Section 2

Program Area

INDEX

Counselling and Support

SSICS offers counsel and supportive assistance to residents of Salt Spring Island and the Outer Gulf Islands. All individuals, families and youth can access counsel and support from qualified practitioners in a variety of 'in house' and outreach settings. Services involve a formal intake process for each candidate to determine which practitioner is best suited to meet the needs of the new candidate.

SSICS counsellors provide both counsel and supportive services to the people they serve. Persons served are encouraged and assisted in the process of identifying obstacles and issues affecting them, and in the co-exploration of a means of resolving these. Consequently, services may involve harm reduction education and skill building, support in understanding and bettering peer, family, and personal relationships, assistance in accessing both intra and extra community services, assistance in developing and implementing employment and educational plans, assistance in overcoming personal, socio political obstacles and challenges, and assistance in determining and meeting both long and short term range goals.

SSICS counsellors strive to practice in a manner that ensures the best interest of the program participant. As a result, services are person centered and person driven. Furthermore, persons served are treated with dignity and are supported in a manner that does not impose on their rights or ability to direct their own outcomes.

Orientation for Program Participant

Each program participant will be provided with an orientation that is appropriate to his/her needs, the type of services to be provided at a level that is understandable to him/her.

The orientation package will include:

1. Description of agency's ability to serve the individual (history).
2. Rights and responsibilities of the child/youth served.
3. Grievances and appeal procedures
4. Ways in which input is given regarding the quality of care, achievement of outcomes and satisfaction of the child/youth served.
5. A description of the agency's services and activities.
6. The Agency's expectations.
7. Hours of operation.
8. How to access after hour services.
9. Code of ethics.
10. Confidentiality policy.
11. Information on emergency exits, fire suppression equipment and first aid kits.
12. An organizational chart to identify staff, their qualifications and who is responsible for program coordination.
13. A description of the purpose and process of the assessment.
14. A description of how the individual plan will be developed and the need for the person to be involved in the planning process.
15. Transition and referral procedures.
16. The agency presents information in line with its ethical practices, which directly relates to its divulgence of potential conflict of interest (reporting abuse).
17. Identifies the person responsible for service coordination.
18. Requirements for follow-up for the mandated child/youth or family served regardless of discharge outcome.
19. Information that may be used for research or reporting to funders.
20. Program policies regarding the use of restraints.
21. Smoking policy.
22. Illicit or licit drug use while receiving service.
23. Weapons brought into the program.

Individual-Centered Planning Process

The individual service plan contains goals and objectives based on the strengths, needs, abilities and preferences of the program participant. It also identifies the challenges and problems that may interfere with achieving plan goals. From intake to discharge, each person is encouraged to be actively involved in and have a significant role in determining the direction of his/her plan. The individual plan may contain pre-determined goal and objectives that the program participant must meet as part of the program and/or mandated service provisions.

1. Goals reflect the informed choice of the program participant and/or parent/guardian and are expressed in the words of the program participant.
2. Objectives reflect the expectations of the client and the treatment team and are measurable, achievable and time specific. Services provided by the program are specific and identify the frequency and type of treatment used.
3. When appropriate, the individual plan will attempt to integrate the program participant into the local community, the family, natural supports and other needed services.
4. The individual plan identifies needs beyond the scope of the program. It specifies referrals for additional services.
5. The individual plan is communicated to the individual in a manner that is understandable.
6. The program participant receives a copy of the individual plan.
7. The individual plan is reflective of the age and culture of the program participant.
8. The individual plan identifies information, or conditions for transition to other services.
9. When applicable legal requirements are identified.
10. The individual plan will be reviewed periodically with the program participant and modified when needed.
11. When the program participant has co-occurring disorders and/or disabilities:
    i. The individual plan specifically addresses the issues in an integrated manner.
    ii. Services are provided by personnel who are qualified.
12. When the person to be served is medically fragile:
    i. The individual plan specifically addresses how services will be provided in a manner that ensures the safety of the individual.
    ii. Services are provided by qualifies health care providers

Records of Program Participant

The individual record of each program participant is maintained in such a manner as to protect confidentiality. The individual record is organized, clear, current and legible. The main record is complete. It is the central record that contains information regarding all the services the persons receives. All documents generated by the agency that require signatures include original signatures.

The individual record includes:

1. The date the case was opened.
2. Information about the individual's parents, guardian or representative including their name, address and telephone number.
3. Information about the person to contact in case of an emergency including the name, address and telephone number.
4. The name of the person currently coordinating the services of the program participant.
5. The location of any other records.
6. Information about the individual's primary care physician including the name, address and telephone number.
7. As applicable, the persons:
    i. Health history and current status.
    ii. Current medications.
    iii. Preadmission screening, when conducted.
    iv. Documentation of orientation.
    v. Assessments.
    vi. Individual plans, including reviews.
    vii. Transition plan, when applicable.
8. Upon discharge, a summary that:
    i. Includes the date of admission.
    ii. Identifies the presenting condition.
    iii. Describes the extent to which established goals and objectives were achieved.
    iv. Describes the services provided.
    v. Describes the reason for discharge.
    vi. Identifies the status of the person at discharge.
    vii. Lists recommendations for services or support.
    viii. Includes the date of discharge from the program.
9. Correspondence pertinent to the program participant.
10. Authorization for release of information.
11. Documentation of internal or external referrals.

