Complex Care Housing projects, but in all housing and homelessness services in general.
- More specialized, experienced and trained staff.

What support is needed to better serve people with complex needs?

- Specialized training and support services for staff working with complex clients.
- Community Living British Columbia partnership to support diverse abilities.
- Indigenous specific housing for complex needs that presents a new model of care.
- Cultural supports and services, including designated funding for cultural programming.
- Partnerships and communication pathways to engage with mental health and addictions providers and practitioners.

Why are services not able to support people with complex needs?

Five agencies reported that they see complex care clients in their services but are not able to support them (informally or formally). When asked for the main reason why, the answer split:

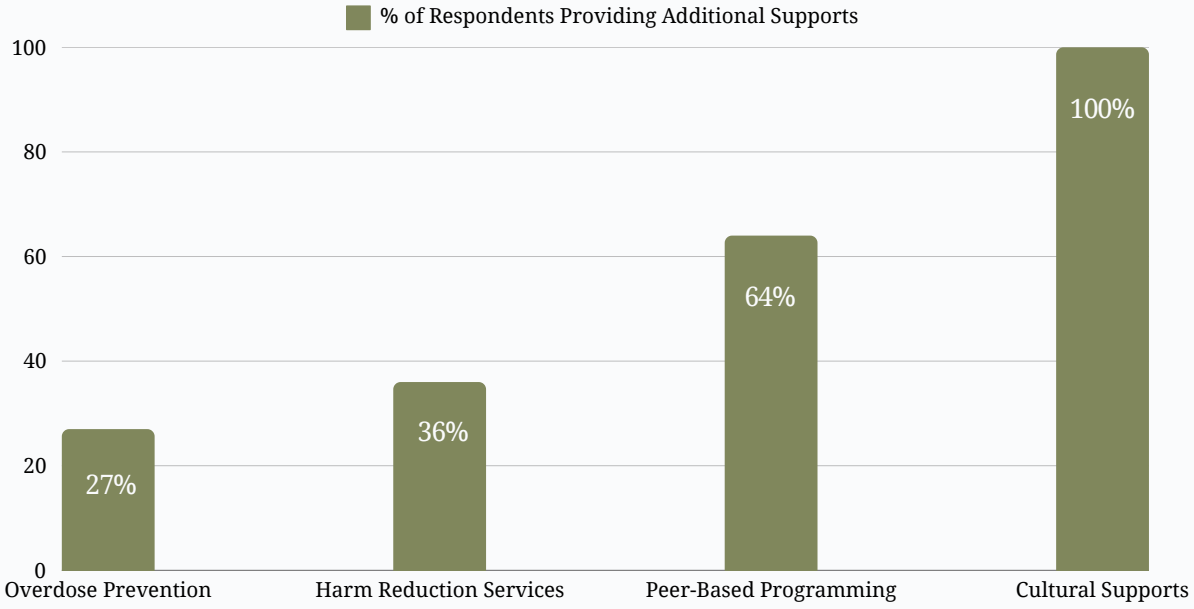
- 50% said they did not currently have capacity and/or resources to support complex care needs.
- 50% said supporting complex care needs was out of scope for their programming.

All respondents replied "Don't Know" if they were planning to support complex care needs in the future. To do so, they report needing new and sustainable resources for dedicated housing and enhanced staff training.

1.3 Additional Supports

Participants were asked about additional best-practice supports available in their housing and homelessness services. Selected best-practice supports included overdose prevention services, harm reduction services, peer-based programming and cultural supports.

While all respondents (100%) report offering cultural supports, a majority also provide peer-based programming. Less than half of organizations provide harm reductions services, and less than one third (27%) provide overdose prevention services.



When asked what organizations need to continue or enhance the selected additional supports (open-ended), respondents noted:

- Long term funding, not just one-time small grants
- Land acquisition and cultural gathering space for ceremony
- Resources and staffing for wrap-around supports
- Resources and partnerships for training
- Safe areas to provide these supports
- Connections with Elders

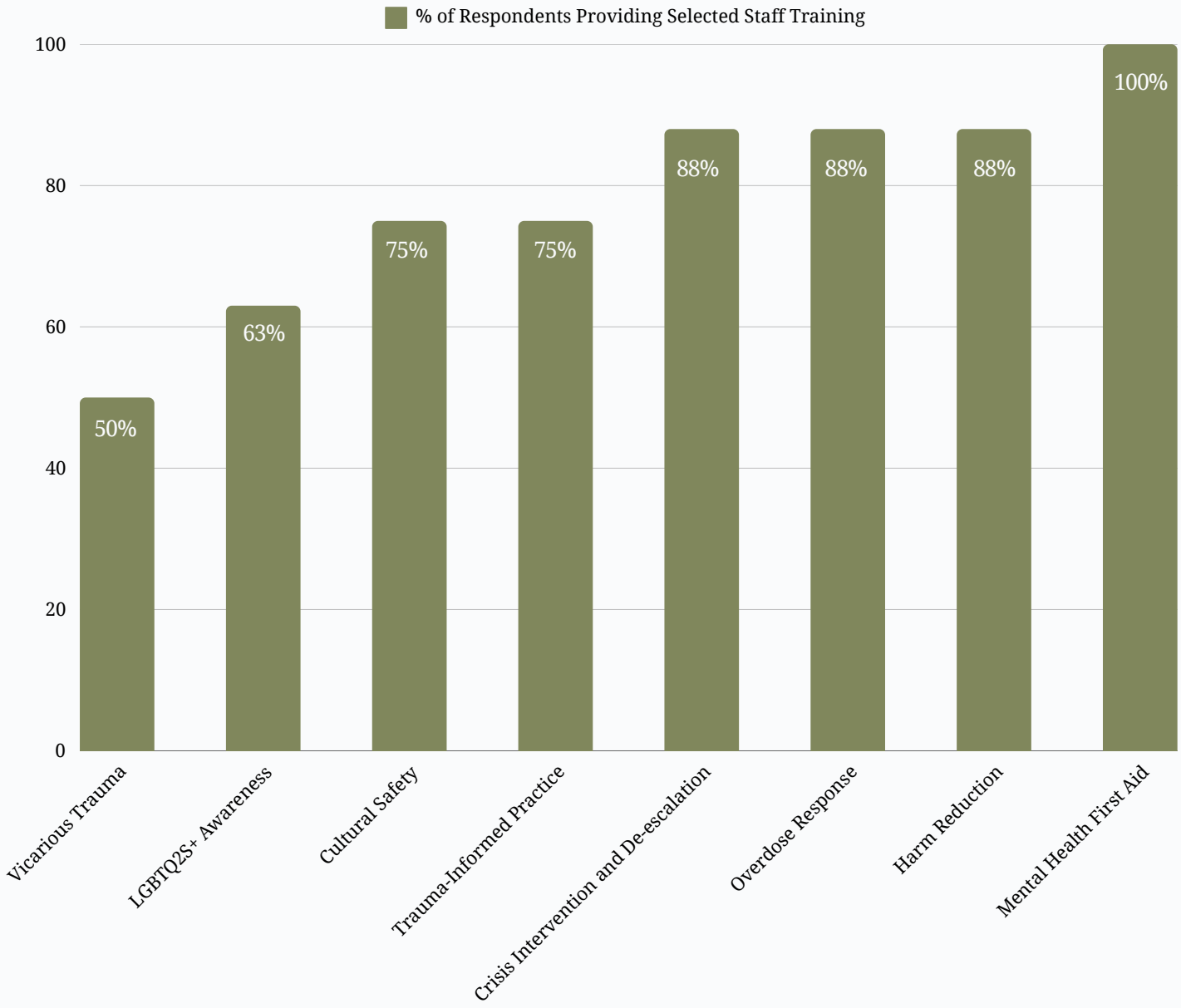
When asked what challenges organizations face in providing these supports (open-ended), respondents noted:

- Staffing shortages
- Safety and security challenges resulting from staffing shortages
- Limited availability of Indigenous staff
- Lack of resources and funding for staff training
- Funding shortfalls
- Unsustainable, time-limited and one-time funding programs
- Discrimination and racism
- Intergenerational trauma
- Addictions
- Lack of equitable partnerships
- Lack of available Elders and Knowledge Keepers for program participation

As described by one respondent, “Elders, especially those from the territory, are already extremely busy so it is continually challenging for us to keep Elders coming in consistently.”

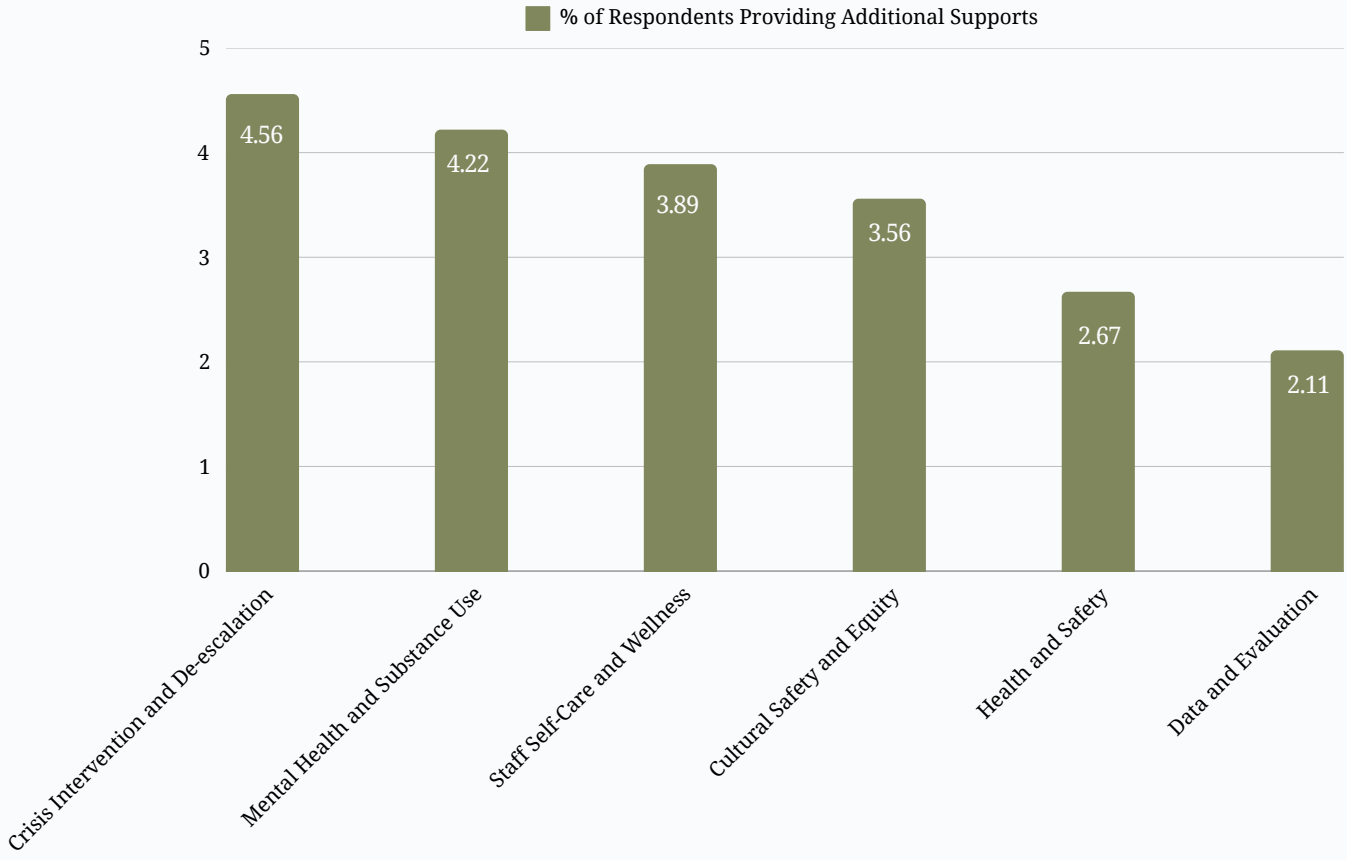
1.4 Training and Capacity Building Needs

