HOUSING FIRST PROGRAM MANUAL

June 2016

Salt Spring and Southern Gulf Islands Community Services Society

Contents

Program Description

The SSICS Housing First Program is made up of several components and funded by various sources. **Outreach** is funded by United Way of Greater Victoria. **Youth Outreach and Housing Support** is funded by the Ministry for Child Development. **Homeless Prevention Program (HPP)** is funded by BC Housing. **Supported Independent Living (SIL)** is funded by Island Health. Ongoing program improvement and community development activities are funded by the **Homeless Partnering Strategy (HPS)**.

The Housing First Program connects people who are homeless or at risk of homelessness with housing and supports. Outreach services directly engage people who are homeless or at risk of homelessness by assessing needs, assisting with personal goals, and connecting individuals and families with stable accommodation (more than 30 days) and support services. Homelessness is a broad term that encompasses a range of housing conditions. These can be understood on a continuum of types of shelter:

- *Absolute homelessness* is a narrow concept that includes only those living on the street or in emergency shelters, specifically:
  - public spaces without legal claim (e.g. on the streets, in abandoned buildings, derelict boats, tent camps);
  - a homeless shelter;
  - a public facility or service (e.g. hospital, care facility, rehab or treatment centre, correctional facility) and cannot return to a stable residence;
  - shelter received as a result of being exploited financially, sexually, physically or emotionally.
- *Hidden or concealed homelessness* is in the middle of the continuum. These include people without a place of their own who live in a car, with family or friends, or in a long-term institution. ;
- *Relative homelessness* is a broad category that includes those who are housed, but in substandard and unhealthy conditions or at risk of losing their homes;
- *At Risk of Homelessness* means individuals and families living in temporary housing where they do not have control over the length and conditions of tenure (e.g. couch surfing or name not on lease), in time-limited housing designed to help them transition from being homeless to living in a permanent form of housing (e.g. transitional or second-stage housing), or housing where the tenancy will be terminated within three months.

***The program is guided by services being accessible and client focused*.** We work from a client-centered, strength-based perspective and use a relationship-building approach. People are the experts on their own lives. We feel promoting positive change in people results from assisting them to grow in the way and direction they envision.

Program Philosophy and Principles

SSICS Housing First services are client-centered and are grounded in clients' strengths with the goal of assisting them to secure stable housing and supports to help them maintain the housing. Stable housing is a basic need that enables people to achieve other goals including employment and good health.

The program believes in the importance of helping relationships that assist individuals to identify the skills that they need to develop to be self-sufficient and to live independently.

Workers assist clients to locate appropriate housing while providing case management services. They work at connecting clients to other supports and services, and work collaboratively to provide wrap around support to help clients rebuild their lives. SSICS is a primary provider of many services for vulnerable individuals and families, so much of this collaborative work involves connections internal to the organization.

The SSICS Housing First Program is accessible to anyone who is homeless or at risk of homelessness, regardless of ethno-cultural background, religious beliefs, physical ability, mental health status, gender identity or sexual orientation. Providing rapid access to housing and support services is the basic approach. Housing readiness is not a requirement. Acceptance of other services is typically not a requirement for accessing or maintaining housing and supports through this program.

SSICS provides an environment that is safe, secure and welcoming for clients. Workers maintain reliable records, policies and procedures that meet the objectives of the program and its funders.

Program Logic Model

Appendix One

Program Outcomes

- Individuals and families are able to secure and maintain stable and healthy housing;
- Individuals are able to increase their skills to enable them to live independently and successfully in the community;
- Individuals are connected with formal and informal supports and services that assist them to life independently and successfully in the community.

Service Model

Best Practices

- Housing First Model
- Risk and Resiliency Models
- Trauma-Based Practice
- Recovery Oriented Mental Health Practice
- Cognitive Theories

Service Methods

- Outreach
- Education
- Provision of Basic Needs
- Life, social, and vocational development
- Advocacy
- Case planning and management

Service Strategies

Clients need to be active participants in the planning and direction of their services. The program uses approaches that are non-judgmental to earn acceptance and trust. It is important to persevere, identify barriers for service, and explore the client's needs while looking for practical opportunities to engage them in services. Strategies include:

- Develop trust and build relationship with the individual to identify service that is meaningful and relevant;
- Identify needs and reduce barriers for the client to access services;
- Assess and build on the client's strengths and resources;
- Provide crisis intervention and support for the client;

- Directly services include:
    - Harm reduction;
    - Vocational development;
    - Food security;
    - Safety skills and social skills training;
    - Housing assistance;
    - Help accessing financial support;
    - Advocacy;
    - Information services;
    - Case management;
    - Other services necessary to address individual needs.

Partnerships

The Housing First Program networks with organizations providing supports and resources to the clients of this program and also takes a lead in addressing homelessness issues in the Salt Spring and Southern Gulf Island area. These networks include organizations such as the Ministry of Social Development and Social Innovation, Island Health, Ministry for Child and Family Development.

Workers participate in community committees that support homelessness and housing needs or community actions to enhance community capacity building to break the cycle of homelessness.

SSICS has initiated the *Salt Spring Island Housing First Housing Supports Advisory Committee.* Appendix Two

Current organizations that also work with people who face homelessness include: Island Health, Copper Kettle, SSI Land Bank, Island Woman Against Violence (IWAV), Lady Minto Hospital. Other helpful resources include Conner Property Management, Island Explorer, Seabreeze Motel, and numerous private landlords.