12. When duplicate information or reports from the main record of a program participant exist or if working files are maintained such materials:
    i. Are not substituted for the main record.
    ii. Are considered secondary documents, with the main record of the program participant receiving first priority.

Progress Notes

All documentation will be signed and dated (day, month, year) by the each individual making an entry into the record.

Individual files contain signed and dated progress notes that document:

1. Progress towards achievement of identified goals and objectives identified in the individual plan.
2. Completion of portions of the individual plan.
3. Significant events or changes in the life of the program participant.
4. The delivery of services that support the individual service plan.

Records Management

All records of persons served shall be organized and stored in a manner that ensures systematic, safe and confidential storage. Access is limited to appropriate persons.

1. All records will be organized in a systematic manner and clearly labeled.
2. All records of persons served will be kept in locking file cabinets in the central file room on the second floor when not in use.
3. Records of persons served may only be removed from the SSICS Society office with authorization from the Program Manager.
4. Inactive files and records will be stored in file cabinets as tightly bunched as possible to decrease potential fire damage.
5. No files or case notes will be stored electronically.
6. To safeguard against destruction of pertinent computer discs in the event of a fire or natural disaster, relevant discs pertaining to

financial management information, policies and procedures, and original forms will be placed in fire proof storage or stored off site.

Access to Records by Program Participant

Files of person's served including intake information, assessments, treatment plans, running records and discharge plans, are available to for their perusal.

We are bound to the policy and procedures of access to client files under the Freedom of Information and Protection of Privacy Act (FOIPP). Thus, the following procedures must be complied with when releasing files of person's served.

1. People who wish to see their files should make a request to the Privacy Officer. A Request to Access Personal File form must be completed.
2. The formal written request will then be forwarded to the Central Information and Privacy Branch Office in Victoria, B. C., as soon as it is received.
3. When the file is released to the program participant, the following means may be used:

a. May be viewed in the agency

b. Picked up in person

4. The Privacy Officer can further review and explain the Freedom of Information and Protection of Privacy Act and access to personal files, at the request of the program participant.

Outcome Management System

Program Participant - Outcome Management:

As indicated in the orientation brief, the people we serve are clearly informed about both the process and the benefits of measuring personal achievement outcomes as a part of service success and development. Outcome measure forms are utilized at intake or within the first month of service delivery to measure and record a client's state of wellbeing in key areas of their life. These areas may include the following:

1) Physical health
2) Emotional health
3) Employment
4) Housing
5) Social wellbeing
6) Legal, criminal involvement
7) Access to the service

The program participant, in partnership with the counsellor, will evaluate themselves in the above areas and record their results using a self rating scale. Notably, they will be responding to questions on an outcome form designed specifically for their given service. This process will repeat itself again at a given point of time during treatment and then again at the end of the service. There will be one final self rating recorded during a post service check in performed after the person has completed service. Please note that all four of the ratings are listed on the same form so they can easily be evaluated and reviewed by the service provider and the client. Once the form is completed and the results evaluated, the form is removed from the persons file and given to the program manager for final review. Wherever, necessary, a program manager will discuss outcome concerns and successes with the counsellor.

Program - Outcome Management:

Salt spring Island Community Services strives to meet the need of the program participant and the community by establishing in its financial planning, program management, and program review and development high standards and a sound strategy that aims to increase the likelihood that in each service area or program, there is the opportunity for successful outcomes for the people we support.

Annual reviews by individual counsellors include a section on their feedback regarding program development. Annual reports are reviewed by program managers and then brought to leadership.

Transition/Discharge Planning

Salt Spring Island Community Services assists the program participant to obtain services needed but that are not available within the agency. Transition activities are critical for the support of the individual's ongoing recovery and well-being. When clinically indicated a transition plan is developed with the program participant at the earliest possible point in the individual planning and service delivery process. It may include referral to outside the agency, transition to other services and/or discharge. A written transition plan is prepared to ensure continuity of service. The plan is developed with the input and participation of the program participant, their family when applicable, their legally authorized representative when appropriate, agency personnel and the referral source when appropriate. Individuals who participate in the development of the transition plan receive copies of the plan when permitted.

1. The transition plan identifies the person's current:
    i. Progress in his/her own move toward well-being.
    ii. Gains achieved during program participation.
    iii. Strengths.
    iv. Needs.
    v. Abilities.
    vi. Preferences.
    vii. Goals
    viii. The person's need for support.

2. The transition plan includes:
    i. Information on the person's medication(s), when applicable.
    ii. Referral source information such as contact name, telephone number, location, hours and days of service.
    iii. Communication of information on options available if symptoms recur or additional services are needed.
    iv. Educational status and goals.
    v. When applicable, employment preparation and planning.
    vi. A housing plan for youths making the transition to independence.

3 .Follow-up for each program participant includes input from resource individuals in his/her home, school and community.

4. When a child or youth moves to a school or other community service, information is provided to the family about the new service.

5. When the transition plan indicates the need for additional services or is unplanned, a staff is identified who will be responsible for follow-up after transition/discharge to:

i. Maintain the continuity and coordination of needed services.
ii. Determine with the program participant whether further services are needed.
iii. Offer or refer to needed services when possible.