The survey asked respondents to identify training and capacity building opportunities that are provided to staff at their respective organization. A note of caution with these results: because training is available does not mean that all staff at an organization are trained or that related services are provided by the organization.



Participants were asked to rank training priorities in relation to client programs and services. A score was created out of six, with a higher score indicating priority.

The top training priorities were (1) crisis intervention and de-escalation (2) mental health and substance use and (3) staff self-care and wellness.



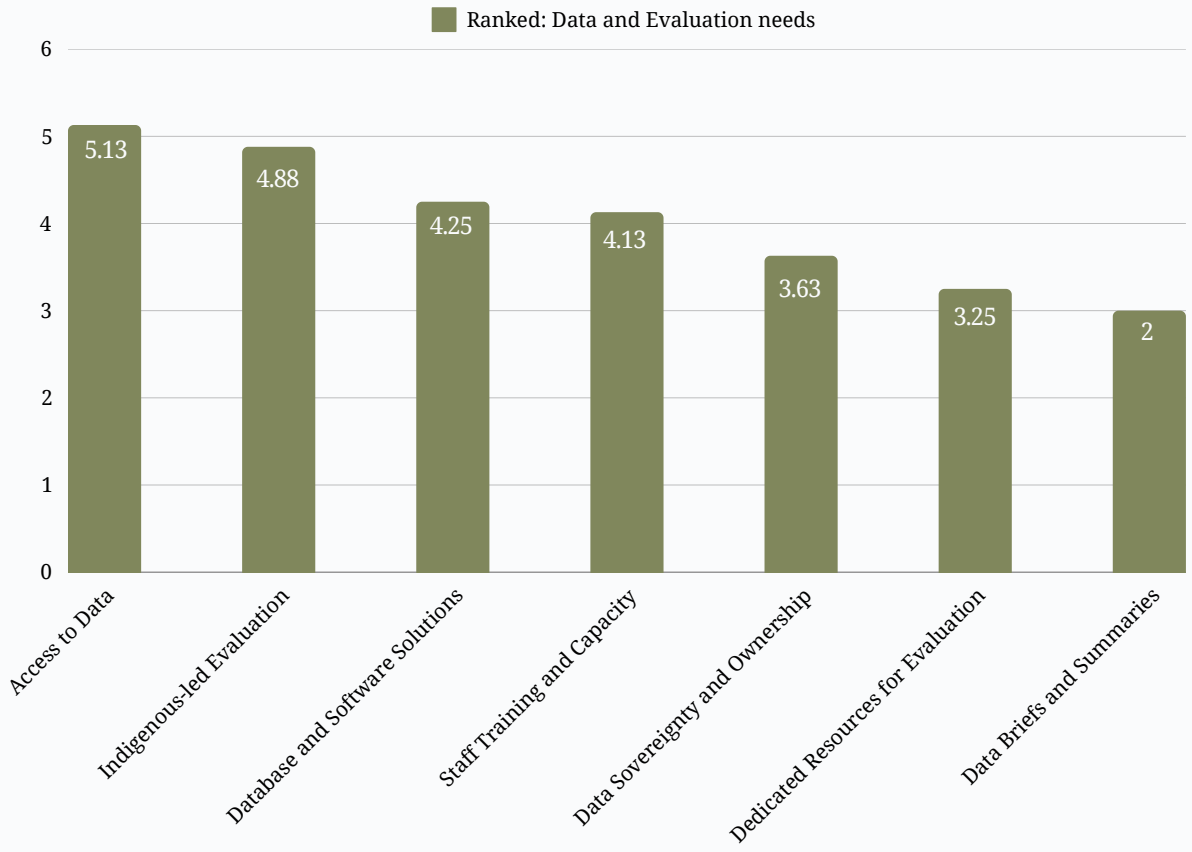
When asked about additional training needs (open-ended question), respondents shared:

- *It's very hard to rate these trainings as they are all high priorities*
- *Operational training for tenant relations roles and responsibilities*
- *Dispute resolution processes*
- *We have nothing in place for any of the above*
- *My staff are new and would benefit from all training right now*
- *It hasn't been easy since COVID to retain staff who have training, so it is all necessary right now*
- *Rental Tenancy Officer training*
- *Indigenous Support Worker certification*

1.5 Data and Evaluation Needs

Participants were asked to rank current data and evaluation needs. A score was created out of seven, with a higher score indicating priority.

The top data and evaluation needs were (1) access to data and (2) Indigenous-led evaluation.



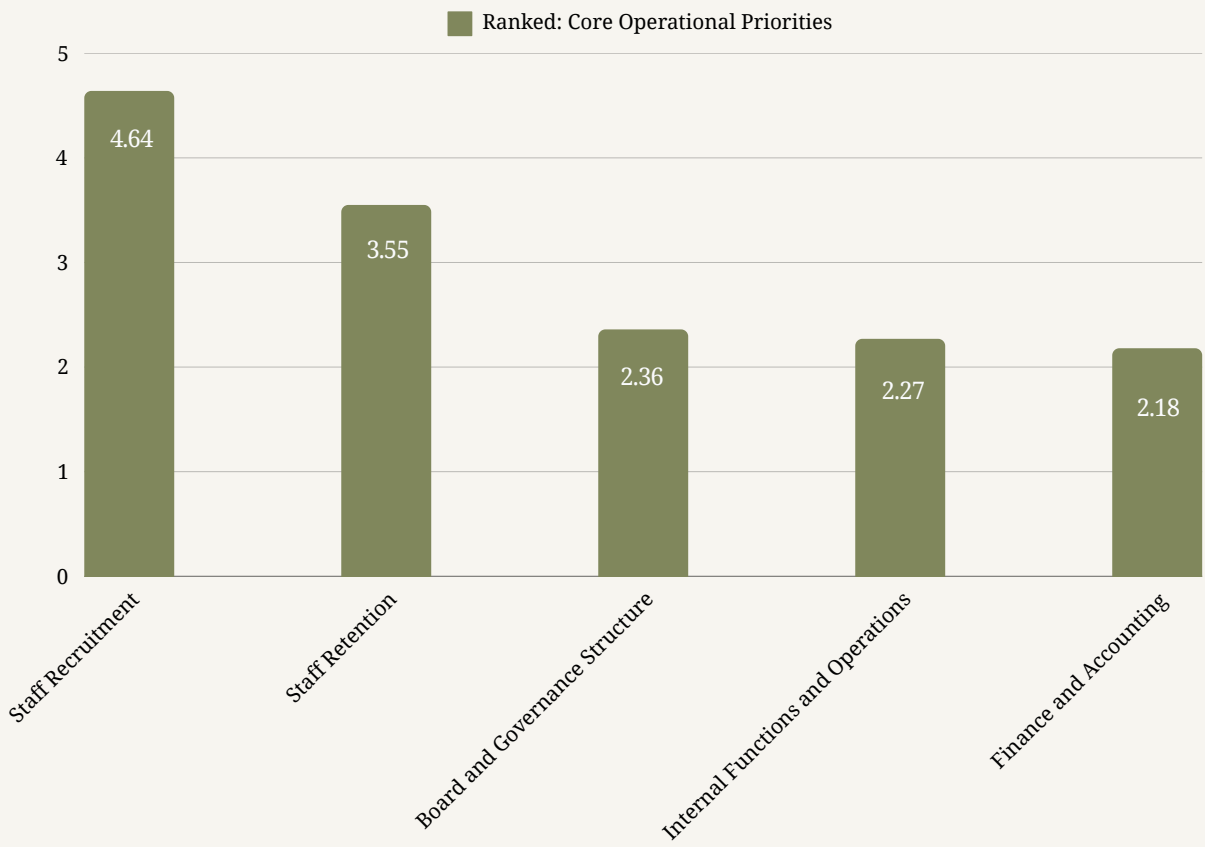
When asked to describe potential supports to address data and evaluation needs, the following open-ended responses were provided:

- *Where would data be held?*
- *Access to HIFIS in our system*
- *Purchased software, not subscription based*
- *Consultant dollars*
- *A program to capture tenant data*
- *A program to manage a waiting list in a transparent way, with change tracking management*