Housing Resources and Landlord/Tenant Relationships

An updated housing list is maintained and shared with partner agencies that also support people who are looking for housing. Lists are updated bi weekly based on advertisements placed in local media including Salt Spring Exchange, Gulf Islands Driftwood, and informal postings. The Housing First Program does not screen all listings for suitability or security, however effort is made to gain as much relevant information as possible to provide individuals with helpful information.

It is important to build strong relationships with landlords to assist clients to secure housing. Workers are honest and forthright with landlords, and support them to resolve issues with tenants. Clients are provided with information on their rights and responsibilities in being a good tenant. SSICS provides the Ready to Rent course for both tenants and landlords, including a youth-oriented version of this training.

Service Delivery Details

Salt Spring and Southern Gulf Islands Community Services will serve all suitable clients within the limits of its mission, resources, capacities and contractual and legal obligations. For people who are homeless or at risk of homelessness, staff will directly engage clients where they are situated which may include people who are visibly homeless living in public places.

Program services include:

- Developing a case plan for all clients;
- Referring clients to appropriate housing options;
- Referring clients to income assistance;
- Referring clients to support services;
- Connecting clients to SSICS services including food security and vocational development;
- Where appropriate, accompanying clients to appointments.

Where clients are placed as tenants, services include:

- Helping clients maintain their housing and their ability to live independently;
- Where appropriate, providing clients with rental supplements;
- Providing tenancy support and skills training;
- Providing follow up and ongoing support to tenants;
- Building and maintaining relationships with landlords that provide housing to clients;
- Providing education and resources to landlords to support and maintain client tenancies, where appropriate.

Resources

Workers will have a cell phone to use for work and safety purposes when out with clients. There are funds for transportation and miscellaneous expenses for the worker when doing outreach with clients. A van is available for the program for the general use of workers, or for specific uses requiring a large vehicle such as transporting groups or moving furniture/belongings.

The program provides financial resources for activities and travel for clients, as well as other client expenses such as beverages and snacks. Reimbursement for travel and client activities is provided on a monthly basis or as needed.

Rent supplements and emergency client support funds are available based on eligibility, assessment of need, and availability of funds. These funds are attached to various program components (HPP, SIL, Youth Outreach) as well as the general SSICS "Swish Fund" available to all SSICS clients requiring emergency assistance.

Excellent resources to provide Workers with the best practices for assessment and case management include: *Case Planning Guide for Homelessness Service Providers (BC Housing)* and the *Vulnerability Assessment Tool (Canadian Observatory on Homeless).* These documents are available in the staff area of the SSICS website. www.homelesshub.ca is also a great source of information.

Support/Teams

- Bi Weekly SSICS Housing First/Outreach meetings
- Quarterly SSICS All Staff meetings
- SSI Housing Supports Advisory Committee
- Consultation with Program Manager
- Peer, clinical, and/or supervisory consultation as needed

Information Management

The Housing First Program uses the organization-wide Efforts To Outcomes (ETO) client database for primary information and case management purposes. It also uses the HSS database provided by BC Housing to collect and report on the services provided through HPP.

Referral

Referrals to the SSICS Housing First Program can be made by clients themselves or by other agencies, landlords, and family or community people. Referrals received will be documented on the ETO database.

Waitlists

This program does not waitlist clients.

Eligibility Criteria

The target population of the Housing First Program are individuals, couples and families who are homeless or at risk of homelessness and who live in the communities of Salt Spring and the Southern Gulf Islands. The various components within the scope of the program have specific eligibility criteria:

Specific HPP Rent Supplement Eligibility Criteria

Individuals or families who are homeless or at risk of homelessness and are within one of the following target groups as determined by BC Housing:

- People leaving the corrections and hospital systems. The client may be required to provide verification from a hospital social worker, physician, or probation officer;
- Women who have experienced violence or are at risk of violence, which is defined as a situation where a woman indicates that she and/or her children are at risk of experiencing domestic, family or intimate partner violence including physical, emotional, economic, financial, sexual and spiritual abuse;
- Youth up to the age of 24 years old;
- People of Aboriginal descent.

Specific SIL Rent Supplement Eligibility Criteria

Individuals who meet the following criteria as determined by Island Health:

- The individual has a serious and persistent mental health illness and may have a co-occuring substance use issu;
- The individual is a resident of Salt Spring Island and the Southern Gulf Islands.
- The individual is over the age of eighteen (18);
- The individual is capable of living independently;
- The individual's total monthly income from all sources is less than $ 1,500;
- The individual has been referred by an Island Health MHSU Case Manager or has been assessed as requiring housing support by SSICS Housing First Program;
- The individual is actively involved in a recovery plan addressing mental health and/or substance abuse issues.

Specific Youth Outreach and Housing Support Eligibility Criteria

Eligibility for any of the supports available through this program component, including rent supplements, damage deposits, emergency funds etc. are limited to individuals between the ages of 15 and 24. Individuals between the age of 15 and 19 are automatically connected with this program component. Individuals between the ages of 20 and 24 may be permitted to stay with the Youth Outreach program id previously served, or to be eligible for the service as a new intake based on an assessment and decision of the Worker, Program manager and MCFD.

Exclusionary Criteria

SSICS believes that all homeless individuals have the right to access Housing First services, regardless of ethno-cultural background, religious beliefs, level of ability, mental health status, gender identity, and/or sexual orientation.

