Exemplary Partnerships for Low-threshold Services: The PHS Community Services Society and Vancouver Coastal Health

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Briefing Note

For up-to-date knowledge relating to healthy public policy

Prologue

Some Canadian regional health authorities have fully committed to partnerships with not-for-profit (NFP) organizations for the purpose of promoting healthy public policy. Some are seeking to go further in this direction and others have not yet embarked on this course. This document is part of a series of texts documenting existing partnership practices and analyzing their contributions in terms of public health. The aim is to allow authorities to weigh the benefits of such partnerships for the health of the populations under their responsibility and to determine the conditions for implementing such action.

Specifically, this document describes how the establishment of partnerships between the Vancouver regional health authority and an NFP organization delivering "low-threshold services" made it possible to reach people living with mental illness or substance abuse problems, while at the same time acting on the social and public policy context that, in part, determined their health status.[1]

First, the intervention context and the program of the NFP organization are described. Next, the nature of the partnership between the Vancouver regional authority and the organization is brought into focus. Finally, an analysis of what this partnership makes possible in terms of the population's health is initiated.

The PHS: intervention context and program

The PHS Community Services Society (PHS) works in an urban sector inhabited by a highly vulnerable population. The area comprising these socioeconomic and health indicators is in the eastern sector of downtown Vancouver, or the Downtown Eastside (DTES),[2] an area often identified as one of the most troubled in Canada. The situation has changed on several fronts, but just a few indicators from the time of the organization's inception speak volumes: an average annual household income of $11,029; an unemployment rate of 29% (three times the national average at that time); 80% of households living below the poverty level; in 1998, 24% of intravenous drug users were infected with HIV, 88% with hepatitis C, and a seroconversion rate estimated at 20%, the highest rate in North America. During the first six months of the same year, the majority of British Columbia's 201 cases of death due to overdose took place in this sector (Gurstein & Small, 2005, p. 722). A few characteristics of the people who use the organization's housing services give a good indication of who it aims to reach, namely people facing multiple barriers: the majority did not graduate from high school; 35% experienced some form of childhood trauma, most often physical or sexual violence; 34% have been diagnosed with a mental illness; 33% are seropositive or have developed AIDS; 25% have hepatitis C; 88% are dependant on alcohol or other drugs and 73% are intravenous drug users (Gurstein & Small, 2005, p. 725).

The Portland Hotel, after which the organization is named, offers single room occupancy (SRO) and various forms of support to "hard-to-house" persons (i.e. those living simultaneously with

[1] The notions of 'high-threshold services' and 'low-threshold services' can be well-understood through contrasting them: 'the first expression refers to services that imply admission and care protocols that are more controlling by requiring medical follow-ups, tests and often abstinence as objectives; the second expression characterizes services and care adapted as much as possible to the user's path and which do not require that the person stop using' (translation, Brisson, 1997 in Noël, 2000, p. 8) In this document, the services described are not only medical; as such, the barriers identified go beyond this field of intervention.

[2] While the average is doubtless an interesting indicator, it very often hides, and this is particularly true here, the rather significant inequalities that exist between various segments of the population.

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mental health or active substance abuse problems, who have often been excluded or even evicted from most other types of housing). It was inaugurated in 1991 in association with the Downtown Eastside Residents Association (DERA) and then came under the auspices of the PHS when the latter was created as an NFP organization in 1993. The organization's mission is to "advocate, develop and implement creative and responsive services for persons living with concurrent disorders" (Shared Learnings on Homelessness, 2003). In the area of housing, for example, sensitivity to the particular needs of this group of people is reflected by the no-eviction policy (conflict resolution mechanisms are used to avoid evicting a boisterous occupant, for example) and the absence of ties between health problems and housing (a person who was assigned a dwelling has the right to keep that dwelling, whether enrolled in a therapeutic process or not, even if that person is "cured").

The Pensylvania Hotel, whose renovation was completed in 2008, is the building where the PHS began its activities. It is the first building offering full units, the others being rooming houses with shared facilities.

Photo: Hotel Pennyslvania, corner of Carrall and Hastings Streets – 1927.

City of Vancouver Archives, Hot N34.

The services provided by PHS now extend well beyond housing, even though this was and probably remains its primary mission (the organization was operating approximately 1000 units in 2010). The organization also operates, alone or in collaboration with other private or public organizations, programs that can be classified into two broad categories: those providing health care and social services and those offering social and economic services. In all cases, the care and services are underpinned by the goal of acting on the structural determinants (social, economic) of health; the aim is to create healthier living environments for the population of the DTES.

In the second category: 1) Pigeon Park Savings, a financial institution serving those who do not have access to the traditional banking system, with the further objective of encouraging the social and economic development of the DTES; 2) the Interurban Art Gallery, a locus of artistic expression for DTES residents, intended to raise their self esteem as well as that for the sector they inhabit; 3) the Life Skills Centre, a place that provides training in job skills and other life skills, and, in particular, peer-support, referrals to other services, a Laundromat, showers, and coffee.

In addition, it should be noted that the PHS provides a free location for the Potluck Cafe Society, a *café* with the dual objective of providing meals to residents of the hotels, and of the DTES in general, while providing them with permanent jobs. In the category of medical services and care: 1) the Community Transitional Care Team (CTCT), an initiative aimed at ensuring proper completion of antibiotic treatments such as the DTES's intravenous drug users are often required to follow; 2) the Sunrise Dental Clinic, a clinic that provides care at reduced or no cost to DTES residents. The clinic is affiliated with the University of British Columbia, being a teaching clinic where students fulfill their training requirements while providing services; 3) Insite, a supervised injection site where intravenous drug users (IDUs) can inject their drugs under the supervision of medical staff, who can intervene in case of overdose. The clinical staff also offers a variety of advice on how to reduce the ill effects of drug injection, explaining, for example, how best to sterilize needles. Insite also offers, notably, a needle distribution and recovery service, referral services for IDUs who would like to undergo addiction treatment and peer-counselling available in the transition zone, where users who need one can

find a willing ear; 4) Onsite, for its part, is a detoxification and short-term recovery centre (it serves as a starting point for IDUs wishing to enrol in a long-term treatment program) for persons living with substance abuse problems. It has twelve detoxification rooms and eighteen recovery or transition rooms.