1.6 Operations and Service Delivery Priorities

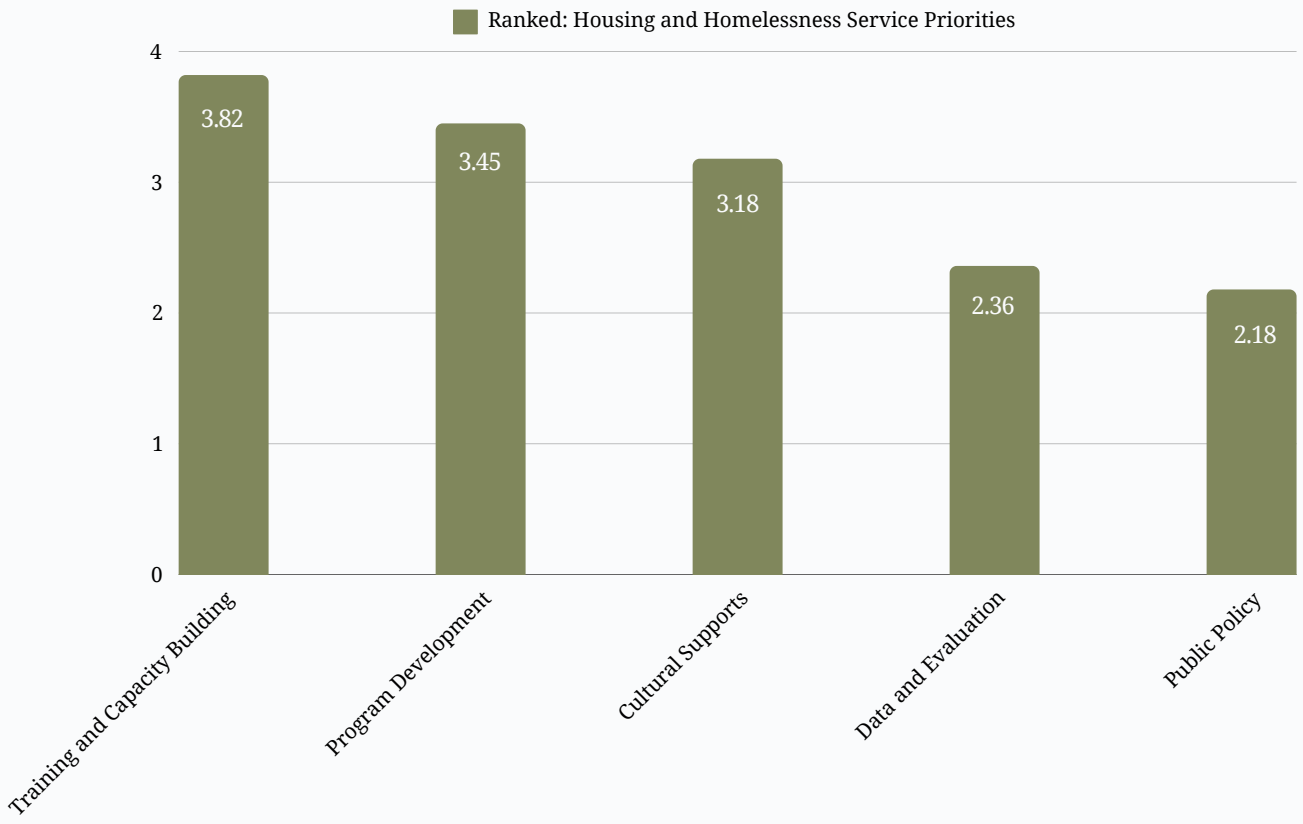
The Survey asked respondents to identify current priorities related to core operational functions within their respective organization. Participants were asked to rank core operational priorities. A score was created out of five, with a higher score indicating priority.

The top core operational priorities were (1) staff recruitment and (2) staff retention.



The survey asked respondents to identify current priorities related to housing and/or homelessness service priorities. Participants were asked to rank core organizational priorities. A score was created out of five, with a higher score indicating priority.

The top two housing and homelessness service priorities were (1) training and capacity building and (2) program development.



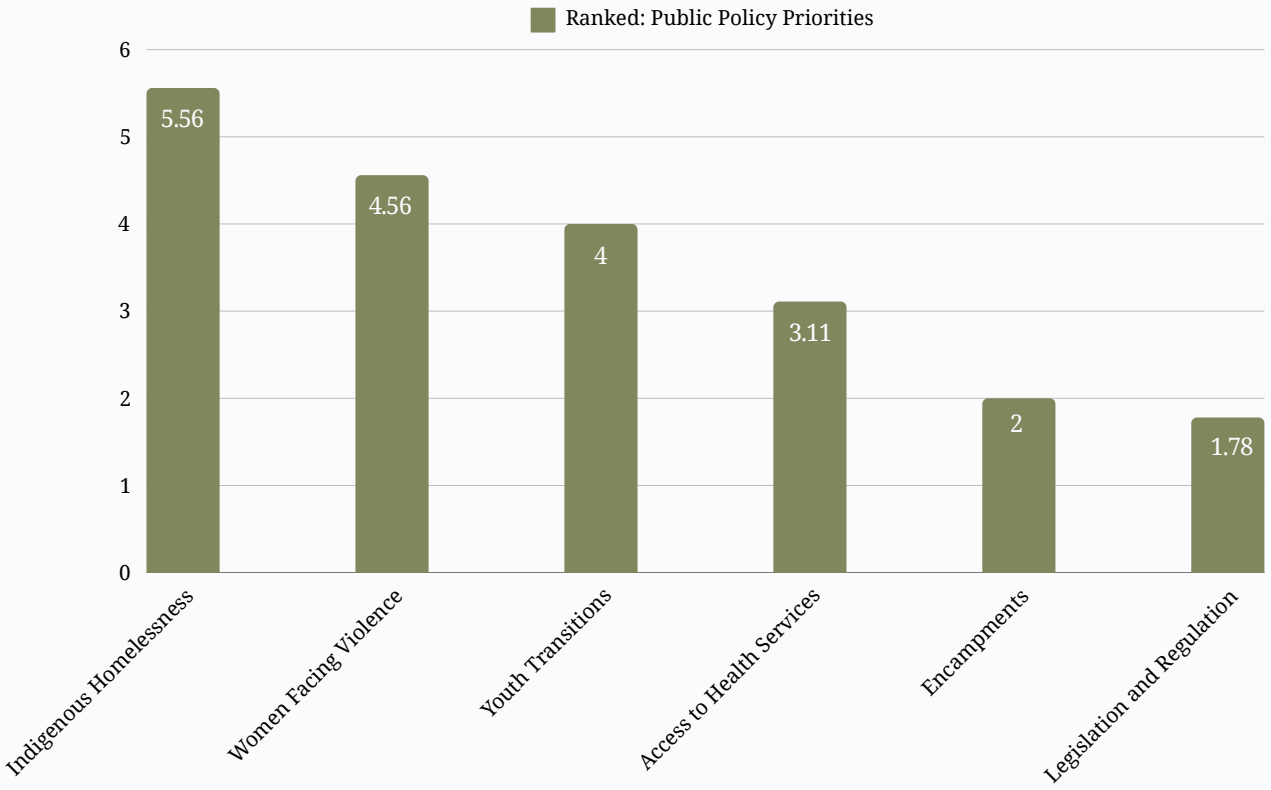
When asked to describe what supports are needed to address identified priorities, the following open-ended responses were provided:

- *Higher wages and benefits*
- *Access to health training*
- *Funding, tools and resources*
- *Mentorship*
- *Time and staff*
- *Not sure outside of funding at this time*
- *Funding and housing to hire from outside our community. Lack of rental unit's makes it difficult for us to find trained staff from outside community. Staff housing would enhance our programs.*
- *Shared resources and data*
- *Cultural structured programs that can work outside business hours*
- *All supports, best practices and suggestions for programs*
- *Equitable funding to support staff*

1.7 Public Policy Priorities

The survey asked respondents to identify key public policy issues in their community related to housing and homelessness. Participants were asked to rank the importance of selected public policy issues. A score was created out of six, with a higher score indicating priority.

The top public policy priorities reported were (1) Indigenous Homelessness, (2) Women facing Violence and (3) Youth Transitions.



Additional public policy needs identified in open-ended responses include diverse housing and assisted care, complex needs and complex care housing, and the United Nations action on the rights of people experiencing homelessness.

When asked if respondents' respective organizations are currently involved in any local or regional public policy initiatives:

- 30% responded "Yes"
- 30% responded "No"
- 40% responded "Don't Know"

Respondents who were involved in public policy initiatives noted areas of focus including encampment bylaws and bylaw enforcement. When asked to describe what could help support public policy needs, the following open-ended responses were received:

- *Comparative data for rural communities*
- *Inclusion*
- *Relationship building*
- *Staff positions and capacity dedicated to policy work*
- *Government regulation and rent caps*
- *Developing a compilation/resource of municipal and law enforcement policies to guide advocacy initiatives and activities*

Section 2: Interview and Site Visit Results

2.1 Participant Profiles

Programs and services provided by AHMA members include affordable housing units, homeless shelters, transition homes, supportive housing, and assisted living facilities. Many AHMA members also offer support services including homelessness prevention, parenting skills, mental health programs, and substance use support.

During interviews and site visits, respondents were characterized by variety in the size and scope of services provided, including:

Large organizations with specialized housing focus that rely heavily on BC Housing for funding:

- Typically apply for supplemental funding outside BC Housing for other needs (e.g., mental health, evaluation), with varying success.
- Focus is often on managing assets, buildings, and tenants.
- High staff burnout and turnover is common due to capped budgets and limited access to alternative funding.