- There are certain conditions where young people may not be eligible for service. Youth under the age of 15 will not be accepted as clients. Youth between the age of 15 and 19 are eligible for the youth-specific component of the program once approved by MCFD. Care will be made to limit housing for clients under 19 to places where they are not co-habitating with adults;
- SSICS staff are not expected to provide services to individuals in circumstances where the safety or security of the staff or any other individual may be threatened;
- Subsidies cannot be provided for emergency shelter, to clients on reserve, or to clients already getting subsidized housing (SAFER, RAP);
- Clients who provide false information or are fraudulent in utilizing rent supplements or other material supports may risk future supplements or supports being denied to them.

Before reaching a final eligibility decision workers will consult with the Program Manager if a client is deemed to fall under exclusionary criteria. The referral source, when appropriate, will be informed of the reason(s) the person is found ineligible for services and recommendations are made for alternative services. Workers will l do their best to help clients and their families access other community services if that is indicated. We will document the decision and actions taken. Individuals are welcome to re-apply at any time if they or others feel their circumstances meet the eligibility criteria.

Clients are provided with information on how to make a complaint and can consult with the Program Manager if they do not agree with the reason they are not eligible for service.

Reporting

SSICS is required by funders to report on a number of outputs and outcomes that directly relate to activities and services to clients. The purpose of collecting relevant data is to monitor the success of the program and for future program planning. The client information provided in the ETO database may be helpful to identify broad trends and emerging needs among people who are homeless.

BC Housing provides the HSS database to track basic information regarding its funded services (HPP component of Housing First, as well as the In From the Cold Emergency Shelter).

Outreach

The following areas in the community should be visited regularly (weekly when possible):

- In From the Cold Shelter (November to March);
- Mouat Park;
- Transition House;
- RCMP;
- Lady Minto Hospital;
- Other agencies that serve clients who match the Housing First focus.

In From The Cold Shelter

The Shelter is open from 6 pm to 8 am every day from November 1 to March 31. 4/7.

The shelter is not wheelchair accessible. Clients must be sober to access the shelter (can smell of alcohol but cannot be drunk).

When connecting with the shelter, ask to see the sign in list and visit individuals that you haven't previously seen. The shelter will also refer those clients to Housing First.

Lady Minto Hospital

When visiting the Lady Minto Hospital, introduce yourself and leave your contact information, program information and housing list.

Rental Supplement Guidelines

Rental supplements are primarily intended to contribute to the rental payments of a client living in market housing in circumstances where they are not able to make the complete payment and are not receiving other forms of provincial rental assistance. It is recognized that, in some cases, other uses are appropriate to address the client's immediate housing concerns. Rental supplements can be used for the following purposes, providing a clear link can be demonstrated between the rental supplement payment and securing or maintaining housing:

- A portion of a client's rent, for clients living in market housing, who are not receiving other forms of provincial rental assistance (for example, SAFER, RAP or living in subsidized housing or transitional housing);
- A damage deposit for a client (all damage deposits will be returned to SSICS if a client ends the tenancy);
- Storage of a client's belongings if they are in the process of obtaining stable accommodation (for example if the client is waiting to move into secured housing at the beginning of the month);
- An expense that will remove a barrier to housing a client or prevent eviction of a client (examples include personal hygiene, haircut, nutrition, identification, acceptable medical expenses, etc.);
- A client's utilities in order to ensure they remain housed. The client must provide verification directly from the utility company. If on income assistance, the client must ask MSDSI for help and be denied by MSDSI before receiving help from SSICS Housing First;
- Transportation of a client to a housing opportunity;
- Moving expenses for a client;
- Startup costs and household supplies (e.g. food, dishes, pots, pans, etc.).

Rental supplements cannot be used to pay for*:*

- Storage of a client's belongings if the client is not intending to obtain housing;
- An expense unrelated to housing the client;
- Any cost related to SSICS employees or management's delivery of services;
- An expense for an individual who is not a client;
- Clinical health and treatment services;
- Child care;
- On-reserve accommodation or expenses;
- Rent for a client who lives in government-subsidized housing or receives any form of provincial rent assistance.

1. Supplements can be one time or short term to assist a client through a crisis or transition. However, clients can receive ongoing supplements for up to 12 consecutive months. Extensions may be granted under exceptional circumstances, and with the approval of the Program Manager. Clients are to engage in regular case planning to assist them in moving towards independence. This may mean reducing supplements incrementally until they can support themselves in market housing.
2. Clients must meet eligibility requirements and be entered in the ETO database as a Program Client before receiving a supplement.
3. Program clients are individuals whose income when they obtain housing (initial occupancy) is at or below the Housing Income Limit. Housing Income Limit is defined as the income required to pay the average market rent for an appropriate sized unit in the private market. Average rents are derived from the CMHS annual Rental Market Survey, done in the fall and released in the spring. The minimum size of unit required by a household is governed by federal/provincial occupancy standards (http://www.bchousing.org/resources/HPK/Rent_calcualtion/HILs.pdf).
4. SSICS is responsible for reviewing the client's proof of income and assets and keeping copies in the file. Typical documents include T4, Notice of Assessment, last 60 days of bank statement, letter from Ministry if on income assistance, and verification of rent, such as a rental agreement.
5. Rental supplement payments should be issued directly to the end recipient instead of the client, for example, a cheque made out to the landlord. An exception can be made after consultation with the Program Manager if it is in the best interest of the client to receive the payment directly to use to pay the agreed upon cost. In this case, SSICS must be able to verify that the rental supplement was used for the intended purpose.
6. Rental supplement payments are logged into the ETO database as they are issued.
7. If the worker is unsure whether a certain expense is appropriate for rental supplement usage, or the worker is seeking approval to apply a rental supplement to an item normally considered ineligible, the following procedure must be followed before making a payment:
    - The worker will contact the Program Manager and explain the situation.
    - If the Manager is unsure whether a proposed rental supplement payments fits within these guidelines or an exception is appropriate, s/he will contact the BC Housing Non-Profit Portfolio Manager to consult and gain approval before authorizing the payment.
    - Rental Supplements will only be given to clients who have exhausted all other means of support. Proof of denial of financial assistance from EI, WCB, MSDSI, etc. may be verified.