As was briefly mentioned earlier, the expression "low-threshold services" is often used to describe the type of program and services developed by the PHS. They are designated as such because the organization set up its services in such a way as to eliminate, as far as possible, the barriers to access created, in one way or another, in a voluntary or non-voluntary manner, by more traditional health and social services. For example, the right to be housed or to undergo antibiotic treatments offered by the CTCT depends neither on being abstinent nor on committing to therapy aimed at stopping or stabilizing consumption—these commonly being implicit or explicit requirements of traditional health and social services. To take another example, the PHS offers free dental services to low-income individuals (in this case, it is specifically the financial barrier to dental care access that is eliminated).

PHS and Vancouver Coastal Health: Roles and functions of the partners

Vancouver Coastal Health (VCH) is one of five regional health authorities in British Columbia and includes 17 regional municipalities or districts.

It is a partner to the PHS in all its programs offering health services.[3] In the case of the Sunrise Dental Clinic, the partnership seems limited to financial support: that is, the PHS administers the program alone, but it is funded by VCH. In the case of the three other programs, responsibility for daily operations is shared between VCH and the PHS. In practice, the staff who provide health services (antibiotic treatments, for example) are supplied by VCH and those who offer "social" services (referrals to detoxification services, for example) are supplied by the PHS. It should be noted that in all cases the PHS receives funding from VCH for the "social services" it provides (in certain cases, this funding is supplemented by other sources of income).

The development of these partnerships was sometimes initiated by the PHS and at other times by VCH. In the case of the CTCT, it was VCH that was approached by hospital authorities and which then approached the PHS in order to develop the program addressing the high rate of failure to complete antibiotic treatments and the health consequences of this for addicts, along with the resulting increased demand for services (one of the effects of failing to complete an antibiotic treatment is very often a new request for health services). In the other cases, it was the PHS that developed the project and then contacted VCH seeking its support and its collaboration in operating the program. In all cases, the programs were to some degree developed in partnership, given the coordination required for joint operation.

Partnerships resulting in improved health status for hard-to-reach segments of the population

While they doubtless produce their own specific positive effects, the limits of traditional public health interventions (vaccination or initiatives aimed at changing individual behaviour, for example) are well-known. In particular, they neither take aim at nor act on the social, economic, cultural or political determinants of the health status of the populations. In the attempt to sidestep these limits, a series of approaches has been developed on a conceptual level and, less often, on a pragmatic level. These approaches are defined, among other things, by the concepts of structural prevention or intervention (Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005).

As can be ascertained from the description given above, the program of the PHS and its partnerships with VCH allow for precisely such structural action by combining classic public health interventions (dentistry, antibiotic treatments, detoxification services, etc.) with interventions intended to act on the structural social, environmental, economic and political conditions that, in part, determine the health status and the at-risk behaviour of the targeted population. In other words, in addition to using more traditional types of public health interventions, they

[3] This information, like the majority of that contained in this section, was provided by Chris Buchner, of VCH, during the course of an interview and through email exchanges. We wish to thank him for his generosity.

look beyond them—and partially succeed at—seeking and initiating partial, but significant, modification of the cultural, political and social context that frames cases of mental illness and substance abuse and their morbid and harmful consequences; and they do so in many ways.

For the purposes of this exercise, only three ways in which the partnerships modify this context will be discussed. Firstly, the partnership mode of service provision allows for the removal of political barriers to health care and social services. Without partnership, the PHS would likely not have the financial resources to provide these services. Without partnership, VCH would have more difficulty removing barriers to care and services, which would be difficult to provide if the PHS practitioners (who generally possess atypical training and experience; that is, not directly related to the "intervention professions") were not involved in their delivery.

Secondly, the partnerships help transform some of the sectoral public policies that are harmful to the health of these population segments. For example, the Vancouver police service has established a policy of encouraging IDUs to use Insite as a way to avoid being arrested—a significant risk factor for IDUs, since the fear of being arrested often leads to hurried injection and thus induces the use of unsafe injection practices (Stolz et al., 2007).

Finally, generally speaking, the location and the ongoing presence of these programs in the urban environment legitimizes the presence and the existence of persons affected by mental illness or substance abuse, and thus creates a social and political context that demands the development of solutions that take their problems into account. Will these actions, and those resulting from other partnerships VCH has formed, be sufficient to counter the forces that have produced and continue to produce the exceptional context of mental illness and drug addiction that can be observed today in the DTES? This remains, and will probably continue to remain for several years, an open question.

In any case, for regional public health authorities seeking to improve the health status of particularly hard-to-reach populations, such partnerships with NFP organizations allow for the development of healthy public policies that show promise or for which the evidence points to generally positive results, able to mitigate the forces that negatively affect the health of the populations in question. Such policies are here presented as exemplary. However, it is understood that they are not the only practices of interest that have been developed in this country that could be documented here, nor should they be viewed as models that can be reproduced regardless of context. Rather they should serve as references that can be adapted on the basis of perceived needs and the analysis of problems by Canada's regional agencies.

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