Friendship Centres with many staff and diverse clients:

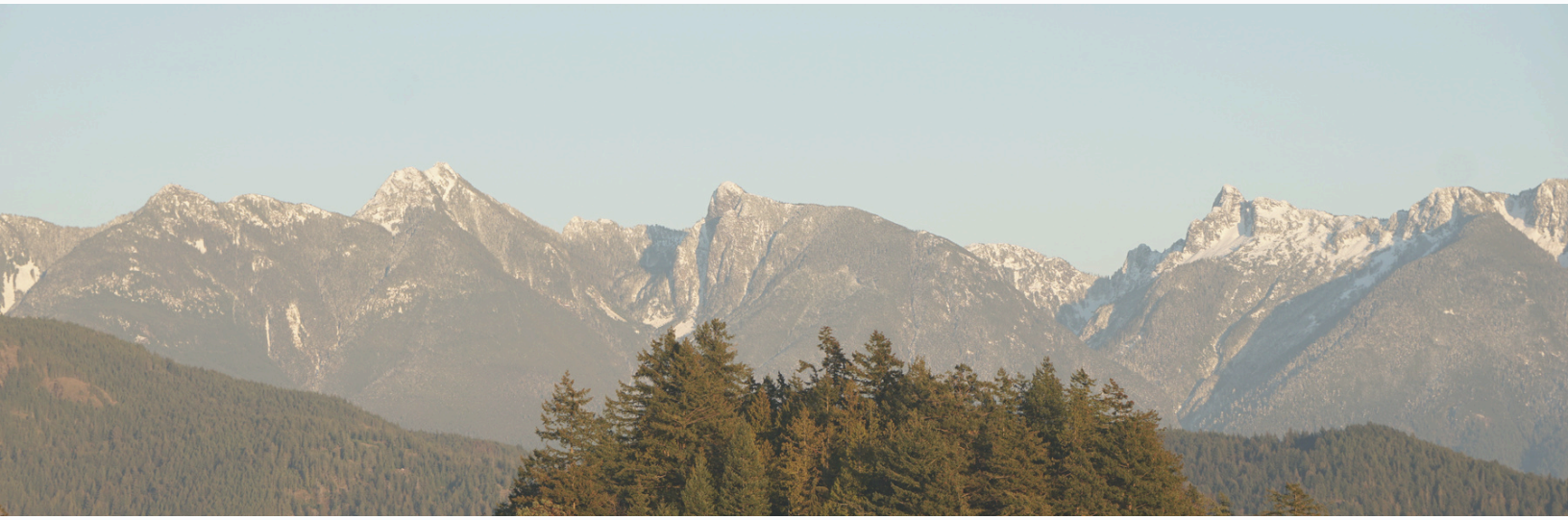
- Housing and homeless services are one part of a broader portfolio that includes services such as childcare, cultural supports, arts/recreation, employment services, basic needs.
- Typically have access to more diverse funding streams, cultural supports, and training options.
- Not overly reliant on BC Housing for funding.
- Typically exist within a wider network of other Indigenous services, partners, and stakeholders.

Organizations in smaller rural and northern locations:

- Often face difficulties trying to maximize impact on small budgets and limited staffing.
- Staff recruitment and retention can be particularly challenging in some locations, especially if dependant on BC Housing for funding.
- Limited access to other services and trusted partners.
- Organizations may be the only Indigenous-led organization in the area and feel compelled to extend beyond existing resources and capacity.

Smaller housing/homeless organizations that focus on one or two programs:

- Specialized focus and expertise in certain program areas (e.g., women fleeing violence, rent supplements).
- May be challenged to incorporate other client experiences (e.g., complex care, overdose response) or expand into new areas.



2.2 Complex Needs Related Findings

The following section outlines interview and site visit findings related to complex needs, defined as mental health and substance use challenges.

Organizations become involved in addressing complex needs out of necessity

Participants consistently reported feeling they have "no choice" but to support people with mental health and substance use issues, despite a lack of adequate resources. As one participant shared, "We are first responders. We can't look away." Participants reported that they do their best to support unmet needs, but in most cases do not have resources to provide clinical and medical services. We heard many variations of this sentiment, including:

- Complex needs are seen as an inherent part of the work in the sector; "a necessity not a choice"
- Organizations regularly observe people with complex care needs ignored and discriminated against in their communities
- Mental health has been a significant challenge among clients for many years; only recently has the organization been able to develop partnership with the health authority.

Staff lack adequate experience and training to support people with complex needs

With a few exceptions, frontline staff involved in supporting individuals with mental health and substance use issues lack necessary clinical experience, training, and capacity. Common roles for frontline staff involved with complex needs include outreach workers, property managers, tenant support workers, custodians, and peer workers. Many staff are not properly trained to deal with complex needs beyond basic interventions such as overdose response or basic first aid. There is a limited pool of subject matter expertise and professional staff engaged in the sector, which limits opportunities and operationalization of new programs and services.

In most cases, organizations do not have staff with specialized mental health and substance use training, in no small part because they operate on small budgets with limited resources to recruit, retain and train skilled staff. As a result, staff often face challenging and potentially dangerous situations without the skills and experience to manage them appropriately. Consider this anecdote from a housing provider:

> "Staff are traumatized, for example, trying to revive someone from an overdose. One time when a tenant overdosed and staff discovered them, they tried to revive with CPR for 45 minutes. Staff ended up on medical leave and eventually resigned. They had PTSD. Without proper training, or the stomach for it, it's difficult for them to be strong."

Other participants also reported negative impacts on staff:

- "They can't look away. If they don't address the issue or client, and just try to ignore it, there is often a greater risk to safety. If people are using substances and not addressing it, that's a safety issue."
- "Tenants were hiding needles in their room, or disposing inappropriately in the garbage, to avoid the issue and appear sober. But this is very dangerous to custodial staff."
- Another participant said they can't accept clients with serious mental health or substance use issues because their staff can't safely manage these clients and they don't have external partnerships to ensure they would be supported.
- Another said they have few formal supports for people during outreach. People come to them for help, but can't house them, so they try to support them with referrals.

A common experience among respondents is deciding between accepting a complex tenant/client although they lack adequate human and organizational resources to provide support, or turning away someone who is unlikely or unable to access critical support elsewhere.

Complex needs can negatively impact the safety of other clients/tenants

Organizations who participated in our interviews often view themselves as a "last resort" for people with significant mental health and substance use issues. Without adequate resources to provide specialized services, staff and other tenants are negatively impacted. Consider this anecdote:

> **"We keep seeing the same cycle – call police or Car 87 for incessant screaming from tenant – but if they don't meet criteria under the Mental Health Act then their hands are tied. Cycle repeats, maybe until it crosses a line (e.g., tenant jumps from the roof). It's very sad. It impacts the quality of life of other tenants who have a right to safety and not disruption. We must balance others' rights to safety and security."**

Other safety and security issues that emerged from interviews include:

- Ongoing physical safety and security issues for staff and tenants.
- Lack of access to mental health diagnoses and treatment, which means staff are unaware of the specific mental health issue and how problematic behaviours could be best addressed.
- Substance use can bring other safety issues into the building, such as organized crime, drug dealing, gang violence and exploitation. It is challenging for police to respond effectively.
- Impact on tenants can be especially adverse for certain vulnerable populations i.e.) women fleeing violence, people in recovery, or families and children. Programs and buildings were not designed to have people with high acuity and complex needs in the same physical space as some vulnerable populations.
- Tenants with complex needs can refuse services and treatment or may be on no-service lists with other agencies. The result is that underlying health needs are not met and there are no opportunities to transition to more appropriate housing services.
- Security is an increasingly urgent concern for some members, especially for vulnerable populations like seniors and families. Some organizations are investing in security features to increase safety, but funding for security enhancements may be limited and prohibitive.
- The integration of supportive housing units and family units within a single building can create tensions and conflict.

The housing continuum does not adequately support complex needs

All participants reported clients with complex needs who are not provided access to the specialized services they require. As one participant reported, "There is nowhere for them to go, it's very discouraging." We heard many variations of this experience:

- Clients with undiagnosed mental health and substance use issues regularly living in inappropriate housing (e.g., market housing, subsidized housing)

- A lack of wraparound support across the housing continuum means that many housing providers are not able to meet the needs of their tenants. They often operate more as building managers than service providers.

- Some organizations are re-evaluating their involvement in supportive housing programs as they are not well positioned to support the increase in complex needs with current resources levels.
- There are limited, or ineffective, specialized access pathways to health and mental health services within housing. Providers report that they must enter the queue in clinics and hospitals like everyone else.

- Health authorities are slow to establish partnerships with housing providers to create culturally safe and low barrier services that can address the overrepresentation of Indigenous people.

- There is limited accountability and transparency across the housing continuum for complex needs clients within BC Housing. For example, one provider noted that if a small fire occurs there is an immediate incident report and preventive action. On the contrary, nothing happens when an overdose occurs. Overdose is considered a normal, everyday event without any further follow up, action planning or urgency.

- Indigenous people face many barriers to diagnosis including a lack of cultural safety, systemic discrimination, inadequate records management and lack of accountability for follow up care. In some cases, individuals can't access specialized services without a diagnosis.

- Some new BC Housing programs have requirements for safer consumption spaces, but no additional resources are provided to meet this requirement. Housing providers take significant risks without the necessary resources to implement required policies, procedures, staffing and training requirements.

Harm reduction services are limited

As survey results confirm, uptake and delivery of harm reduction services within respondent organizations is limited. Often, harm reduction services emerge in response to an urgent need to support clients using substances, experiencing overdose and fatal drug poisoning. Throughout the interviews, respondents described varying levels of openness and readiness to implement harm reduction services. Some organizations describe fully integrating harm reduction into all services. Other organizations have "zero-tolerance" policies regarding substance use but expressed interest in learning more about Indigenous approaches to harm reduction to best support client wellness.

2.3 Organizational Needs and Gaps

Respondents identified gaps, needs, and challenges within their organizations, communities, and the broader housing sector.

Organizational needs include training and capacity gaps, staff recruitment and retention, data and evaluation challenges, land and financial resources.

Contextual challenges within communities and the housing sector also affect organizational ability to provide adequate services to meet client needs. This includes gaps in health services, detox and treatment, corrections reintegration services, supportive housing, and a lack of safe housing for priority populations.

Training and Capacity

AHMA members interviewed offer a variety of training to their staff, while balancing limited or non-existent training budgets, as well as challenges with availability, scheduling and coverage of an already limited number of staff. Respondents identified training needs related to mental health and substance use support for clients, staff wellness, and building administrative and asset management capacities. However, in many cases coordination and expenses are prohibitive.