- Rental supplements will not be given to clients who are receiving SAFER or RAP, or who are living in any type of supplemented housing. However, depending on circumstances and as determined by the worker, they may be given a one-time supplement if they are waiting for EI, WCB, SAFER, or RAP to take effect.
- Clients must give consent for their information to be recorded in the ETO database and will be contacted for a housing follow-up after six months. This information will be logged in the ETO database.

SSICS is responsible for ensuring that the rental units secured through rental supplements meet a reasonable standard of accommodation for clients, and that the immediate living environment, given available resources, provides satisfactory shelter, consistent with the goals of the program to maintain stability of tenancy.

Rent Supplement Amounts

HPP – the maximum amount per month per individual/couple is $450.00 note-the contracted total monthly amount available for all clients is $2,250, so funding is allocated carefully to ensure priorities are met in a fair and reasonable way.

SIL – the maximum amount per month per individual/couple is $300.00 (the contracted total monthly amount available for all clients is $1,200). HOP payments should be for one month only. If this is to be extended, the reasons must be well documented.

Clients cannot receive both HPP and SIL Rent supplements at the same time.

Youth – there is no specific limit. An assessment of need is done on a case by case basis

Occupancy Standards

Rental Units should be suitable for the size of the client's household in accordance with the Occupancy Standards. The standards state that no more than two people can share a bedroom. Empty or "spare" bedrooms are not covered by funding so rental units cannot be larger than required. Spouses and couples may share a bedroom, but parents are not expected to share a bedroom with children. Dependents aged 18 or more may not share a bedroom and dependents of the opposite sex may not share bedrooms when they reach the age of five.

Case Management

Intake

Workers will complete the required SSICS Housing First Intake Form. Appendix Three

This information must be entered in to the ETO database and is required before a supplement can be issued.

Workers will provide new clients with an orientation to services at the initial meeting, or at the second meeting once they determine they are eligible for Housing First service.

To help clients be fully informed, SSICS will provide current information about the organization and about their specific service. Workers will inform the client about their qualifications and any potential conflicts of interest. The staff member will inform clients that all SSICS staff members are required follow a Code of Ethics. The SSICS Code of Ethics will be posted in service sites and made available to clients on request. These forms are available in the Staff Area of the SSICS website.

Clients will be provided with a copy of the Handbook for Persons Served.

Immediate safety needs will be assessed during intake. If a safety plan is required one will be developed and information about emergency services and resources will be provided.

During the screening and intake stage workers will verbally review the Rights and Responsibilities of Persons served with the client to ensure a basic understanding of the organization's expectations and obligations. Informing the client of their rights and responsibilities includes reviewing the limits to confidentiality, including describing instances when confidentiality does not exist. During orientation to the program, staff will verbally inform clients of the consequences of bringing illicit drugs, alcohol, and weapons into the program. Staff will explain that in such cases we will not continue with the session, but the client will be invited to come back and participate in the next session without drugs, alcohol or weapons.

A review of rights and responsibilities will include an explanation of the complaint procedure and the complaint form that is available any time during service that the client is dissatisfied. A copy of the complaint form will be offered to the client.

The worker will ask all clients to sign a release of information form. This provides for personal information to be entered into the Homelessness Services System Database (HSS Database) provide by BC Housing. Release of client information is required before rental supplements can be paid. However, provision of other services is not dependent on the client signing the release form.

Clients are provided with the relevant information about rental supplements and what documentation is required in order to be approved. Clients will be required to sign an agreement for the supplement.

Consent to Collect, Use or Disclose Information

During the information gathering stage, the worker may require additional information from other sources. If so, the worker reviews and completes the Release of Information Form with the client. This form:

- Identifies individuals that the client gives the worker permission to contact and share information with.
- Includes the purpose for which released information will be used.
- Is dated and signed by the client and held in the client's file. This form is time sensitive and is reviewed periodically, at a minimum of one year.
- Documents the revocation of the consent – if consent is revoked at any time by the client, reasons why are documented in case notes and noted on the Release of Information Form.

Annual Review of Client Information and Consent

The following forms must be reviewed annually with the client and new signatures obtained as appropriate:

- Rights and Responsibilities
- Release of Information

The annual review is then documented on the intake page checklist indicating the date these forms were reviewed and updated. There also is a space at the bottom of the Release of Information Form for workers to indicate any update of who may be contacted and what information the client gives permission to be shared.