Primary categories of training requested were:

Mental Health and Substance Use (Harm Reduction, Overdose Response, Naloxone administration, Trauma-Informed Practice, Mental Health First Aid)

Crisis Intervention and De-escalation (Violence Prevention, Non-Violent Crisis Intervention, Conflict Resolution, ASIST Suicide Prevention)

Health and Safety (First Aid and CPR, Medication Management, Food Safe, WHIMIS)

Staff Self-Care and Wellness (Vicarious Trauma, Lateral Violence, Building Resilience for Frontline Workers, Mindfulness-Based Stress Reduction)

Cultural Safety and Equity (Indigenous Cultural Awareness, Cultural Safety Training, LGBTQ2S+ Awareness, Equity, Diversity and Inclusion)

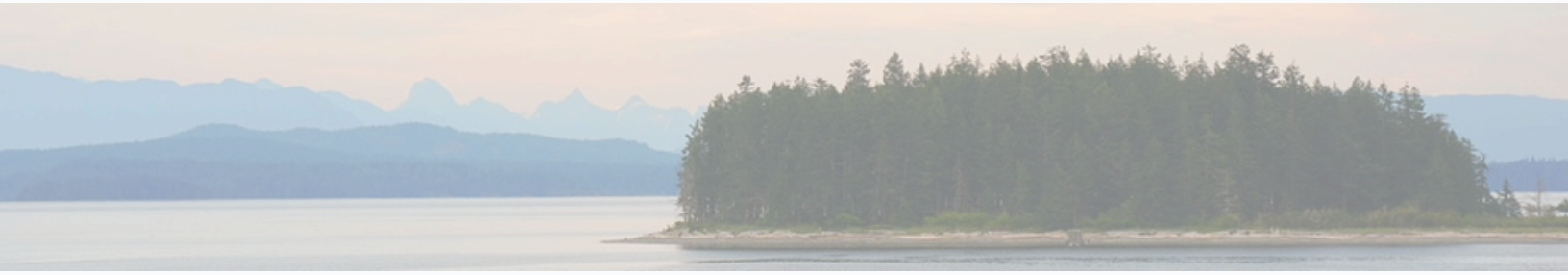
Data and Evaluation (Data Privacy and Security, Data Management, Indigenous-Lens Evaluation)

Fund Development (Grant Writing, Requests for Proposals)

Asset Management and Maintenance (Property Management Software, Asset Planner, asset condition inspections)

Tenant Management (Residential Tenancy Act, landlord and tenancy issues: evictions, overdue payments, responsibilities, bylaws, and evictions)

As some AHMA members are larger organizations with access to training resources, and others are small societies with limited financial capacity for staff training, there is a diverse set of needs and available resources. For example, some members can offer Mental Health First Aid and Non-Violent Crisis Intervention training, while others cannot cover the costs of these certifications. Similarly, many organizations note staff training requirements described in Operating Agreements (e.g. Food Safe, First Aid), but lack budgets to complete and renew staff certification.



Recruitment and Retention

Most participants highlighted issues with staff recruitment and retention, particularly for Indigenous staff. Members face difficulties in filling staff positions across departments, from front-line staff and social workers to maintenance staff, administration, and management.

Many respondents cited low salaries and high workloads as major contributors, with staff leaving the sector for higher-paying jobs or lower stress workloads. With staff leaving, there are additional time and financial costs for the organization to onboard and train new staff. Additionally, with staff already at capacity, important organizational planning and growth (i.e. program development, policy advocacy, partnerships development) may be de-prioritized to keep daily operations and basic services running.

Program administration costs are growing rapidly due to the quantity and acuity of individuals requiring case management and support services. A smaller number of housing and homeless service staff are supporting a higher number of complex cases than ever before, resulting in negative impacts to staff, clients and other programs.

Members identified the following needs to address recruitment and retention challenges:

- Increased funding for staff remuneration
- Dedicated funding to train, certify and upskill new recruits
- Professional development and wellness programs for existing staff

Data and Evaluation

Participants identified limitations with data collection, management and access. For many organizations, data collection is focused on reporting to funders, financial compliance, and quality assurance for buildings and assets. Client-level data analysis is often made inaccessible by the mandatory use of funder-owned databases, a lack of funds to purchase proprietary data management systems, and a lack of staff capacity and skill to collect and analyze data.

Members interviewed were interested in:

- Access to training and capacity support around data management and evaluation
- Database and software solutions
- Data sharing and pooling of data among AHMA members
- Collaborative initiatives with other service providers, funders, and government bodies in relation to data collection, management and access

Land and Financial Resources

Participants identified land and financial resources as a gap in their ability to provide services needed in their communities. Some identified the need for land ownership to successfully apply for funding. Others noted limited opportunity for smaller organizations to successfully compete with larger organizations for new funding opportunities.

To address these gaps, respondents identified the following needs:

- Assistance in land acquisition
- Advocacy for changes to government funding requirements and RFP processes
- Resources to upskill staff in grant writing and fund development

Health Services

For many AHMA members interviewed, a lack of access to health services was identified as an impediment to providing holistic housing support. Waitlists for mental health and substance use services are very long, primary care is difficult to access, and shelters often send clients to the emergency room with limited follow-up and mental health support.

As one respondent described:

> "As no medical information is accessible about tenants, we may not know about medical issues until something manifests into a larger problem - like a heart attack. Complex Care Housing is on to something, as it would help to identify medical issues. Rather than just guessing that perhaps tenants are in pain or self-medicating, Complex Care health professionals could diagnose and prevent these issues. In a shelter, clients are so often sent to the hospital - it's a revolving door. At hospitals, care is not consistent or regular - important things are being missed. It is devastating to families - one x-ray can save a life."

Respondents identified the Complex Care Housing model as a step in the right direction to addressing these issues, with built-in support for mental health and substance use, and regular access to health care professionals.

Substance Use Detox and Treatment Services

Respondents described substance use treatment and detox programs as major service gaps in their communities. As one member described, clients must wait three weeks to access services and the client may no longer be ready or available when a bed is open. Alternately, when the client is ready, beds are no longer available. Clients who do access a bed are often discharged without a housing plan and left un-housed after treatment.

Respondents would like to see a detox and treatment system that is more responsive to the realities of their clients, where beds can be accessed when clients are ready and where discharge includes a housing plan.

Corrections Reintegration

Respondents also identified discharge from corrections as a service gap in their communities. In many cases, individuals are released from corrections without a housing plan. In some cases, a lack of housing has led to a breach of probation and a return to corrections.

Some members are working with local corrections facilities to connect with inmates before release to identify individual needs and develop a housing plan. Respondents would like to see more reintegration programs from corrections, with dedicated funding, resources and support.

Supportive Housing

Respondents identified challenges within the supportive housing model, including a lack of wrap-around support, gaps in services addressing overdoses and the toxic drug supply, and supportive housing policy issues.

Respondents noted that clients within supportive housing are often referred to outside services that are not appropriate for their needs, don't build accountability or relationships, and don't move with clients if an individual situation changes. Members felt that the services for opioid poisoning and overdoses are not sufficient within supportive housing, that services do not balance the dignity and independence of clients with harm reduction and emergency needs, and that there are simply not enough resources and funding available.

As one respondent described:

> "When clients overdose, nothing happens. There is no inquiry, investigation, or backlash. If a client sets a fire, there is a lot of attention and backlash. The building has controls in place to prevent fires and improve safety. With overdoses and opioid poisoning, there aren't the same controls or support: there aren't questions about what happened or why, or how to improve safety."

Respondents also identified policies within the supportive housing model that act as barriers for both clients and service providers. As supportive housing falls within the Rental Tenancy Act (RTA), there is often a balancing act between managing tenancies and providing compassionate housing care. For example, when clients are unable to pay rent, service providers must balance compassion for clients with financial implications and funder expectations.

Additionally, policies requiring clients to have at least one support worker to access supportive housing provide challenges in cases of worker-client relationship breakdowns, noncooperative clients, or clients not ready to seek or follow up on help.

A respondent described the situation as follows:

> "In supportive housing, clients must have at least one support worker. Problems often start when clients refuse to seek help or don't cooperate with the support worker. If clients end up at the hospital, and it is not communicated to the support worker, the health information will not be recorded. The housing provider may try to engage with the client's health worker to follow up on health needs, but staff often face health duties that are outside their training and pay grade - for example, cleaning up and managing incontinence."

To address these challenges and gaps, the following needs have been identified:

- Resources and funding for integrated wrap-around services
- Resources and funding for opioid poisoning and overdose services
- Advocacy for a review and redevelopment of supportive housing policies

Safe Housing for Priority Populations

Respondents highlighted the need for safe housing for four key populations within their communities:

- Families: a lack of 3 to 5 bedroom suites
- Women: need for transition houses (including third-stage housing) and treatment centres
- Seniors: lack of housing with support for aging clients
- Youth: need for housing for youth aging out of care, youth with complex care needs

To address these gaps in housing, respondents suggested:

- Increasing the number and amount of housing subsidies available
- An increase in program funding to staff and operate new and existing supportive housing and complex care housing projects
- An increase in capital funding to maintain existing assets and develop new supportive and complex care housing projects

Section 3: Key Findings and Discussion

The 2022-2023 AHMA Member Needs Assessment underscores the fact that For Indigenous and By Indigenous (FIBI) Housing and Homelessness Service Providers are serving individuals with increasingly complex needs in an under-supported, under-resourced and increasingly complex landscape. Further, FIBI organizations often provide both formal and informal holistic supports that are outside of their organizational capacity and outside what they receive funding to do. There is an overarching need for enhanced support to organizations and the people they serve.

In addition to limited funding for emerging needs and supports required by the populations they serve, FIBI Providers describe a lack of access, coordination and accountability across systems they work in when trying to address client needs. This is especially notable when considering the intersection of housing and health services. Mental health and substance use challenges were a common theme we heard about from members. This is tied to the toxic drug supply and fatal drug poisoning epidemic. It is aggravated by other social and economic factors such as cost of living and inflation, lingering effects of COVID-19, social isolation, climate events, etc. These issues are intersecting and require intersecting holistic responses.

As needs assessment data describe, 100% of respondents have people with mental health and substance use needs in their programs but only half (50%) can provide related support services. Some of these services are formally funded with dedicated staff and budgets, but many are not funded. Instead, services are provided out of necessity and often “off the side of someone's desk”. Respondents who do not provide mental health and substance use supports report that that it is either out-of-scope or they lack adequate capacity and resources to provide specialized services.

Throughout the needs assessment, participants described familiar challenges and shared experiences. For further discussion and understanding, common themes are collected into 6 Key Findings:

1. Equitable Access to Services
2. Safe Services and Pathways
3. Coordination and Accountability
4. Holistic Supports: Informal and Unfunded
5. Harm Reduction and Recovery
6. Staff Recruitment, Retention, Capacity and Wellness

1. Equitable Access to Services

A lack of equitable access to services, partnerships and referral pathways in the community was a common challenge described by participants. One respondent shared how a lack of strong connections in the community makes it difficult to refer clients to necessary services. Another respondent said they can't accept clients with serious mental health or substance use issues because their staff cannot safely manage these challenges and they don't have external partnerships to guarantee individuals would be adequately supported. A common experience for respondents is deciding between (1) accepting a client who they do not have resources to support and could negatively impact client and staff wellness; and (2) turning someone away who is unlikely or unable to access support elsewhere.

Participants described a lack of specialized access or pathways to health and mental health services within the housing continuum. Organizations report that they must enter the queue in clinics and hospitals like everyone else. Health Authorities have been slow to establish partnerships with housing providers that would create culturally safe, effective, and low barrier access for Indigenous clients.

Indigenous people face many barriers to diagnosis including systemic racism and discrimination, trauma histories, lack of accountability and proper records management. However, many specialized services (e.g., FASD, PTSD, addictions treatment) require diagnosis to access services. Many clients are not served by the health system because they don't have a formal diagnosis. Existing access to the health system, as detailed in reports such as In Plain Site: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (2020), does not meet the needs of many Indigenous people with complex health concerns.

Further, there is a critical need to connect people living in rural, remote and northern areas to both primary and specialized health services. Individuals often must relocate to access hospitals, health services and treatment centres. This pattern has adverse social and economic impacts to individuals and communities. Examples include interfering with stable housing and employment, and breakdown of family and cultural cohesion.

2. Safe Services and Pathways

Participants described working within a landscape where systemic racism is prevalent. Indigenous people report facing discrimination, neglect, unsafe situations, abuse and violence when accessing services. According to some respondents, calling for help or referring an Indigenous client to other service providers and systems can have its own risks.

One organization described finding themselves "between a rock and hard place", forced to use policing and hospital services that they know are unlikely to lead to wellness or positive outcomes. "Had a recent case of a tenant they evicted with severe mental health, and they wouldn't leave, lost connection to supports, refused help. They had no choice but to call the bailiff – we don't know where the bailiff brought her."

Additional anecdotes further describe clients facing vulnerabilities from partners and institutions:

- One participant noted concern that people are treated poorly at a partner organization, including being taken advantage of, facing violence, and being placed in unsafe situations.
- Another respondent described many people who are not served adequately, not advocated for, and not able to access services they're entitled to. As a result, the organization is careful to prioritize connecting clients with trusted partners.
- A respondent described needing to "think twice" about calling an ambulance during overdose events. When police are called to the scene, along with EMS and fire services, and there is often a negative interaction, in addition to community blame for "wasting emergency services."
- Another participant described hesitation to bring clients to hospital because "they will be left alone and it's not safe."

3. Coordination and Accountability

Several respondents described a landscape where people are discharged or transitioned among systems with no accountability for follow up to ensure critical supports are provided. Authorities are slow to establish partnerships and special arrangements with housing providers, creating a cycle where vulnerable people are discharged from institutions into homelessness without coordination or consideration for housing.

Participants noted Detox and Treatment programs often discharge patients without a housing plan or connection to housing supports which can lead to homelessness and relapse. Respondents also identified discharge from Corrections as a service gap in their communities. In many cases, individuals are released from corrections facilities without a housing plan. In some cases, a lack of housing has led to a breach of probation and a return to incarceration. Organizations report being "challenged and frustrated", feeling like a "last resort" for highly vulnerable Indigenous people who they are not funded to support.

Participants consistently described a pervasive lack of accountability and coordination across systems including EMS, police, corrections, hospitals, etc. In many cases it is unclear who is responsible for monitoring and follow up to ensure vulnerable individuals receive essential support and services. According to one respondent, "The system is failing Indigenous clients, and no single ministry or organization is accountable."

4. Holistic Supports: Informal and Unfunded

Due to the changing landscape, many emerging and complex needs must be addressed through holistic supports. However, many organizations are providing these services out of necessity, informally and without core funding.

Participants described clients with undiagnosed mental health and substance use issues living in inappropriate housing such as market or subsidized housing. A lack of holistic supports across the housing continuum means that some housing providers are unable to meet needs of the people they work with. One respondent reported feeling "no choice" but to support people with mental health and substance use issues, although they clearly lack the proper resources. Multiple participants described doing their best to support unmet needs, but lacking resources to provide sustainable solutions.

Participants shared many variations of this sentiment, including:

- It is seen as part of the work in housing and homelessness, not by choice, and they need to do it. They observe people with complex needs ignored and discriminated against in their communities, and they are often one of the last places that will help.
- Additional resources for staff or service delivery are nonexistent or time limited by short-term and one-time funding. Seeking new funding opportunities is often done off the side of someone's desk or can't be prioritized due to already overburdened operational capacity.
- One respondent described how new BC Housing buildings have a safe consumption room requirement, but organizations are not provided additional resources for staff and supports. Housing providers take significant risk without the necessary resources to implement required policies and procedures.

Lack of funding for holistic, wrap-around support services means staff are often working outside their roles, skill and experience. Many staff, like custodians or property managers, were not previously expected to address complex needs as part of their daily interactions. Examples include challenging substance use related behaviors, overdose, and untreated mental health challenges. Staffing, training and capacity building resources have not been provided to meet the emerging demand across diverse organizational staff and roles. As a result, crisis response is becoming normalized without necessary resources and for both clients and staff. As one participant shared, "We are all first responders. We can't look away."

Organizations in rural, remote and northern locations often face additional challenges when trying to maximize their impact with small budgets and inadequate staffing schedules. This is especially common if an organization is solely reliant on funding from BC Housing. There is often limited access to other services and trusted partners in small communities. Organizations may be the only Indigenous friendly agency in the area and feel compelled to extend beyond their resources and capacity to support people in need.

5. Harm Reduction and Recovery

Participants described complex intersections and reflections regarding substance use related harm reduction practice. The histories and impacts of colonization and genocide must be considered carefully when working to understand and promote readiness for harm reduction in Indigenous communities and organizations. Participants described community values and safety as important considerations.

Among respondents, harm reduction services often emerge in response to urgent need to support clients using substances and experiencing overdose. Participants described varying levels of readiness to implement harm reduction services. Some organizations fully integrate harm reduction into everything they do and have adapted harm reduction approaches to align with an Indigenous cultural lens. Others embed harm reduction practice within abstinence and recovery-based models.

Examples of participant observations include:

- *Indigenous harm reduction is looking at ways to reduce the harm associated with colonization. All our services are harm reduction based and meeting people where they are at. Not just about drug use, more about safe options, more than just avoiding harm.*
- *This is a philosophical approach and readiness and education awareness, including for our staff and other providers.*
- *Organizational values and alignment with harm reduction are evolving with the changing impact of the drug supply. We notify people, encourage people to use with a friend. We are upfront with people who use drugs in our program.*

While some organizations are not ready to engage with standard harm reduction models, they are interested in learning more. For example, some organizations have zero-tolerance and abstinence-only policies but support client choice about participation in recovery-based programming and recognize the need to train staff on overdose response.

6. Staff Recruitment, Retention, Capacity and Wellness

All needs assessment participants highlighted challenges with staff recruitment and retention. Organizations face difficulties filling staff positions across departments, from front-line staff and social workers to maintenance staff, administration, and management. Many respondents cited low salaries and high workloads as major contributors, with staff leaving the sector for higher-paying jobs or lower stress loads. Organizations describe challenges competing with the private and public sectors, especially for experienced staff with specialized skills required to work effectively with complex needs.

Because staff are working with complex challenges, often outside their role and capacity, staff wellness is an emerging concern. Burnout, fatigue and trauma responses are increasingly common among staff at participant organizations. Training and capacity building resources are essential to maintain staff wellness and support workforce development. As one participant shared, “Staff are traumatized… without proper training, it’s difficult for them to be strong.”

Respondents described limited or non-existent budgets and prohibitive costs as challenges to providing adequate training and capacity building resources to staff. Without adequate training resources, staff are more likely to experience burnout and wellness challenges. In turn, this leads to attrition and turnover which requires even more organizational resources to recruit, onboard and train new hires.

One participant described how over-extended workloads and lack of specialized training results in other organizational functions (e.g. program development, policy advocacy, partnership development) being deprioritized to keep operations and basic services running. On the other hand, it is often difficult to find funding and time to pull staff away from already stretched frontline rotations to have them participate in training. These common issues are particularly challenging in small communities where training opportunities are already limited.

Conclusion

The needs assessment process provided an important opportunity for the AHMA Operations Department to connect with and learn from the experiences of For and By Indigenous Housing and Homelessness Service providers across the province.

This report-back outlines the data, key findings and core themes shared by AHMA members. By gathering and sharing these experiences, our aim is to help shape understanding of the Indigenous housing and homelessness sector in BC and bring evidence to the critical work of AHMA members and our collective goals to advance housing rights for all Indigenous peoples living in British Columbia.

AHMA sends sincere gratitude to all participants who shared their observations, thoughts, strengths and struggles through the needs assessment process.

Appendix A: Methods

The needs assessment used a mixed methods approach, which combines quantitative data to capture broader trends and qualitative approaches to understand the context, interconnections, and experiences.

We used three data sources to collect this information:

1) Online survey (Survey Monkey), which asked 34 questions across a range of topics including demographics, service profiles, training, evaluation, and policy. See Appendix A: Needs Assessment Survey Questions for more detail. The survey was anonymous and confidential. We did not know who filled out the survey unless they consented for later follow up. Survey data was collected from April 2023 to November 2023.

2) In-depth interviews with member organizations were conducted over Zoom. The interviews lasted between 60 to 120 minutes, with opened-ended questions around five key topics:

   - Organizational needs and priorities
   - Complex care and enhanced health
   - Training and capacity building
   - Data and evaluation
   - Public policy

   See Appendix B: Needs Assessment Interview Guide for more details. All participants consented to the process. Interviews were not audio recorded, but recorded by AHMA staff note taking. At least two staff were present in all interviews, with one person leading the discussion and the other taking notes. We agreed to maintain respondent confidentiality and to share findings by grouping into themes. Interview data was collected from June 2022 to August 2023. An honorarium was provided to each organization in recognition of respective time and contribution.