Detailed Intake Process

1. Ask the client "what brings you here today?" or "what has happened that brings you here today?" If the client is just seeking information, has to obtain more information/documentation before you can assist them further, or you have referred them to another agency, keep case notes and file in the brief service file.
2. If you determine from the conversation that the client may be eligible for HOP or HPP, have the client sign consent forms. Other agencies may have their own consent forms that must be completed before you will be able to speak with representatives of those agencies. For example, MSDSI, Mental Health, and MCFD have their own consent forms that the client must sign before staff at those agencies will be authorized to speak with you. In these cases, obtain copies of the consent forms from the appropriate agency, arrange for the client to sign the consent form and send the completed form to the agency.
3. Complete the Intake Form and note if the client is eligible for HPP, SIL or Youth Services. Tell the client that, before financial assistance can be provided, they need to provide proof of income and verification of rent (if they have an outstanding BC Hydro bill, then they need to provide the disconnection notice,) or doctor's/hospital note. If they already have the information with them, photocopy it for the file. If they don't have that information with them, let them know that funding is based on a first-come first-served basis and that you will hold the funds for one week to allow them time to bring in the required documentation. After one week, funds will be released to the next person.
4. If the client is on income assistance and they don't have a home, they are entitled to a living allowance of $250.00 from income assistance. If they want to get the additional shelter portion from income assistance, they must have a tenancy agreement or an equivalent document. If they do not have a tenancy agreement, you can give them a Shelter Form to complete to verify rental information. The owner/landlord completes a section and the client completes a section. These are Ministry "intent to rent" forms.
5. If the client meets eligibility criteria, advise the client of the amount of assistance that can be provided and for what months/dates. If you are not sure, let them know that you need to consult the Program Manager and will get back to them. Remind the client that this is short term funding with the goal to assist them to move towards independence and describe how else you might be able to help them with referrals or case management. Be aware of how much of the current monthly contracted amount allotted to this program has been used up to make sure funds are still available. SSICS requisition forms must be submitted to the Program Manager for signing each Tuesday. After signature, the Program Manager will forward the requisition to the SSICS accounting department. Cheques will be available for release on Thursday morning.

6. If rent is outstanding, call the landlord to ensure that they will accept a rent payment from you on next possible payment date, especially if the client has been presented with an eviction notice. Confirm that the housing is not part of subsidized housing.
7. If a BC Hydro payment is to be made, call BC Hydro to ensure that they will accept a payment plan from you on the next cheque issue date. If an agreement with BC Hydro cannot be reached, send the client to the MLA (Gary Holman). Call the MLA's office and advise them of the situation. They have an advocate that can speak to BC Hydro.
8. For damage deposits, ensure that income assistance clients contact Income Assistance first. We can pay if they refuse to.
9. Any combinations of rent, hydro, and damage deposits cannot exceed the maximum amount allowable for HPP monthly rent subsidies.
10. Enter the client information into the BC Housing database.
11. Complete the SSICS Cheque Requisition Form.
    - If rent is being paid, be sure to capture the landlord or owner's name correctly as the cheque will be made out to the landlord. These have to be completed each month that assistance is being provided.
    - The client must sign at the top of the form and initial the form in two places below.
    - Let the client know that they will be asked to pick up the cheque and give it to their landlord.
    - BC Hydro payments will be made out to the Minister of Finance. Let the client know that you will pay the Minister of Finance directly. Write the client's BC Hydro account number on the cheque requisition.
12. Make two photocopies of the cheque requisition form (total of three copies including the original).
    - One copy goes to the SSICS accounting department.
    - One copy goes to the client file.
    - One copy is placed in the current month payout folder.
        - Attach it to the summary sheet.
        - Write the client information on the summary sheet.
13. Update the budget spreadsheet with the client and cheque data.
    - If you are holding funds (because you are waiting for documentation or information), highlight in yellow.
    - Do not hold longer than one week (you can attempt to contact the client to remind them of the deadline) but release the funds at the end of one week to be used by someone else.

Assessment of Risk

A Risk Factors Form will be completed by the worker. An assessment of the client's home will be done before any home visits are completed. Workers are to refer to SSICS Health and Safety Policies for working alone procedures.

Women Fleeing Abuse

Make sure that the confidentiality agreement is signed with a clear understanding of the limits of confidentiality. When supporting a woman who is fleeing abuse, make sure you document everything carefully and thoroughly. Ask if the client has reported the abuse and if she needs support to do so. Ask if there were any children present and if the children witnessed the abuse. If the children were present, this must be reported to MCFD. Refer the client to IWAV. They have services available to help women fleeing violence.

Client Safety Plans

Safety planning begins at intake and is determined through referral information, assessments, service planning meetings, and at any time during service. Information about client safety is entered into the client's record and any identified client risk factors require a written safety plan created with client involvement. When a safety plan is required, it should be entered into note in the client's file. A copy of this plan can also be made into a document and provided to the client and others that the client identifies as being involved.

Assessment

No formal assessments are required for this program; however, an informal assessment of need and risk occurs throughout service. Each time the worker and client are together, the worker will informally assess the service needs. An informal assessment identifies strengths of the client that will facilitate change and build resiliency. The *Vulnerability Assessment Tool* is a useful resource for assessment and case planning.

Despite not using a formal assessment, it is recommended that staff be aware of the different elements that assessments cover, and that they develop an understanding of the implications in those elements. This is because knowing the potential impact that different factors can have on a client's situation means you are always in a better position to be helpful regardless of your role.

Below are examples of different areas that might be explored as part of an assessment.

- Demographic data (age, gender identification, sexual orientation, culture, ethnicity, spiritual beliefs);
- Presenting issues (including current stressors);
- Personal and family strengths;
- Preferences;
- Abilities and/or interests;
- Individual history (including any mental health, physical or behavioural issues);
- Incidents of violence, abuse, neglect, trauma;
- Medical status (including medication use, allergies and relevant history);
- Family history (including family mental health history);
- Parental/custodial status (including willingness of parents to participate in service);
- Relationships (including family, other supports and any need for additional social supports);
- Urgent needs (including suicide risk);
- Current mental health, physical, behavioural concerns and needs;
- Current level of functioning (including intellectual and life skills);
- History of substance use (alcohol, drugs, tobacco);
- Interaction with peers;
- Risk taking behaviour;
- Risk factors;
- Co-occurring disabilities and/or disorders;
- Legal involvement;
- Previous involvement with SSICS or other community services;
- School history (including current level of education);
- Employment status;
- Language functioning (including speech, hearing and visual);
- Immunization record.