3) AHMA employees performing routine in-person site visits also collected information about needs and services, as appropriate. An abbreviated version of the survey was developed for site visits. See Appendix C: Needs Assessment Site Visit Guide (Short Version) for more detail. Consent processes were followed, including that results would be anonymous and confidential. Unlike in-depth interviews, detailed notes were not recorded. High level themes and observations were documented. Site visits were conducted from July to October 2023.

Participants were recruited in two main ways: (a) AHMA Communications team, using several different approaches to reach members; and (b) in-person meetings and events (e.g., AHMA Gathering, AHMA AGM). Our aim was to include all 48 AHMA member organizations in the process. We did not exclude any members from this opportunity.

Established, best-practice approaches guided data analysis. Survey data was analyzed using basic principles of descriptive statistics in Survey Monkey. Qualitative data from interviews and site visits was analyzed using thematic analysis in NVivo software.

The needs assessment received a satisfactory rate of participation (58%), with 28 participating member societies and 40 individual participants. The table below outlines the number of participants and organizations involved in the findings presented in this report.

Table #1: Number of Participants and Member Societies in the Needs Assessment

Data Source	# of participants	# of AHMA member societies
Survey	14	14[1]
Interview	8	6
Site visit	18	8
TOTAL	40	28

Our methods had several limitations that should be considered when interpreting the results, including:

- Most participants were from leadership positions like Executive Director or Board Member. We had limited participation from frontline staff, although site visits did improve the diversity of staff included in the report.

[1] All surveys were anonymous, so we are unable to determine if survey results overlapped with interviews or site visits. There was no overlap among interviews and site visits.

- We asked members to estimate (to the best of their ability) some data, rather than pull exact numbers from their databases and reporting. This has some limitations but is consistent with best practice methodology.
- The site visits were used as a supplementary data source, since the importance and time given to discussing related needs varied during each visit. This is the obvious limitation of 'piggybacking' these questions into an existing process. Site visits were also limited because detailed notes were not recorded on the visits, only a summary (briefing note) of the themes.
- Regional representation among members was strong. No survey results were collected from the Vancouver Island region, though interviews and site visits from the region were included.
- We did not record and verbatim transcribe the interviews. Conversations were more comfortable for participants, but there could be errors or omissions. Likewise, we may have missed detail and nuance from the interviews without verbatim transcription.
- The number of survey participants was on the low side, and does not represent all AHMA member experiences, which are diverse and varied. Findings only represent those who participated.
- Interviews were limited by video conference (online) technology. It is preferable to conduct interviews in-person as it can improve rapport and communication.

Appendix B: Needs Assessment Survey Questions

Introduction

AHMA is reaching out to you because we want to better understand your needs and improve how we support your work. This needs assessment survey takes about 15 to 20 minutes to complete. Results will be anonymous, and participation is completely voluntary.

What is this survey about? Housing and homeless services. While we know our members are involved in other areas, this survey is specifically focused on your housing and homeless services.

Who should complete this survey? We want to hear from a variety of perspectives across your housing and homeless teams, such as frontline staff, managers, and boards. More than one person can fill this out from your organization.

AHMA will use these results to inform how we support members, strategic planning, and advocacy work. We will share our key findings with members. If you have any questions, please email Bryan (bsluggett@ahma-bc.org), AHMA's Data and Evaluation Specialist.

Background Information

1. What is your role in the housing and/or homelessness sector?

- Outreach worker
- Tenant support worker
- Healthcare professional
- Administrative staff
- Peer support worker
- Manager, Leadership, Executive or Board position
- Other (please specify)

2. What region do you provide housing and/or homeless services within?

- Northern BC
- Cariboo Chilcotin Coast
- Thompson Okanagan & Kootenay Rockies
- Vancouver Island
- Vancouver Coastal
- Fraser Valley

3. What housing and homeless services does your agency provide? Check all that apply.

- Rent supplements
- Shelter
- Supportive housing
- Women's Transition Housing
- Youth supports
- Homelessness services
- Subsidized housing
- Other

4. What client populations do you support in your housing and/or homeless work? Check all that apply.

- Indigenous
- Women
- Children
- Youth Seniors
- Two spirit people and LGBTQ+
- People who use substances
- People with mental health issues
- People with developmental disabilities
- Other

5. How many unique clients did you support last year in housing and/or homeless programs? (estimate is fine).

6. What percentage (%) of your housing and/or homeless clients identify as Indigenous? (estimate is fine).

Supports

We are interested in learning more about four types of support: peer programming, harm reduction services, overdose prevention, and cultural supports.

7. Do you offer these supports to any of your clients? Check all that you currently provide to clients in any program within your organization.

- Peer-based programming
- Harm reduction services
- Overdose prevention
- Cultural supports
- We don't provide any of these supports

8. Do you offer these services within your housing and/or homeless services? Check all that apply.

- Peer-based programming
- Harm reduction services
- Overdose prevention
- Cultural supports
- We don't provide any of these supports

9. What does your organization need most for the continuation of these supports? [open ended]

10. What challenges do you face providing these supports? [open ended]

Complex Care

Complex care refers to people who experience overlapping mental health, substance use and/or other health issues.

11. Do you support clients with complex care needs in your organization?

- Yes
- No
- Don't know

12. What percentage (%) of your clients have complex care needs? (estimate is fine).

13. Are any clients with complex care needs in your housing and/or homeless services?

- Yes
- No
- Don't know

14. What needs or gaps do you have supporting people with complex needs? [open ended]

15. What supports would you need to better serve people with complex care needs? [open ended]

16. What is the main reason you do not currently support people with complex care needs?

- We do not see these clients in our service
- We do not have the capacity and/or resources to support them
- Out of scope (not part of our programming)
- Other reason (please explain)

17. Are you planning to support clients with complex care needs in the future?

- Yes
- No
- Don't know

18. What would you need in place to support clients with complex care needs? [open ended]

Housing Priorities

19. What are your current priorities related to core organizational functions? Rank the importance of these priorities from highest (#1) to lowest (#5). You can either drag and drop or use the arrow buttons. Click N/A if it's not applicable.

- Staff recruitment
- Staff retention
- Board and governance structure
- Finance and accounting
- Internal functions and operations

20. What are your current housing and/or homeless specific priorities? Rank the importance of these priorities from highest (#1) to lowest (#5). You can either drag and drop or use the arrow buttons. Click N/A if it's not applicable.

- Cultural supports
- Data and evaluation
- Training and capacity building
- Public policy - analysis and advocacy
- Program development

21. What support would you need to address these housing priorities? [open ended]

Training and Capacity Building

22. Which of the trainings below are currently available to your housing and/or homelessness program staff? Check all that apply.

- Trauma-Informed Practice
- Vicarious Trauma
- Harm Reduction Overdose Response
- Mental Health First Aid
- Crisis Intervention and De-escalation
- Cultural Safety
- LGBTQ2S+ Awareness
- Other

23. What are your current training priorities? Rank the importance of these priorities from highest (#1) to lowest (#6). You can either drag and drop or use the arrow buttons. Click N/A if it's not applicable.

- Cultural Safety and Equity (ex. EDI, Indigenous Cultural Awareness, LGBTQ2S+ Awareness, Cultural Safety Training)
- Mental Health and Substance Use (ex. Harm Reduction, Overdose Response, Trauma- Informed Practice, Mental Health First Aid)
- Crisis Intervention and De-escalation (ex. Violence Prevention, Non-Violent Crisis Intervention, Conflict Resolution, ASIST)
- Health and Safety (ex. First Aid and CPR, Medication Management, Food Safe, WHIMIS)
- Staff Self-Care and Wellness (ex. Vicarious Trauma, Building Resilience for Frontline Workers, Mindfulness-Based Stress Reduction)
- Data and Evaluation (ex. Data Privacy and Security, Indigenous-Lens Evaluation)

24. Do you have any training needs? Or any topics that you are interested in exploring? Please explain [open ended]

Data & Evaluation

We use the following definitions for this section:

Program data refers to any information about a program that is collected (for example, the # of shelter spaces used or demographic information like age and gender).

Evaluation uses data about a program to monitor and evaluate how it is doing (for example, the % of Indigenous clients in the monthly HIFIS reports).

Data sovereignty is the inherent right of Indigenous peoples to determine the use, access, interpretation, management, and sharing of data that impacts their lives and communities.

25. What are your data and evaluation needs? Rank the importance of these topics from highest (#1) to lowest (#7). You can either drag and drop or use the arrow buttons. Click N/A if it's not applicable.

- Database and software solutions
- Staff training and capacity
- Dedicated resources for evaluation
- Indigenous-led evaluation
- Access to data
- Data briefs and summaries
- Data sovereignty and ownership

26. What type of housing and/or homeless data would be most important? Check all that apply.

- Population-level data
- Needs and gaps
- Information about services
- Organizational information
- More platforms for people with lived/living experience
- Other (please specify)

27. What would help support your data and evaluation needs? Please explain. [open ended]

Public Policy

For AHMA, policy is relationship driven and involves building connections with key decision-makers in government before decisions are made about major policies, legislation, and budget allocations. AHMA does this effectively by communicating our priorities to the right contacts—at the right time; this has proven to be a successful strategy in making change.

AHMA has recently undergone growth in the public policy space to increase our presence at relevant decision-making tables and to ensure that voices of Indigenous Housing providers in BC and their concerns are being listened to and addressed.

We would like to hear about your needs and priorities.

28. What are the key public policy issues in your community related to housing and homelessness? Rank the importance of these topics from highest (#1) to lowest (#5). You can either drag and drop or use the arrow buttons. Click N/A if it's not applicable.

- Youth transitions
- Women facing violence
- Access to health services
- Legislation and regulation
- Encampments
- Indigenous homelessness

29. Are there other housing/homeless policy priorities in your community, not listed above? [open ended]

30. Are you currently involved in any local or regional initiatives aimed at supporting public policy change?

- Yes
- No
- Don't know

31. Please briefly describe the local or regional public policy issues you are involved in. [open ended]

32. What would help support your public policy needs? [open ended]

Thank you!

Thank you for participating!

If you have any questions, please email AHMA's Data and Evaluation Specialist, Bryan at:

bsluggett@ahma-bc.org

Appendix C: Needs Assessment Interview Guide

Introduction

Date:
AHMA site:

Background Information on the Needs Assessment

AHMA is reaching out to our members to do a Needs Assessment. As part of our accountability to you and the recently released "Urban, Rural and Northern Indigenous Housing Strategy," we are trying to improve how we engage with and support your work. We really value your time and feedback. As part of that, we are providing remuneration to your organization for participating today.