If needed, the worker can access the clinical director for support, consultation and feedback on observations and concerns relative to the provision of service.

Service/Case Planning

BC Housing has a framework for case planning. It is a tool that is used to facilitate the client's progress toward self-sufficiency and reintegration into the community. This document is available in the Staff Area of the SSICS website.

Service planning is based on the best interests, safety and well-being of the client and the community, and is done in collaboration with the client. The program provides safety planning with the client in need. Service provision will be adapted and/or modified to minimize barriers and to accommodate special needs.

Goals are established with the client based on the informal assessment of strengths, need, and risk, and the desire for change. Goals can be found documented in case notes.

Ongoing progress and change in the client's situation will be documented in case notes. Changes in service will be agreed upon by the client and other service providers, if appropriate, and documented in the case notes.

Collaboration

Effective service delivery means working collaboratively with clients, families, and other professionals who are part of our clients' lives. Collaboration should be carried out with the client's wishes in mind, and with awareness of our confidentiality policy and guidelines. To best help clients reach their goals, all client-approved collaterals should be involved in planning and decision-making phases of service delivery. If clients are leaving someone important out of the process, you can try to find out why and work with the client to see if there's a way that person can participate.

Progress Review

At any time, for example, when the client's status changes, if there appears to be a gap in service, and/or at the time of a service review, service can be modified to suit the needs of the client and/or family.

- At every session, progress towards and/or completion of the service goals is addressed and documented in the case notes;
- Status of progress and change will be shared with others involved in service through ongoing consultation, collaboration and/or written progress summaries- The client will agree upon changes in service and will participate in the development of new service goals and strategies;
- Formal progress reviews are conducted as needed, but not more than six months from the time the client is entered into the HSS database*;*

- For clients receiving an HPP supplement, it is a BC Housing requirement that clients are contacted at 6 months and document if they are still housed and their current situation. This is to be recorded in the HSS database;
- Progress summaries must be prepared and recorded in the client's ETO file.

Planned Transition/Discharge

Transition plans need to be developed with input from the client and/or family or other community agencies, as applicable, and include information on strengths, progress made and identified needs.

Transition/discharge criteria will be discussed with the client at intake and recorded in the client's file.

When a client identifies the need to be referred, transitioned or discharged to other services, the worker will support the client to do this in accordance with that service's admission and/or referral procedures. With appropriate consent, copies of the discharge report and/or transition plan will be provided. Workers will support clients by providing information on services and/or community, accompanying the client, and researching applicable services.

When additional supports and services are required, collaboration will occur between SSICS, the client and the program referred to. This could include visits for out-of- town programs, attendance at case conferences, and consent to share information.

Within 30 days of discharge, a closing summary is entered into the client's file. This is done for all discharged clients. If permitted, a copy of the discharge plan is given to the participating individuals, which includes:

- Reason for discharge;
- Summary of services provided;
- Summary of progress client made towards achievement of goals;
- Client or family strengths and abilities;
- Recommendations for any future services (includes individuals preference to enhance service experience) or unmet needs;
- If additional services are requested a transition plan will be clearly identified on this document;
- Date of admission and discharge as well as presenting issues at intake and status of client at last contact;
- At discharge the staff person will work with the client to document outcomes achieved while in the program. The client will also be asked to complete the SSICS satisfaction survey.

Unplanned Transition/Discharge

When a client unexpectedly leaves or is discharged from service, SSICS will attempt to contact the client within a week of being made aware of this. The worker will seek clarification on whether the service is required, offer to refer to other services, inform the client of the re-admission process (if applicable), and notify those involved in planning for the client. This will be done via phone call whenever possible.

Managers will review client files on a quarterly basis to ensure transitional planning and discharge planning is an ongoing consideration in case planning with clients. Conversations with the client and their family, as applicable, should be reflected in case notes. Managers sign off on all discharged files to ensure planning is appropriate to service needs.

Referrals to other Services

Referrals to other agencies can happen at many different intervals of service. For example, when a different service is more appropriate, and during service when other needs are identified and can be met by another service, or at discharge.

The worker will make a referral to another service with the permission from the person being served. The worker will help to increase access or reduce barriers to clients accessing these services. This may include transporting the client and being present during the first or subsequent sessions.

Exiting and Re-Admission Criteria

Whenever a client refuses services, or demonstrates an inability or unwillingness to follow program expectations, staff will explore with the client the impediments to their participation. They should try to establish whether there are any valid difficulties, reasons, or concerns that may have resulted in their non-participation. This may include a review of the client's right and responsibilities to help bring clarity to the situation.

If after this review the client is still unable or unwilling to participate, program staff should consult with a supervisor and/or the referral source (as appropriate). Based on the consultation, a course of action will be recommended, which may include termination or discharge from the program.

Subsequent admission to this or any other program will occur based on the program referral and admission procedures.

Client Information and Case Notes

With appropriate consent, all client contact will be entered in to the ETO database.

1. Staff will strive on a daily basis to enter client information into the ETO database. If the staff person is unable to enter the information daily, they will do so by the end of the week.
2. Staff will enter on a daily basis into the database:
   - External referrals to support services;
   - Housing record created each time a client is housed;
   - Six month housing follow-ups that have been completed by SSICS staff
   - Rental supplement usage;
   - New case plans that have been accepted or declined.

Case notes entered in the ETO database will record the delivery of services provided to the client and ongoing interactions between the worker, the client and other stakeholders.

Case notes will reflect the progress of the service and goals, and any significant events or changes in the client. Case notes are recorded within 24 hours of the session and entered into the ETO database.

If an ETO database file has not been opened, case notes will be handwritten, legible, dated and signed by the writer.

For guidelines for case note recording refer to *SSICS Clinical Policies and Procedures*

Medication

If a client is taking prescription or alternative medicine, it's important for us to educate ourselves about the medication in order to be able to provide the best possible service. For example, many medications can cause mood changes and if your client is unaware of that, they may misattribute the cause of what they are feeling to some other internal or external factor. Your program manager can suggest a pharmacist or other reliable source of information to learn more about a particular medication. Any medication your client is taking and your steps to educate yourself about the medication should be documented in case notes.

Things to be educated about may include:

- How the medication works;
- The risks associated with each medicine;
- The intended benefits, as related to the behaviour or symptom targeted by this medication;
- Side effects;
- Contraindications;
- Any complications associated with diet/exercise;
- Risks associated with pregnancy;
- The importance of taking medications as prescribed, including the identification of potential obstacles to adherence;
- The need for laboratory monitoring;
- The rationale for each medication;
- Early signs of relapse related to medication efficacy;
- Signs of non-adherence to mediation prescriptions;
- Potential drug reactions when combining prescription and non-prescription medications, including alcohol, tobacco, caffeine, illegal drugs, and alternative medications;
- Instructions on self-administration;
- Wellness management and recovery planning;
- The availability of financial supports and resources to assist clients with the costs of medications (for example Plan G available through CYMH or Adult Mental Health.

Service of Homeless Children under 19 years of age

The intent is to ensure timely and appropriate service to youth who present as being homeless or at risk of homelessness.

Due to safety concerns and the fact that at-risk children fall under the jurisdiction of the MCFD, the HPP, SIL and general housing first services will not normally provide services to children under the age of 19. Efforts will be made to connect the youth directly to the Youth Outreach and Housing Support Worker.

The SSICS Youth Outreach Worker is funded through MCFD to provide services to youth who are struggling or unable to live at home for various reasons. The Worker collaborates closely with MCFD and the Ministry of Social Development & Social Innovation, to secure funding and housing for the youth. The Worker provides case management services to help the youth develop needed skills to live independently.

If a youth under the age of 19 presents at the SSICS office to see the Homeless Outreach Worker, they will be directed to see the Youth Outreach Worker or Navigator for assessment and support.

If a youth under the age of 19 connects with a Housing First Worker outside the SSICS office, the Worker will assist in making the connection to the Youth Worker. If the youth is not willing to see the Youth Worker, the Housing First Worker will inform MCFD (Children's Help Line at 310-1234) or MCFD duty worker that the child is homeless and request instructions on how to proceed.

The Housing First Program may provide services if requested by MCFD until MCFD is able to make other arrangements, but only if the worker can arrange a private sleeping space for the child. The youth service component of the Housing First Program will support youth to maintain their housing situation as they transition out of care and into the adult system.

Critical Incidents

Prevention of Critical Incidents

SSICS staff are expected to work with clients, their families, and other professionals to prevent critical incidents. Activities include an approach to service provision that

- Reflects safe, proactive and positive principles of practice
- Reflects a range of options aimed at supporting people
- Minimizes risk and respects the choices of people with disabilities
- Provides procedures to monitor and adjust options according to the needs of the individual and the environment.

Reporting Critical Incidents

SSICS will, as soon as is reasonably possible, provide funders (BC Housing, Island Health and MCFD) with details on all incidents significant enough to threaten the continuous operation of the services or that may attract public or media scrutiny, such as all outbreaks of infectious diseases and the death of clients and staff on site.

The Program Manager will notify funders when appropriate, including BC Housing, Island Health and MCFD before making any changes that could change the ability of SSICS to fulfill its obligations or any material changes to services levels.

For complete information regarding then reporting of critical incidents refer to SSICS Health and Safety policies and procedures.

Program Review and Improvement

Elements that will be considered when evaluating the program include:

- Client outcome measurement on ETO database;
- Client Satisfaction Surveys;
- Six month housing question follow up;
- Staff satisfaction;
- Annual program review that will look at trends including barriers to clients achieving goals. In particular, barriers to gaining employment and the community's perceptions about our clients that contribute to barriers will be assessed.

Ways to measure the anticipated outcomes will be developed and implemented during the first year the program is operational. In June of each year, we will review outcomes of the previous year with program staff. Based on this data and other relevant information (economy, change in staff, etc.) we will identify strengths and make recommendations for the program. At this time we will identify a program goal for the current year, determine how we will know if we are meeting it, and collect the needed data.

Opportunities exist for peer consultation and supervisory consultation/supervision on an as-needed basis through your Program Manager and the SSICS Clinical Consultant.

Refer to SSICS File Review policies

Feedback and Outcome Survey

During service you are encouraged to ask the client for their feedback on the service they are receiving. This feedback assists you to know what is working for the client and to follow-up in this area. As well, feedback about what is not working helps us to adjust our service in order to meet the needs of the client.

During the exit interview, please invite the client to complete the program specific feedback survey. Information provided through the survey is summarized and included in the SSICS Performance Improvement Plan.