This is funded through CCH MMHA

Today, we want to learn more about how we can best support and engage with you. We are not judging or evaluating your services. Topics include:

- Your organizational needs and priorities
- Policy issues
- Training and capacity building
- Data and evaluation
- Complex care

Do you have any questions?

Consent

Our discussion is voluntary. You can stop at any time and refuse any questions. The interview could take up to 2 hours. We are not recording this discussion. Answers will be written as we go along.

The interview is anonymous and confidential. We will not be attaching any direct findings or statements to individual people or organizations. Results will be grouped together to share larger themes and perspectives.

A summary report will be shared with you and our stakeholders involved in Complex Care (they are funding this consultation). Internally, AHMA will also be using the results to improve how we engage with AHMA members.

Do you have any questions?
Do you consent to participate in the interview?

Section 1: Organization

Maybe we can start first with a few questions about your organization.

1. Can you tell me about the range of housing services that you provide? High level

2. Can you tell me about your clients? Please describe the demographic profile of the clients who use your housing services.
   a. Estimated # of unique clients supported last year:
   b. Estimated % of Indigenous clients:
   c. What other populations do you support?

3. Do you support any clients with complex care needs (defined as people with mental health and substance use issues)?

If yes, then ask:
   a. Estimated # of clients (last year) with complex care needs:
   b. How did you get involved in supporting complex clients?
   c. Do you face any needs or gaps supporting these clients?
   d. AHMA role?

If no, then ask:
   a. Reason why:
□ Does not see CC clients [Skip to question 4]
□ See CC client demand, but we can't currently support [Proceed below]

If can't support CC clients, then ask:
   a. What would need to be in place to support CC clients?
   b. Are you planning to support CC clients in the future?
   c. AHMA role?

4. Do you offer Peer- based programming (peer support/navigation/mentoring)?

a. Other Lived Experience initiatives?

b. Strengths/challenges?

5. Do you offer Harm Reduction services - Indigenous harm reduction is looking at ways to reduce the harm associated with colonization.

a. Organizational values/alignment

b. Challenges/Concerns

c. Opportunities/Strengths

6. Do you offer Cultural Supports programs/services?

7. What does Cultural Safety mean to you in your programs/services?

a. Challenges/Concerns

b. Opportunities/Strengths

8. Next, we'd like to learn more about your housing needs, either in your community or agency. What are the most pressing needs and gaps that you face?

a. How can AHMA help you address any of those needs? Please describe.

Prompts:

□ Recruitment/retention

□ Housing investment/capital/funding

□ Data and evaluation

□ Training and capacity building

□ Collective voice and advocacy

Section 2: Training and Capacity Building

Now I'd like to learn more about training and capacity – what you're doing in this area and how we can support you.

9. Current training – What do you provide? Any that are mandatory?

10. What are your training needs – What do you want to provide?

11. Complex care related needs – NVCI, ASSIST, Others

12. How can AHMA help meet Training & Capacity Building Needs?

Section 3: Data and Evaluation

This is the final section. I'd like to ask you some questions about data and evaluation. We'd like to learn more about your data collection and how we can support you in this area.

13. Very briefly, can you tell me about your data collection process? For example, you could describe your in-take process.

a. Staff involved?
b. Databases?
c. Any barriers?

14. One of the things we're trying to develop is culturally safe and appropriate practices. What do you think culturally safe data collection looks like?

a. Do you have any wise practices to share?
b. How do you ask about Indigenous identity in a culturally safe way?

If they have experience with Complex Care clients:

c. What have you learned about data collection or the in-take process with CC clients?

15. I'd like to get a sense of how comfortable your agency is with data. This is not a judgment. Just trying to get a sense of where you are at, knowing that data has never been formally supported with resources and supports.

a. On a scale from 1 (low confidence) to 5 (high confidence), how comfortable is your organization with data? Please explain.
b. Do you have any gaps or needs relating to data capacity?
c. How could AHMA support you?

Prompts:

□ Data sharing and pooling of data
□ Data briefs/summaries
□ Training/capacity support
□ Community of practice
□ Database and software solutions

16. What required reporting (housing only) do you have? Please briefly list programs.

17. Aside from required reporting to funders, do you ever use that data for anything else? If so, please describe.

If no, then ask:

a. Do you have any interest in using the required data you collect for other purposes, such as program improvement and advocacy?

□Yes, has an interest

□ No, don't have an interest

Explain:

b. What would you need to make that happen?

Prompts:

□ Training and capacity building

□ Data analysis and reporting support

□ Database/software solution

□ Community of practice

18. Another important piece we're working on at AHMA is Indigenous data governance and data sovereignty (briefly define). A big part of this work is trying to create principles for how we collect, share, analyze, and report data about Indigenous clients.

a. What is the best way for AHMA and member sites to advocate as a collective?

b. One option could be more coordinated and strategic data sharing and analysis (reciprocity piece – from AHMA to members, and from members to AHMA). Is that something you would be interested in exploring with AHMA?

□ If yes, please describe:

□ If no, please describe:

Section 4: Policy Priorities

Now moving on to some policy questions. For context, AHMA has five policy analysts in the areas of health, housing, homelessness, and Ending Violence Against Indigenous Women and Girls. We want to learn more about the housing issues that you're seeing and what areas of support our policy team can help with.

19. With that in mind, it would be helpful to learn more about your policy priorities around housing. For example, are there initiatives you are trying to advance or committees that you want to join? That sort of thing.

a. What are your most immediate housing priorities in the short term?
b. Among those priorities: do you see any quick fixes or immediate wins?
c. Over the next five years, what do you see as your most pressing long-term housing needs?
d. Any role for AHMA to help support?

20. Are you planning to expand or add any housing services in the next couple of years? Please describe.
a. Are you planning any new housing investments in the next few years? Please describe.
b. Any role for AHMA to help support?

21. Another piece that we want to know about is your external partnerships. How would you describe your relationships with key partners?
a. Do you have any gaps or challenging relationships with partners?
Prompts:
□ Complex care
□ Health authority
□ Coordinated Access
□ FN and Metis service coordination
□ Municipalities
If gaps/challenges are identified, then ask:
b. Is that something AHMA can help with? Discuss.

22. We are trying to strike the right balance between "consultation fatigue" and engaging with frontline providers like you, who provide crucial feedback and experience. What is the best way for us to communicate and keep you informed about our work at AHMA?
a.Preferred format? Prompts:
□Email updates
□Webinars
□One-pagers and briefing notes
□In-person gatherings
□Site visits
b. How frequently do you want to be informed?
c. What level of detail and length are you looking for?

Scale from 1 to 5: Short/High Level (1) to In-Depth/Technical Detail (5). That's all the questions I had.

23. Is there anything else you'd like to add? **Thanks for interview.**
Contact information if they have questions or comments. Our next steps.

Appendix D: Needs Assessment Site Visit Guide (Short Version)

Introduction

Date:

Member site:

What role/position does the person(s) have at the member site?

Background Information on the Needs Assessment

AHMA is reaching out to our members to do a Needs Assessment. We are trying to improve how we engage with and support your work. This work is through our Complex Care Housing (CCH) project.
Today, we want to learn more about how to support your needs best. We are not judging or evaluating your services. Topics include:

- Your organizational needs and priorities
- Policy issues
- Training and capacity building
- Data and evaluation
- Complex care

Do you have any questions?

Consent (verbal agreement)

Our discussion is voluntary. You can stop at any time and refuse any questions. Answers will be written as we go along. The interview is anonymous and confidential. We will not be attaching any direct findings or statements to individual people or organizations. Results will be grouped together to share larger themes.
A summary report will be shared with you and our stakeholders involved in Complex Care (they are funding this consultation). Internally, AHMA will also use the results to improve our support of AHMA members.

Do you have any questions?
Do you consent to participate in the interview?

Questions

Scope – we are only asking questions about housing and/or homelessness supports that our AHMA members provide. Other areas outside of housing/homelessness are not in scope.

1. Do you support any clients with complex care needs (defined as people with mental health and substance use issues) within housing and homelessness services?

If yes: Do you face any needs or gaps supporting these clients? Any role for AHMA to support?

If no: Why? Are you planning to support CC clients in the future? Any AHMA role?

Follow up question (Y/N):
Would your organization be interested in submitting an RFP for new Complex Care Housing projects in the next 6-12 months? This would involve new units with 24/7 wrap around intensive support, including direct health service delivery in a harm-reduction based model.

2. Do you offer peer-based programming (peer support/navigation/mentoring) within housing and homelessness? Please tell us more about that.

3. Do you offer harm reduction services within housing and homelessness? Please tell us more about that, including barriers and successes.

4. What are your data and evaluation needs related to housing/homelessness? Any areas that AHMA can support?

Follow-up: Would you like to connect with the Data and Evaluation team at AHMA?

5. Do you have any Training and Capacity Building needs for staff/employees within housing and homelessness? Please explain. Some prompts include:

- Cultural Safety and Equity (ex. EDI, Indigenous Cultural Awareness, LGBTQ2S+ Awareness, Cultural Safety Training)
- Mental Health and Substance Use (ex. Harm Reduction, Overdose Response, Trauma Informed Practice, Mental Health First Aid)
- Crisis Intervention and De-escalation (ex. Non-Violent Crisis Intervention, Conflict Resolution, ASIST)

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- Health and Safety (ex. First Aid and CPR, Food Safe, WHIMIS)
- Staff Self-Care and Wellness (ex. Vicarious Trauma, Building Resilience for Frontline Workers, Mindfulness-Based Stress Reduction)

Follow-up: Would you like to connect with the Training team at AHMA?

6. Over the next year, what are the main policy priority areas you are working on in housing and/or homelessness?
    a. Youth transitions
    b. Women facing violence
    c. Access to health services
    d. Encampments
    e. Indigenous homelessness

Next Steps:

1. Are you interested in participating in a longer version (1 or 2 hours) of this interview?

2. Needs Assessment Survey

We are very interested in learning more from all your staff. The interview is focused on leadership/executive level experiences, but AHMA wants to hear from all staff about their needs and experiences.