For clients receiving a supplement, it is a BC Housing requirement that clients are contacted at 6 months and document if they are still housed and their current situation. This is to be recorded in the HSS database.

Appendix 1

SALT SPRING ISLAND HOUSING FIRST
HOUSING SUPPORTS ADVISORY COMMITTEE

PURPOSE:
Cross organizational committee to ensure the access to supported housing resources are coordinated, equitable and efficient.
Supported housing resources currently include:

a) Supported Independent Living (SIL) rent supplements funded through Islands Health
b) Homeless Prevention rent supplements and supports funded through BC Housing

Other supported housing resources may be added to this list in the future.

MEMBERSHIP:

a) Salt Spring and Southern Gulf Islands Community Services Society (SSICS)
b) Island Health Mental Health and Substance Abuse Services
c) Island Women Against Violence (IWAV)

Other organizations that provide community housing or housing supports may be added in the future.

ACTIVITIES:

- Meet regularly to review new referrals and assign resources to ensure resources are being applied to those in greatest need.
- Review overall assignment of resources and budget to new and existing clients to ensure funding is spent fully and effectively each fiscal year.
- Identify other housing and housing support issues and concerns that may be communicated to the respective management of each participating organization.

OTHER:

- The work of the committee, including terms of reference, will be reviewed annually to ensure it is relevant, effective and efficient.
- The responsibility for convening and chairing meetings will be with SSICS as part of it's role in initiating a Housing First Strategy for the community.

November 2015

SALT SPRING AND SOUTHERN GULF ISLANDS COMMUNITY SERVICES SOCIETY
LOGIC MODEL: HOUSING FIRST PROGRAM

INPUTS	*ACTIVITIES*	*OUTPUTS*	*SHORT-TERM OUTCOMES*	*LONG-TERM OUTCOMES*	*INDICATORS OF SUCCESS*	*MEASUREMENT METHOD*
• Housing Outreach Workers • Rent subsidies • Administrative Support • Van and travel funds • Staff Training • Office and Drop In Space • Computers and Telephone • Funds for Direct Client Costs, Supports and Emergencies	• Assessment & Goal Planning • Conflict Resolution & Mediation • Information & Education • Case Management • Provision of supplies for basic health and safety • Provision of rent subsidies • Connection with shelter and housing • Referral & Advocacy	# of individuals served # of landlords and housing units identified # of connections to support services made	• Increase feeling of well-being and stability • Increase problem solving and life skills • Improved tenancy skills • Increase ability to identify goals and steps to address basic needs • Basic needs including food and clothing secured • Connection with health care • Safe housing /shelter secured • Increase access and connection to helping services and supports	• Increase in supportive relationships and helping resources • Improve skills that enable the person to be successful living in the community • Stable housing maintained	*Short term:* • Individuals report increased well-being and stability • Individuals report increased problem solving and life skills • Individuals report increased ability to identify needs, goals and plans • Individual and workers report improved health, housing and meeting of basic needs *Long term:* • Individuals report increased supportive relationships • Individuals report improved ability to function in the community • Individuals report leading healthy and stable lives • Individuals maintain stable housing	*Short term:* • Face to Face Interview • Questionnaire/ Survey • Satisfaction Surveys • Worker Observation *Long term:* • Face to Face Interview • Questionnaire/ Survey • Worker Observation • Case File Review

Appendix 3

Intake Form

Date dd / mm / yyyy

Client Name _____ Worker Name _____

Date of Birth dd / mm / yyyy Gender _____

Phone ___-___-_____ Phone2 ___-___-_____

Email _____

Best way to contact _____

Address : Street _____

City _____ Province _____

Postal _____-_____

Emergency Contact Name _____ Phone _____

Personal Health # _____

Income Source _____ Approximate Monthly Income _____

Income Source _____ Approximate Monthly Income _____

Monthly Rent _____ Utilities _____ Landlord Name_____

Landlord Contact _____ Tenancy Start Date dd / mm / yyyy

HPP client ☐ Yes ☐ No

Please check all that apply

☐ Aboriginal Descent ☐ Youth at risk ☐ Leaving Correctional System

☐ Leaving Mental Health Care System ☐ Women Leaving Violence

Housing First Client ☐ Yes ☐ No

Supportive Independent Living (SIL) Client ☐ Yes ☐ No

If Yes, please fill out additional SIL forms

Appendix 3

Homeless Status (see definitions below)

☐ Absolute Homeless ☐ Emergency Shelter / Transition ☐ Provisionally Accommodated
☐ At Risk of Homelessness

Referred Client ☐ Yes ☐ No If Yes, who _____

Other Community Supports ☐ Yes ☐ No If Yes, please list supports _____

_____

_____

_____

Homelessness describes a range of housing and shelter circumstances, with people being without any shelter at one end, and being insecurely housed at the other. That is, homelessness encompasses a range of physical living situations, organized here in a typology that includes:

1) Unsheltered, or absolutely homeless and living on the streets or in places not intended for human habitation;

2) Emergency Sheltered, including those staying in overnight shelters for people who are homeless, as well as shelters for those impacted by family violence;

3) Provisionally Accommodated, referring to those whose accommodation is temporary or lacks security of tenure, and finally,

4) At Risk of Homelessness, referring to people who are not homeless, but whose current economic and/or housing situation is precarious or does not meet public health and safety standards.

It should be noted that for many people homelessness is not a static state but rather a fluid experience, where one's shelter circumstances and options may shift and change quite dramatically and with frequency.

Canadian Observatory on Homelessness